HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) INTEROPERABILITY STANDARDS WORKGROUP MEETING
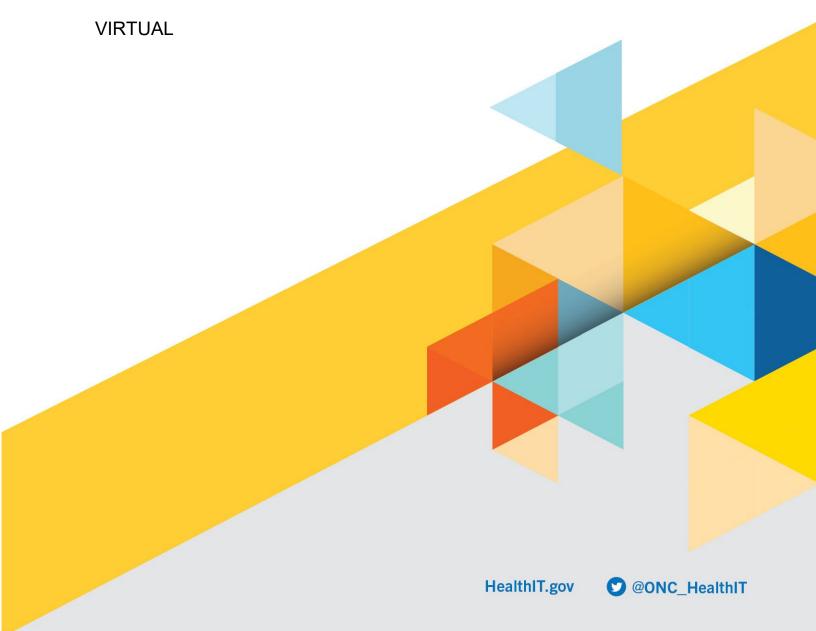
January 25, 2022, 10:30 a.m. – 12:00 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Steven Lane	**Sutter Health**	**Co-Chair**
Arien Malec	**Change Healthcare**	**Co-Chair**
Kelly Aldrich	Vanderbilt University School of Nursing	Member
Hans Buitendijk	Cerner	Member
Thomas Cantilina	Department of Defense	Member
Christina Caraballo	HIMSS	Member
Grace Cordovano	Enlightening Results	Member
Steven Eichner	Texas Department of State Health Services	Member
Rajesh Godavarthi	MCG Health, part of the Hearst Health network	Member
Adi Gundlapalli	Centers for Disease Control and Prevention	Member
Jim Jirjis	HCA Healthcare	Member
Kensaku Kawamoto	University of Utah Health	Member
Leslie Lenert	Medical University of South Carolina	Member
Hung S. Luu	Children's Health	Member
David McCallie	Individual	Member
Clem McDonald	National Library of Medicine	Member
Aaron Miri	Baptist Health	Member
Mark Savage	Savage & Savage LLC	Member
Michelle Schreiber	Centers for Medicare and Medicaid Services	Member
Abby Sears	OCHIN	Member
Ram Sriram	National Institute of Standards and Technology	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Al Taylor	Office of the National Coordinator for Health Information Technology	ONC Staff Lead
Denise Joseph	Office of the National Coordinator for Health Information Technology	ONC Staff Lead

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

<u>Michael Berry</u>
And, hello, everyone, and thank you for joining the kickoff of the Interoperability Standards Workgroup. I am Mike Berry, I work for ONC, and we are pleased that you could be with us today. We would like to thank our cochairs, Steven Lane and Arien Malec, for serving as cochairs of this workgroup, and to all the workgroup members for lending their time and expertise. As a reminder, your feedback is always welcome, so it should be typed in the chat feature to everyone throughout the meeting, or it can be made verbally during the public comment period that is scheduled at approximately 11:55 Eastern Time this morning. So, let's get started with our meeting. I will now call the meeting to order and begin roll call of our workgroup members, so when I call your name, please indicate that you are present. Let's start with our cochairs. Steven Lane?

<u>Steven Lane</u>
Good morning, I am here.

<u>Michael Berry</u>
Arien Malec?

<u>Arien Malec</u>
Good morning.

<u>Michael Berry</u>
Kelly Aldrich?

<u>Kelly Aldrich</u>
Good morning, everyone.

<u>Michael Berry</u>
Hans Buitendijk?

<u>Hans Buitendijk</u>
Good morning.

<u>Michael Berry</u>
Thomas Cantilina? Christina Caraballo?

<u>Christina Caraballo</u>
Good morning.

<u>Michael Berry</u>
Grace Cordovano?

<u>Grace Cordovano</u>
Good morning.

Michael Berry
Steve Eichner?

Steven Eichner
Good morning.

Michael Berry
Adi Gundlapalli?

Adi Gundlapalli
Good morning.

Michael Berry
Raj Godavarthi?

Rajesh Godavarthi
Hey, good morning.

Michael Berry
Jim Jirjis?

Jim Jirjis
Good morning.

Michael Berry
Ken Kawamoto? Leslie Lenert? Hung Luu?

Hung Luu
Morning.

Michael Berry
David McCallie?

David McCallie
Good morning.

Michael Berry
Clem McDonald?

Clem McDonald
Good morning.

Michael Berry
Aaron Miri?

Aaron Miri
Good morning.

Michael Berry
Mark Savage?

Mark Savage
Morning.

Michael Berry
Michelle Schreiber? Abby Sears?

Abby Sears
Good morning.

Michael Berry
And, Ram Sriram?

Ram Sriram
Good morning.

Michael Berry
Good morning, everyone, and thank you. Now, please join me in welcoming Steven and Arien for their opening remarks.

Arien Malec
I did not prepare any opening remarks.

Steven Lane
Thank you all for joining us. Do you want to start, Arien? Go ahead.

Arien Malec
No, no. I was like, "Eh? Opening remarks?" Go for it, Steve.

Steven Lane
Well, I just want to welcome everybody to our new workgroup. This is very exciting to be with you all this morning and to start in on this important work under the auspices of the ONC. Many of you have been with us through prior task forces that have focused on a similar scope of work. We are combining the USCDI Taskforce and the Interoperability Standards Priorities Taskforce. There were two different task forces that we have been running parallel for the past few years that are now being combined into this workgroup, so I think we have had our status in the FACA hierarchy somewhat elevated. We have a larger group with, as I say, a number of you who have been with us before and a number of new participants who are really excited to dig in with all of you, and we have a pretty quick timeline to turn around a lot of deliverables, so

there will be a fair bit of homework and out-of-band work that we will all be engaged in and looking forward to all of that too.

Arien Malec

As Steven said, we are combining these charges because it just made sense. We interoperate via standards the data that is collected and normalized under the USCDI, so it really does make sense for these two formerly separate workgroups to combine charges and really set a floor for the nation in terms of data and exchange. Shall we go to introductions?

Workgroup Introductions (00:04:01)

Steven Lane

Yeah, I think that makes sense. We are going to redisplay the roster here, and we are just going to go down the roster and let people introduce themselves. Since I am at the top, I will go right ahead. I am a practicing primary care physician and clinical informaticist at Sutter Health. My informatics focus has very much been on interoperability for the past 15 years, and like many of you, I have the chance to sit on the HITAC. I also serve currently as the chair of the Sequoia Project, the chair of the Care Quality Steering Committee, and work on a number of other national and regional initiatives to support interoperability, so I live and breathe this stuff.

Arien Malec

Cool. Arien Malec. I lead up our R&D teams at Change Healthcare that support our large-scale information exchanges, including the clearinghouses, our clinical exchanges, including CommonWell, as well as pharmacy adjudication. I have had a number of years in life sciences and healthcare, starting out first in clinical trials and then using informatics to advance oncology trials, and then had a big, long run-on patient engagement, interoperability, information exchange that has never really ended, and may it not end. So, this is the latest incarnation of that work. Let's turn it over to Kelly.

Kelly Aldrich

Hello, everyone. Thanks for having me. I am an informatics work specialist. I work at Vanderbilt as the Associate Professor and Director of Innovation in informatics, as well as the Chief Clinical Officer at the Center for Medical Interoperability. I have been there for a number of years, where we have been working on how to seamlessly exchange from a platform medical device information with the test certification lab. Prior to that, I was with HCA as the CNIO, working mostly in medical device interoperability. I think this is my fourth or fifth ONC committee that I have been on, but I am new to this group, so I am really glad to join the group, so, thanks for having me.

Arien Malec

Hans is having some technical difficulties, so we will come back to him when he figures out how to connect his audio. Thomas, are you on? All right, Christina?

Christina Caraballo

Hey, everyone. I am Christina Caraballo. I am the Senior Director of Informatics at HIMSS. Part of my portfolio is to have strategic oversight of things such as the interoperability showcase, our immunization integration program, and our interoperability and health information exchange community, which includes groups in social determinants of health and information exchange in general. I have also been a past

member of the HITAC, and was cochair of USCDI Taskforce a couple of years ago, so I am very excited to be back and continue this work. Thank you for having me.

Arien Malec
Fantastic. Thank you, Christina. Hans is back. Hans, go ahead. All right, Hans is not back. Grace?

Steven Lane
We had hoped.

Grace Cordovano
Good morning, everyone. I am Grace Cordovano. I am a board-certified patient advocate specializing in the oncology space. My day-to-day is working with patients and their families from point of diagnosis through survivorship or end-of-life care planning. Much of the work that I do is rooted in access to medical records and seamless actionable interoperable access. I previously had the opportunity to work with the USCDI Taskforce last session. I also am on the HIMSS Public Policy Committee, I help with the HL7 Patient Empowerment Group, and recently started working on including the patient perspective in the Protecting Privacy to Promote Interoperability, so I am really looking forward to working with all of you on draft V.3.

Steven Lane
Thank you, Grace. Hans is in, I think.

Hans Buitendijk
Can you hear me now?

Steven Lane
Yes.

Hans Buitendijk
All right, I finally got it to work. Sorry about that. Hans Buitendijk. I am Director for Interoperability Strategy with Cerner, focusing on our interactions and engagement with the industry, working together there. I have been active for a number of years, which sometimes feels like decades, in interoperability, initially focused on standards development, but still very active in HL7 to develop standards. I have been in various leadership roles there as well on the organization overall, and over time, I have progressed to participate as CommonWell Care Quality started to emerge. I participate in that currently.

I am on the board of Care Quality and a member of the steering committee. I am active in a couple of different groups in CommonWell. Within HL7, I am active cochair of one of the workgroups, plus a number of other activities around FHIR Management Group, etc. And then, working with the EHRA, collaborating with other EHR vendors, but I am currently the chair of the EHRA, plus the chair of the Standards and Interoperability Workgroup, where we are trying to work together to help progress the interoperability and general EHR/HIT space as well. So, I am looking forward to this discussion. I have been active with USCDI in the last round, and I think it is a great idea that the two aspects, USCDI, etc., plus standards are being looked at together in harmony. So, I am looking forward to working with everybody.

Arien Malec

Thank you, Hans. Steven Eichner? We have a Steven overload.

Steven Eichner
Good morning, and thank you. My name is Steve Eichner. I am the Health IT Lead for the Texas Department of State Health Services. I have been actively engaged in collaborations between public health and the private sector, supporting data exchange, both for registry and patient care information, longtime work in looking at the integration of behavioral health and primary healthcare, as well as work in rare disease research and patient registries, and I am very happy to be here and looking forward very much to advancing interoperability. Thanks much.

Arien Malec
Thank you, Steven. Adi?

Adi Gundlapalli
Yeah, good morning, everyone. Adi Gundlapalli from CDC. I am an informatician and infectious disease physician, Chief Public Health and Informatics Officer at the Center for Surveillance, Epidemiology, and Laboratory Services at CDC. My office provides strategic public health informatics leadership to the agency, supports public health data modernization efforts, and promotes interoperability and use of data standards. And so, I am really honored to be here and part of the group. As you all know, interoperability is what seems to be a never-ending journey, and it would be great to reach some tangible and much-needed milestones, especially for public health. Thank you.

Arien Malec
Indeed. I think we have all learned quite suddenly, and then quite slowly, that interoperability is important over the last couple of years. Rajesh?

Rajesh Godavarthi
Thank you. Hi, my name is Raj from MCG Health, serving as Associate Vice President of Technology and Interoperability. My last 18 years of experience has been around clinical decision support, and primarily in the provider space dealing with clinical decision support. For the last few years, I have been actively engaged with HL7 groups, primarily on the Da Vinci side, dealing with clinical data exchange on various use cases. I have had tons of experience dealing with the prior-authorization-related standards defining, and I am a co-lead in HL7 groups and some of the committees writing the specs, and also a member of the WEDI group, working on the joint data exchange and policies. I am very honored to be a part of this group, and am looking forward to working on the next set of specs on the USCDI.

Arien Malec
Fantastic, Raj. Good times to be working in ePA. Jim Jirjis?

Jim Jirjis
Hi, I am Jim Jirjis. I am a member of HITAC. I have been working for a few years now on several of these task forces. I worked for HCA. We are in 22 different states, 44 or 45 markets, so we get a good sense of some of the variation in how people interpret standards, etc. So, I am very much looking forward to this now combined workgroup.

Arien Malec

Cool, thank you. Ken? No Ken. Les?

Leslie Lenert

Hi, Les Lenert. I am the Assistant Provost for Data Science and Informatics at the Medical University of South Carolina, and I am also a Professor of Internal Medicine there. I am also the Vice President and Chief Medical Officer of Health Sciences South Carolina, which is a statewide health information exchange and research collaborative. At HSSC and at MUSC, I do research in interoperability, particularly focused on FHIR population health applications, and translational informatics, accelerating translation from research results into the healthcare system through informatics.

Arien Malec

Thank you. Hung?

Hung Luu

Hi. I am a hematopathologist and clinical informaticist at UT Southwestern Medical Center, and I currently serve as Director of Clinical Pathology for Children's Health, a pediatric healthcare system in Dallas, Texas. I am also a member of the College of American Pathologists and have been serving as the delegate to the FDA SHIELD Initiative. I was involved in crafting the implementation plan, and some of you might not be aware, but the SHIELD Initiative is to promote laboratory data interoperability, and I am happy to be on this taskforce and look forward to contributing where I can.

Arien Malec

Fantastic. Yes, an earlier incarnation of the ISP Taskforce recommended the FDA, ONC, CDC, and CMS collaborate on lab interoperability starting at the source, so that is fantastic. David?

Steven Lane

David, you are on mute.

David McCallie

You would think I would know how to operate these things by now. David McCallie. I am an individual, but before becoming an individual, I spent a career in informatics at Cerner. I started at Boston Children's, where I got my training, and studied neurology. Then, I joined Cerner and spent almost 30 years there, working on a variety of product development areas, but with most focus on interoperability. I was an original member of the HIT Standards Committee, a cofounder, along with Arien, of CommonWell, and have basically spent a career focused on trying to improve some of these thorny interoperability issues, and I am glad to have a shot at doing some more. I am retired now; I do not actively participate in a financial sense in the industry any longer.

Arien Malec

He keeps trying to get out, and we keep trying to pull him back in. Clem?

Clem McDonald

I am Clem McDonald, and I think I told people about who I was in a previous meeting. I do not need to repeat it. But, right now, I am the Chief Clinical Data Standards Officer at NLM, and we are building tools.

We have a UCUM validator that now is getting half a billion hits a year. We have tools for the questionnaire. We implemented a questionnaire of FHIR which has been downloaded over 100,000 times. And, we are doing a lot of different things in that space, and as others on the committee, like David, I have been at it for a long, long time and am eager to see this stuff work even better, but it has come a long way. In the last couple years, I think we have really made a lot of progress. Thank you.

Arien Malec
Thank you, Clem. Aaron?

Aaron Miri
Good morning. Aaron Miri, the Chief Digital Officer for Baptist Health here in Florida. Did you know today is National Florida Day? This is the day the 27th state joined the Union, so, FYI, factoid. I am the cochair of the HITAC, was a previous member of the Health IT Policy Committee, I serve on the board of CommonWell, I do a whole lot around interoperability. I love this stuff, love where rubber meets the road, and more importantly, how can we effect change for the country, but also, in my day job, how can we help northern Florida and southern Georgia really, truly be interoperable and a better experience for all? I look forward to joining.

Arien Malec
Thank you, Aaron. Mark?

Mark Savage
Good morning. Mark Savage. I was on the USCDI Taskforce, and actually, may taskforces over the past eight to 10 years. I am also the policy lead for the Gravity Project, working on standardized content and exchange for social determinants of health, and a part of USCDI Version 2 at this point. Generally, I am channeling the patient/consumer/community perspective along with other perspectives on the ecosystem, special interests in health equity. Thanks very much.

Arien Malec
Thank you, Mark.

Michelle Schreiber
Hi, good morning to everybody. I am Michelle Schreiber. I am the Deputy Director of the Clinical Standards and Quality Group at the Centers for Medicare and Medicaid Services, and also the director of the Quality Measures and Value-Based Incentives Group. I am a general internal medicine physician by background, having implemented many EMR systems in my day at that time. I have the honor of sitting on the HITAC committee and was part of the USCDI committee before this, and it is my group at CMS, actually, that stewards the Promoting Interoperability Program and that helps work across CMS, actually, on interoperability issues. I am a personal believer in moving us to fully digital quality measures. It has been one of the things we have been driving at CMS, and as such, we are also working across all our federal partners on USCDI Plus for quality measures, and I am delighted to join this group, so, thank you.

Arien Malec

Fantastic, thank you. This has been a passion project for me, the notion that it would be pretty cool if we could take the clinical output of providing care and just get the CQMs for free, as it were, as opposed to doing extra special work. Abby?

Abby Sears

Hi, thank you. I am a member of HITAC. First of all, I am the CEO at OCHIN. We are an organization that does software-as-a-service, specifically with safety net providers across the country. We are probably most well-known for our research division and for the hosting of Epic that we do across the country. We host a single master/patient index of Epic, with almost 200 unique organizations in 28 states, so, just like Jim, we have a unique perspective because we are moving data all across the country in a lot of unique environments.

Our patients are 50% Medicaid and 27% uninsured. A third of them have English as a second language, two thirds of them have a chronic disease, and then, another 60% of that have a significant mental health diagnosis as well. So, we focus on a very comprehensive set of care. I sit on HITAC. We are very interested in helping to move data and thinking about it from an equity standpoint and a more culturally competent approach as well. So, I sit on HITAC. We sit on NQF, we sit on HL7, we are on the Gravity Project, we are one of the five domains for the NIH AIMS Project that just got awarded, we are a CORI data node, and we sit on the Sequoia board as well. Thank you.

Arien Malec

Thank you, Abby. And, Ram?

Ram Sriram

Yeah, this is Ram Sriram. I am at the National Institute of Standards and Technology, and I am a representative of NIST to HITAC. I have been leading the NIST health IT program for several years, and we kind of do two things, the clinical informatics and the bioinformatics. In terms of clinical informatics, we have been working on developing the test methods and tools for certifying EHRs for quite some time, starting with the 2009 HITECH Act, so we are interested in developing tools and techniques for testing interoperability across the enterprise. In addition to that, we also have developed some R&D and deployment of security protocols again for the health IT network.

So, we also do other kinds of things in terms of some fundamental research in how the biological pathways work and what kinds of representations you have, and my specific interest is more in terms of the ontologies and the semantics as aspects of representing information. That is my day job, and my weekend job is to help my wife, who has a small primary care practice, and she has an EHR. Doing interoperability in a small medical practice, using an EHR, which is not very big, is a challenge.

Arien Malec

Thank you, and thanks for combining theory and practice. Well, I can confidently say that if we do not solve interoperability in this workgroup, it is not for lack of talent and expertise. This is a pretty impressive team, and I think our only challenge is going to be finding the areas of focus that we can go make significant progress on. So, Steven, back over to you.

IS WG Charges and Timelines (00:23:56)

<u>Steven Lane</u>

Thank you. I could not agree more. This is an amazing team of folks, both the returning members and the new members. I really want to especially welcome Kelly and Hung, who I think are the only ones who are totally new to this particular effort. I am not sure, Jim, whether you were with us last time, I cannot remember, and Raj as well, but thank you to everybody who is joining this group and contributing your expertise. I also want to give a welcome to the members of the public who are joining us. Thank you all for dialing in and for being interested, and I believe the chat function does allow participation by members of the public. I am not 100% sure, but from our end, we have the opportunity to communicate with everyone, or just our hosts and panelists.

So, let's go ahead and dive in. We are going to talk about our charges and timelines, and if we can go to the next slide, I will just review the charges that we have for our workgroup over our work this year. The overarching charge is to review and provide recommendations on draft USCDI Version 3, as well as the interoperability standards that support interoperability, specifically the ISA. So, specifically, to drill into that, our first charge and our first area of focus will be to evaluate the draft USCDI Version 3 that was recently published, and to provide recommendations back to the HITAC, both regarding new data classes and elements that have been proposed in the draft Version 3, as well as looking at Level 2 data classes that were not included in draft Version 3 if we feel that some of those really would be important to include in the final Version 3 that will be published later this year. And, as you can see, our due date for this is the middle of April, so we have a lot of work to do between now and then on this charge.

Our second charge will be to identify opportunities to update the ONC Interoperability Standards Advisory, or the ISA, as we will call it, to address HITAC priority uses of health IT, including related standards and implementation specification. So, this is important. We are interested not only in the data elements and classes, but also in the supporting data standards and specifications, and we will be diving into that, and what it means to have supporting standards and specifications, and what the criteria are for those to allow items to move forward into either this Version 3 of USCDI or a future version.

So, moving on to the next slide, we are going to drill in a little bit deeper on those specific charges. The first one, again, looking at the draft Version 3, what was included, what was not included, and providing input about that. There are some potential areas of specific focus that ONC called for on the draft Version 3 content. Specifically, are there any improvements needed in the data classes or elements that were included in the draft Version 3? So, ONC has a process, they look at all of the submissions, they level those, which is to say they determine based on their level of maturity and use in the community whether they are comment level, Level 1, or Level 2, and then out of Level 2, those that are felt to be sufficiently mature to advance, they select a subset to include in the draft, and then we will provide feedback as to whether the appropriate subset was selected.

So, the appropriate meaningful and data class and element names and definitions are something that we are going to review. Did they pick the right classes, did they name them appropriately, define them appropriately? Is there anything that needs to be refined there? And then, we have been asked to suggest representative examples of value sets that have been used by health IT developers and implementers to

really fully understand the intent of these data elements, so we are going to want to dig pretty deeply into those.

Then, there is the question of if other data elements that are currently classified as Level 2 but not included in the draft Version 3 should be added or substituted for any of the elements that were included in draft Version 3, and if so, why? So, we are going to need you to think deeply about what was and was not included from Level 2. And then, identifying significant barriers to the development, implementation, or use of any of the draft V.3 data elements that would suggest that perhaps they are really not ready to be included. So, what should be subtracted, what should be added, and drilling down deeply into each of those. That is what we are going to be doing with draft Version 3.

On the next slide, within the publications that the ONC put out last week, there were some specific requests for additional feedback on what was included in draft Version 3. One was related to sex assigned at birth. There has been a lot of work done by a group called the Gender Harmony Project in looking in a deep, detailed way about how to specify gender information. There is a specific question about a data element called recorded sex or gender. We have reached out to the folks from Gender Harmony and asked them if they might be willing to come and give us a presentation about where they have been and their recommendations. Steve Posnack has been very much involved in that, and we are looking forward to digging into that question, the question specifically as to whether we should realign the ONC value set with that that has been proposed by Gender Harmony, which I think is something we should seriously consider.

And then, also, most of you are probably aware of Project US@, which was published fairly recently by ONC, and then, the question of whether that new standard should be incorporated into the USCDI as a standard for documenting the current and previous patient addresses. And: a good reminder here: We say "Project USA," we do not say "Project US at." So, that is the additional information that we have been asked to provide on USCDI, and then, Arien, do you want to talk about the ISA on the next slide?

Arien Malec
If I can get off of mute, absolutely. So, we have a pretty brutal schedule for USCDI, and just as soon as we get our arms around that, we will have a pretty brutal schedule for the ISA, so we would like to make some progress here. We had an early discussion on how to prioritize the ISA charge. There is an almost infinite set of things that we could concentrate on, but we believe that given the recent announcement of the TEFCA, and in particular of the FHIR roadmap, it would be useful to contemplate what a FHIR roadmap might be, to do a standards assessment, and make recommendations in this area. And then, secondarily, look at exchange purposes that were contemplated in CURES but not currently in the TEFCA to be able to provide some air cover and runway, and then, contemplate what potential standards or implementation guidance might be useful for certification.

Generally, when we think about the ISA, as well as in USCDI, your focus is what is the stuff that wants to happen one or two years out where it would be useful to do that paves the way or prepares the way for the world of the future. We made some recommendations in the last incarnation of the ISP on SDOH standards. In particular, we want to take another look at Gravity standards for interoperability, and then, there is a sort of quasi-urgent area here in vocabulary subsets, as I think people are aware. We have an OMB vocabulary that is fairly constrained, and then a CDC vocabulary that is incredibly exhaustive, and it might be useful to look for a subset vocabulary that is slightly more expansive than the OMB vocabulary, but more constrained

than the full CDC vocabulary in order to address social determinants of health, better localize community impact for epidemics, etc.

We have already mentioned the SHIELD Project, but as I said, in earlier incarnations of this workgroup, we made recommendations related to orders and results and looking at all the way back to LIS and IBD, all the way through to bilateral orders and results. So, the axis of information from a clinical order through to analyte and reporting, and then, from there back to the clinician as well as to public health seems like a fertile area for exploration, particularly given the SHIELD Project, and given some of the very public challenges we have had in getting, for example, demographic and contact information for public health reporting.

And then, relating to CDC, potentially data systems certification and ECR standards as potential certification measures for public health reporting. We probably should not call it the CDC, we should probably be calling that public health reporting, but there is a set of standards and certification that likely wants to happen. It would be useful to clarify standards readiness in this space. Do we have one more slide here?

Steven Lane
I think that is it before we hand it over to Al.

Arien Malec
Thank you. So, that is a tentative set of potential topic areas. We certainly are open to workgroup feedback about other priority areas. As usual, although it seems like between now and June is a large amount of time, we will be hard pressed to make significant progress, even in this highly constrained set of areas, so it is definitely open for swapping out items or adding addition priority items, but let's remember that it takes a lot of work to go through each one of these. All right, and with that, we are going to turn it over to Al to talk through USCDI Plus.

Steven Lane
Before we go there, I did want to make a comment. I am very excited, especially, that Hung Luu is here with his experience in the SHIELD Project and lab interoperability. This has been a real challenge for our community over the past multiple iterations of these meetings, and I think that it will be very helpful for us to dig deeply into that area when the time is right, in our second phase, I believe, to see what, if anything, we can do to further unjam those logs that are getting in the way of interoperability of orders and results.

Arien Malec
Absolutely. All right, Al? USCDI V.3.

Al Taylor
Christina had a question. I am going to defer to her for a minute.

Steven Lane
There it is. Thanks, Al. Christina?

Christina Caraballo

Thank you. I was wondering if we were pausing here for discussion on the priorities of the ISA phase, or did we want to table that for later?

Arien Malec
It is a good call. We probably should have some discussion of the overall charge of the workgroup. I do not know that we have time right now to go deep on the ISA charge, and given the timeline, I think we are going to focus first on the USCDI V.3, and then do a longer run at the ISA, but it might be worthwhile at the end of the call to contemplate how we can do some of that long-running work and maybe create a sub-workgroup taskforce that can concentrate on firming out the charge for the ISA portion and making some progress against it. Are there any other questions on the overall charge of the task force, either relating to USCDI and USCDI V.3 or relating to the ISA portion?

Steven Lane
And, Steve, thank you for your comment about engagement in public health certification.

Steven Eichner
My pleasure. Just briefly, looking at broad discussions about what is on the charge for the subcommittee and how we want to address the different topics, whether we want to roll out or can roll out task forces, subcommittees, or whatever probably would be a good idea, if not today, at some point, or just create a roster of who is interested and what based on the information shared today.

Arien Malec
Absolutely, and I think we all know from previous work that trying to get all the work done in the main meetings is a little bit of a futile errand, and so, creating smaller groups that can go make progress offline and then come back and take their work to the full workgroup is a useful approach. Any other questions? David?

David McCallie
Not a question looking back, but looking forward to Al's presentation on USCDI, just to queue up that some of us who have not worked deeply with USCDI, like me, would like to be reminded of the impact of USCDI. In other words, what is the effect of the decisions that we will be debating. I know we will dive right into all the mechanisms of how USCDI works, but what happens when we make something in the USCDI? I would love to get a quick overview of that at some point.

Arien Malec
Got it. Al, maybe we can ask you at the beginning of your presentation to remind us all about the certification or programmatic impact of being or not being in the USCDI.

Al Taylor
Sure.

Steven Lane
And, I think the other seed, Al, to place for your presentation, which we will then let you get on with, is the whole question of USCDI Plus and how that fits into the work that we are going to be doing or how it is separated from it so that we know that up front.

Al Taylor
Okay.

Arien Malec
Well, let's let Al go, and then we will open it up for discussion at the end of Al's presentation, both around USCDI and the larger charge for the task force.

Draft USCDI v3 Overview (00:39:50)

Al Taylor
Great. Thanks, Arien and Steve, and I am glad to be part of this workgroup again. I previously was the technical lead on the USCDI Taskforce over the last two years and continue to serve as the technical lead for USCDI development at ONC and the Office of Technology. Next slide. So, the first couple slides are background, and I can touch on the impact of changes to USCDI as I go through these, but some key features of USCDI is that it is a core set, and generally, it is structured or unstructured data, and the intent is to support patient care and patient access to their data.

It is designed as a consistent baseline, and by that, I mean it is a reliable baseline that people can understand and trust to see where they are starting from, whether that starting point meets all of their data requirements in their particular arenas or not. It is at least a relatively stable baseline. That stable baseline, though, does evolve over time, and it evolves over time using a process that we defined about two years ago as part of the 21st Century CURES Act final rule that we put out in 2020, and so, most of the update process is based on that process that we established. Next slide.

So, the collaborative process that we talked about is based on public input into what ought to be added to USCDI or ought to be changed to USCDI with each subsequent version, which we are publishing now on an annual basis, and plan to do so. That public input is evaluated by ONC based on a set of rules that we have developed, both internally and with feedback from the HITAC and from this group in its previous versions to determine the maturity, the extent of use, and the applicability of data elements that the public feels ought to be collected across all EHRs and exchanged between all EHRs.

So, amongst the data elements that are submitted, and so far, we have had over a thousand data elements submitted for consideration for addition to the USCDI, of those, we have established that a certain set of those are more mature, more broadly applicable to the general health IT and healthcare community. So, those Level 2 data elements are further evaluated, and we determine which of those gets to be in the next version of USCDI, and that prioritization criteria initially, when we published our Version 2 last year… I am sorry, not last year, but we did publish it last year.

So, basically, there is a set of data needs that are generally those data elements that are not already part of the USCDI. I call them gaps, although other people would call them just additional data needs for the broader community. And, we want to add data elements that are not too difficult to specify, which means that it would be relatively easy for developers and implementers and providers to use in their respective settings. Because the USCDI data elements are exchanged using two primary exchange specifications, which are US CORE or FHIR and the C-CDA structure documents, we are also mindful of the burdens of development of those standards, and that has been brought up as because it is necessary to use those

exchange standards to handle USCDI, we want to make sure that we are not causing undue burden on the development of those updated standards.

And then, overall, with each version of USCDI, we want to try to ensure that the overall burden of whatever certain number of data elements that we want to add to USCDI is not an overwhelming amount, and the reason that we want to do that is because we want to promote this incremental adoption of this new set of data elements with each version, and once this new version of USCDI becomes available for updates, those are voluntary changes, so systems can decide if they want to update to, say, Version 2 at some point in the future or Version 3 at some point farther down the road. We feel like these updates are appropriate and important for a broad variety of settings, and so, we want developers to develop these updates, to implement the updates, and to provide those updates to their customers.

And so, we are looking at relatively modest changes to each version of USCDI as opposed to adding a certain number of data elements with each version, and then, some day down the road, when we put these changes into a potential new rule, which could very well happen sometime in the future, once a new rule comes out, those changes are actually going to be required for all systems to be able to update, and so, systems that have been updating incrementally over time or each year with each version will be in a better position to update to the new final rule whenever that comes out in the future, and so, overall, there are a lot of high-quality data elements that could be considered, but we cannot add all of them to serve that need for this modest aggregate interval lift. I am going to stop there for a second and ask Rajesh, who has his hand raised, to say **[inaudible – crosstalk] [00:47:17]**.

Rajesh Godavarthi
So, probably it is a process question. When I looked at the prior position criteria, then looking at the annual report, then we did opportunities and then **[inaudible] [00:47:32]** laboratory section. As an example, exchange of data for transitions of care, and a couple of other things. So, how do these priorities intersect between what we said in the annual report versus how we are defining the priorities in USCDI?

Al Taylor
Are you talking about the HITAC annual report?

Rajesh Godavarthi
Yeah.

Al Taylor
So, the recommendation for priorities, and I do not know if we are talking about the priorities that were set by the HITAC recommendations last year, those priorities were adopted, and they are reflected by the prioritization criteria that were specific to Version 3 that is listed below. And so, almost verbatim, we adopted those new prioritization criteria and applied them to what would become the draft V.3, which I am about to talk about.

Rajesh Godavarthi
Okay.

Steven Lane

And, Al, there is a question in the chat from David, and now three hands up.

Al Taylor

I got it. So, to answer David's question, I guess the first thing to say is that the subsequent versions of USCDI are not a rule. So, Version 2 and Version 3 are new version updates that, at some point in the future, can be voluntarily adopted by health IT developers in providing those updates to their customers. It is not a requirement that any system updates their capabilities to what was published in Version 2 and what will eventually be published in Version 3 later this year. We have a process, called the Standards Version Advancement Process, which is currently considering USCDI Version 2, and if that advancement process identifies USCDI Version 2 as an available standard for updates, this likely will consider the upcoming FHIR US CORE 4.0.1, which adopts those changes in USCDI.

If they both come out in the summer, systems can then voluntarily update their systems to USCDI Version 3, but it is not required in any way that the systems do that update to Version 2, and then, sometime next year, Version 3, not until we come out with the new final rule, like we did that introduced USCDI Version 1. USCDI Version 1 is required of all certified health IT, and then, at the end of December of this year, systems will be required to have certified to the USCDI Version 1, and so, that is the requirement, and nothing else after USCDI Version 1 is yet to be required. It is only voluntary. So, let me go back to Mark's question because I think he was next in line for asking the question.

Mark Savage

Yeah, one more question about the impact of USCDI inclusion. This is Grace's question, but I think Grace speaks for all of us. Can you comment on the overlap or tie between USCDI and information blocking, particularly tying between USCDI V.3, and the work that we contemplate, and its potential impacts on information blocking?

Al Taylor

I can touch on information blocking, and I do not want to say "rabbit hole," but it is a complicated topic. But, as most people know, blocking of information exchange is, under most circumstances, subject to penalties for blocking. There are exceptions to blocking for various reasons, which we will not get into, and the amount of information that, if blocked, would comprise information blocking, is that information that would comprise part of USCDI Version 1? So, there is a lot of data that is out there that could be exchanged that is not part of USCDI Version 1, but at this current time, blocking that information would not be subject to civil penalties, but blocking the content that is in USCDI would be currently. That changes in October, whereby any electronic information that is managed by a system must be exchanged without permitted exceptions. It does not fully explain the information blocking in Version 1, but it is a start.

Now, regarding Version 2 and Version 3, there is no relationship at all between information in Version 2 and Version 3 because none of them require their systems to be updated. After October, the extent of information that is subject to the information-blocking provisions is much broader than Version 1, Version 2, and Version 3 anyhow, so there is not a direct relationship between what is in Version 2 and Version 3 and information blocking.

Steven Lane

Al, I am a little concerned that if we take questions as we go along, we are never going to get through your materials. I appreciate the hands that are up. Is anyone going to blow a gasket if we let Al go ahead for a few slides and get this out on the table? Mark, Clem, you guys are okay for now?

Mark Savage
Yes.

Steven Lane
Great. Go ahead, Al, and we will stack up the questions for after you are done.

Al Taylor
Okay, sounds good. So, in addition to the prioritization criteria that we mentioned before, we also adopted these additional prioritization criteria that were, No. 1, outlined by the recommendations from the USCDI Taskforce to the HITAC, passed along to the national coordinator, and those prioritization criteria were established even before the new administration came in and set guidelines that informed our adoption of these standards.

So, equity, reduction of disparities, reduction of discrimination based on race/ethnicity, plus sexual orientation and gender identity, were all laid out in executive orders that were published on the first day of the administration, but we had already adopted and published these prioritization criteria that addressed inequities and disparities, that addressed the needs of underserved stakeholders, and specifically addressed unique public health reporting investigation and emergency responses. So, all eight of these priorities combined were taken into consideration to look at this list of about 150 different data elements that were considered Level 2, both that were submitted last year and this year for the Version 3 cycle. We considered about 150 data elements for inclusion in Version 3. Next slide, please.

So, this is the summary of what I talked about. We had over 400 submissions that were either recommendations for new data elements or recommendations on data elements that were submitted last year. So, over 400 entries advocating for particular data elements/data classes. There are about 42 submitters, but some submitted just comments on last year's and some for this year's, but we had a significant amount of participation from the community, and quite a few entries for us to consider. Next slide, please.

So, here it is, and I think we have all read about it. We came out last Thursday with the new draft USCDI Version 3, introducing two new data classes and a total of 20 new data elements. The two new data classes are health insurance information and seven data elements around health insurance information, including coverage, and then identifiers related to coverage. There is a new data class called health status, and health status is kind of a merge of several other data classes and data concepts.

As you know, health concerns was its own data class with its own single data element in it, so, to broaden the scope of health status was to recognize that other things besides health concerns were things that could be measured and determine a course of action for clinical care, but were not necessarily a clinical or health concern, but rather, things like functional status, which is really just a determination of status. Disability status is the same, mental function and pregnancy status are all new elements that are not quite health concerns, but are just things that need to be assessed over the course of time.

And, let me just do a quick intro of the icons that we used. We added data elements to draft V.3 for several different reasons. One of them is did it address this concern about equality, disparities, and underserved communities, did it address particular public health concerns, particularly in the face of the pandemic, and those are indicated by the little bug under a magnifying glass, and then, the two that are in gold are things that ONC considered not because necessarily somebody submitted them, although these were submitted, but these are data elements that are already required as part of existing certification, and so, certified health IT is already collecting and, in most cases, exchanging these data, and therefore, there is essentially no lift for developers, implementers, and providers to capture and exchange these data. And so, just to sort of level things up to where we already are in certification, we added several different data elements, and then, other ones were more general, like the laboratory data. These were simply more like gaps in USCDI that had some clinical relevance to it, and so, we added those as well. Next slide, please.

This is an overall view of draft USCDI Version 3, and the little gold stars indicate new data classes or new data elements, and then, as you can see in the health status data class, we rearranged some of the data elements into the health status, including merging the health concern data element and the smoking status data element into the health status data class. It does not change the characteristics of each of these two data elements, it does not affect the applicable standards for each one of them, but it just rearranges them into a more logical collection of data elements in the same concept area. So, the rest of the data elements did not change, although we did add some additional information in the final USCDI draft V.3. Next slide, please.

I discussed a lot of this before. So, these are the data elements that were added in the health insurance information data class, and so, they sort of speak for themselves. So, we added specific definitions to the data elements. We added more definitions to the data elements this time around than we did in the past, and where appropriate, where it was clearly identified that there is a specific set of values that defined those data elements, so, different value sets, we added those to the applicable vocabulary standards category, and what this means for adoption is that developers who want to implement these new data elements can use these value sets as guides to what the capabilities ought to have, what the systems ought to have as far as capabilities go, and most likely, these value sets will be part of the test data for when systems do their updates. They will be tested against the content of these value sets, most likely. That has not been finalized yet, but most likely, our test data for certification or for updates will be based on these value sets. Next slide.

The other one is health status. Like I said, we reclassified health concern and smoking status and added disability status, mental function, functional status, and pregnancy status. There clearly is some overlap between disability status, mental function, and functional status, but we thought that they were specific enough areas that warranted addition that we did split them up into those, but certainly, there is some overlap between especially these three, the disability, mental function, and functional status. Next slide, please. Two new additional data elements under laboratory to specimen science and result status were added, partially reflecting the specific data requirements around in vitro diagnostic testing that have been critically important in the pandemic response. Next slide.

We added several new patient demographics data elements, including date of death, tribal affiliation, and two new concepts of related person name and relationship, and this originally came in as a next-of-kin data

element, but because there are additional relationships of people that are involved with the care of the patient, they could be a custodian, they could be a parent or other caregiver, could be a power of attorney, all of these related person, related by a variety of things, including blood and legal relationship, can be involved in the patient's care, and then, this allows for that formal identification of these related persons.

And, two new data elements under demographics for related occupation. We have been considering adding employment information to USCDI ever since our 2015 rulemaking process, whether we are looking at employment or employment status, and the evolution of the new data model called occupational data for health, which is developed by NIOSH at CDC. This addresses a variety of different data needs and use cases around employment, and in particular, I wanted to point out that occupational data for health also includes military service as an employment status, if you will. And so, we felt like this also addressed the concerns that were raised way back in 2015 for addressing military service and veteran status as well. These two data sets are defined by NIOSH, and they are available on Finbad's website, and again, these value set would be likely to be used for assisting with implementation of these new data elements.

So, let me answer David's question about the value sets because it popped up. The value sets were defined, robustly specified. They are a specific list of terms, and you can look up each of these value sets in their respective locations, but they are all finite lists of terms that are generally carried within a particular standard, and in this case, the ODH standard defines all of the members and the value sets that are listed here, but we are looking for input into whether or not this is the most appropriate or the other value sets that are identified are the most appropriate value sets, and could those value sets be expanded or changed, whether the value set itself could be changed to a different value set, or the value set itself could be expanded. Next slide.

And then, this one was simply added because it is a requirement under certification for certain settings, and the reason for referral is part of the transition to care certification requirement, so, again, systems are generally already capable of managing, capturing, and exchanging reasons for referral, and so, we added it as well, and that is the last data element in draft V.3, the delta. Next slide, please.

Arien Malec
Al, you do have a couple hands up.

Al Taylor
Yeah, those were the same two hands that were up, unless they have come up again. Mark and Clem, is that the case? Do you want to hold your questions to the end?

Mark Savage
I am holding.

Clem McDonald
Yeah, we can hold a little bit. I just want to get a shot.

Al Taylor
We got you. And, as we have done before, we have updated the applicable vocabulary standards. These are the standards that can also be voluntarily updated by systems at any version with each new version to

meet the needs of their customers, and so, as we had done before and as we plan to do when we publish our final USCDI Version 3 in the summer, we will have the applicable vocabulary standards be the most recent update at the time of publication. And so, our intent is to do that again for the USCDI V.3 final. Next slide.

This is a reminder about the timeline, and this touches a little bit on what David McCallie was talking about earlier. So, here we are in the timeline. We are actually now into 2022. It is time to start adding stuff to the right of this. But, we are here in January, we have just published the V.2 draft, and we are in this red and dark blue cycle of having the HITAC and this workgroup look at the content of draft V.3 and make recommendations. We are also looking for public comment in the same subject, the particular elements that we added that were discussed earlier when talking about the charge related to USCDI. So, the HITAC has a little bit less time than the general public does for making comments on draft V.3, but at the end of April begins our internal review process. We are going to look at all the recommendations, look at all the public comments, and decide what of draft V.3 ought to be changed or what is sustained, and then, the plan is to publish that in July of this year.

Once that becomes final, it will eventually be considered for addition to the Standards Version Advancement Process, but we shifted the timeline for the USCDI Version 2 consideration because those exchange standards, the US CORE and the C-CDA exchange standards, took additional time to update, and they are in the process of being validated now or very soon, and because those standards are required to implement USCDI Version 2, we delayed that period for consideration for SVAP until May of this year, at which time we expect to have those other two standards updated as well. And so, hopefully by June of this year, USCDI and those other standards will be part of the SVAP and shortly thereafter become available for update in systems. And so, this whole process repeats itself. USCDI Version 3 will not be considered until next year, when the next version of the implementation guide for FHIR and for C-CDA get updated to reflect the USCI V.3 standards.

Steven Lane
Thank you, Al. Let's go ahead and take Mark and Clem's questions now. There are more that stacked up in the chat. We are also sensitive to time. We have public comment at 55 minutes after the hour.

Clem McDonald
I do not know who is first, Mark or me.

Steven Lane
I think Mark actually had a hand up first.

Clem McDonald
Go ahead.

Mark Savage
I will jump in quickly. Al, this goes back to your discussion about prioritization criteria. You mentioned that exchange is occurring by both FHIR and C-CDA, so, looking for minimal burden, modest, incremental increases. At the end of 2022, we have certification for FHIR APIs before. Does that impending shift on the timeline influence the thinking at all on the incremental approach?

Al Taylor

It does not, because the FHIR API standard will apply to only USCDI Version 1. The API requirements that we are talking about, the deep end criteria, will have to exchange USCDI Version 1 by API.

Arien Malec

I would encourage everybody who is thinking about this and just scratching their head about it to recognize that as a workgroup, we have the opportunity to comment on appropriate policy levers for any future policy actions, including certification, so I would just encourage us to not get too confused by the current mismatch and just contemplate what kinds of policy recommendations we might want to make as recommendations.

Steven Lane

Clem?

Clem McDonald

I have a variety of comments, but maybe I should not deal with them all. The big one is that in last week's Version 3, I think, at least two thirds of the comments were "Do not do too much," low effect, moderate effect. This has been going on for 30 years. I do not know why we are so hesitant when it is not even regulatory. So, that is one question. Why are we so shy? And, just remember that having all these structure standards does nothing for interchange if everybody uses different codes. It does nothing, and we faced that in Indiana. I was so happy when we had HL7. It did not do V.2. Everybody was using it in their hospitals, but when you crossed the hospitals, it was gibberish. So, we have to remember these codes were really important. So, the question is why are we so shy?

Al Taylor

I would not say that we are shy, Clem, but the impact of a new requirement is very widespread and felt by all, and even though these are voluntary updates, if a system volunteers to update, they have to do it in the way that we say, they have to meet the standards that are laid out, and so, we are mindful of the regulatory impact or the impact of making these changes, and we want to take that modest approach so that we can encourage this incremental update. If we were to come out and put all 150 Level 2 data elements into Version 3, I do not think there is anybody out there that would want to take that on until they had to.

Arien Malec

One second, Clem. Just as a reminder to the workgroup, we are the workgroup who is doing the analysis and recommendations back to the full HITAC, and ultimately back to the ONC, so, if there are areas where, as a workgroup, we think that we could have better alignment between policy levers for floor and ceiling, that is certainly within our remit to contemplate recommendations, so, rather than beat Al up right now, maybe we can just start doing some early thinking about what potential policy recommendations we might want to make.

Clem McDonald

I want to take back something that I said because there were two things that showed up, the radiology reports and the clinical reports. That is a nice, big gift to clinicians, so, thank you for that, and that is not teeny, so that is a good one. But, the other question I had was about the interaction between FHIR. I think

you said something about it and USCDI. I thought FHIR already required certain code systems in certain fields, and then, FHIR is required by the federal regs, I thought, so how do they interact?

Al Taylor
The content is at least partially defined by USCDI. The content must include at least USCDI Version 1 in the FHIR criteria. We can go into more detail about it, but it is one means by which USCDI is exchanged, and so, there are some changes to USCDI that, when incorporated into the FHIR standard, would allow for those changes to be collected.

Clem McDonald
Just one more small one. SDOH is now listed under procedures and conditions, I think, but the Prepare survey is probably one of the more powerful approaches. There are also other ones, but there is no way to fit that in as it is now listed, or is there?

Al Taylor
The point of the SDOH assessment, Clem… We can talk about the details of that, but the Prepare is an assessment instrument which would fall under the SDOH assessment data element.

Clem McDonald
All right, thank you.

Steven Lane
Okay, Grace?

Grace Cordovano
I just wanted to ask for clarification. On the slide USCDI version update process on 2022, there is the public comment V.3, it is a navy box, and I just wanted to say that there is confusion that I noted from patient and consumer communities where it asks for public comment, and there are actually two processes, if I understand correctly, the general comments that can be submitted under the USCDI website and then the ONDEC submission part for suggesting new data elements. So, that is not very clear here, so I am wondering if it is worth clarifying that.

Al Taylor
Sure, good point. To the public comment, we are looking for public feedback through the USCDI website, and we did make that clear in our publication of both the USCDI standard document itself, the published PDF, as well as the companion standards bulletin, which we also published last Thursday. So, we specifically say go to the website, make your feedback or comments there. If you want to get started early and submit something for USCDI Version 4, go for it. You can do that now. But, we are looking at comments and feedback directly on the USCDI website.

Steven Lane
So, Steve Eichner, I am going to hold your hand for just a minute here and go to the next slide. We do need to make it to public comment in four minutes. So, we have a lot of work ahead of us. Go to the next slide, please. These are the list of meetings that we have laid out week by week between now and the end of March. We really do need to complete our USCDI comment work by that time so that we can get it finalized

and presented to the HITAC by April 13th. Recall that our recommendations then go to the HITAC, where they are debated, Arien and I will present them, and historically, they have been pretty well accepted at HITAC, but that is sometimes with comment, and then those get transmitted to the national coordinator. So, we have nine meetings to get the first phase of our work done. Arien, you had some ideas for some focus groups. Do you want to mention those?

Arien Malec
Yeah. So, I think we should solicit input from the workgroup for some sub-workgroups that we might want to contemplate for focusing on particular areas. So, in particular, I think there is an obvious area for deep focus on USCDI versus a sub-workgroup that could focus on the charge for the ISA and do a little bit of forward thought there. So, we maybe have people who lean more ISA and people who lean more USCDI. Obviously, no limitations on attending or working on both sub-workgroups, and if there are particular areas of interest, it might be useful to indicate those areas of interest and just communicate via email to ONC staff and Steven and myself, and we will do some work offline and see what we can do to slot people into focused sub-workgroups.

But again, I think at this point, it might be useful for people to start thinking about affiliation relative to deep focus on USCDI, and then, maybe a small sub-workgroup that can do forward-looking work on the charge for the ISA portion of our overall work. And then, if you have particular sub-focus areas, it would be useful to understand those so that we can do some offline work to see if we can slot people with the appropriate sub-workgroups.

Steven Lane
The only adjustment I would make to that, Arien, would be to say that I hope we have pretty much everyone on the workgroup focused deeply on USCDI over these next couple of months as we do this work, but I agree with you that some people have a particular interest in ISA issues that I think could potentially have some meetings during these two months, and then, when we get to ISA as a whole workgroup, some prework might have been done that will make that work more efficient.

Arien Malec
Completely agreed.

Steven Lane
Great. So, there have been some excellent comments coming in through the chat. I would like to just check with the ONC team and Accel. I trust that everything that gets put in the chat directed to everyone is going to be captured and made part of the public record. I would also hope that the chat that was directed to the workgroup members alone would also be captured and made available to workgroup members. Can we count on you guys for that?

Michael Berry
Yeah, and I was going to say if we could just remember for the workgroup, and even for the public, if you change the category when appropriate to "everyone," then those comments are captured with the audio recording that will be posted on healthIT.gov, so if you just look for this particular meeting or any workgroup meeting, the recording will be there with the everyone chat, so I do not believe the host and panelist chats

will show up, so it is important that if you want everyone to see it and be part of the public record that you change the category to "everyone."

Steven Lane
Great, thank you. Let's go to public comment.

Public Comment (01:24:01)

Michael Berry
All right. So, we will have a public comment period for every workgroup meeting. This is really an important step in our process, and so, it is a pretty easy opportunity for the public to make comments, and all you have to do is raise your hand. There is a hand raise feature at the bottom of your screen if you are on Zoom. If you happen to be on the phone only, you would press *9 to raise your hand, and then, once I call upon you, you would press *6 to unmute your phone. So, let's see if there are any public comments in the queue. I do not see any, so I will turn it back to Arien and Steven to continue to the conversation.

Workgroup Work Planning (01:24:49)

Steven Lane
Wonderful. And, for those of you who are new to this, it is often the case that we have no public comments. It is always a little disappointing to me because I know a lot of people are out there listening, so I really do want to encourage members of the public to feel free to comment. We really welcome that input. Let's see. So, we have not gotten to the point today of clarifying exactly what we want you to focus on between now and our next meeting, but what we are going to do is start with our charges, and again, just as a reminder, our very first charge, which is Charge 1A, is to look at the new data classes and elements that were proposed in draft USCDI Version 3, so that is where we are going to start our work.

What we will do is the cochairs will be having a debrief with ONC just after this call, and we will try to put together and clarify a precise assignment for your homework, but you can assume that that is where we are going to start, so, digging into those elements that were proposed in draft V3 and looking to see whether there are opportunities to refine them, to ask questions about them, to specify any appropriate data sets, or value sets, or standards, that is where we are going to be starting our work over this coming week. Arien, did you have anything else to add in closing?

Arien Malec
Yeah, I have some ideas, but we just might want to think about those offline, and then maybe get some more focused workgroups or sub-workgroups contemplated.

Steven Lane
Any comments from workgroup members?

Arien Malec
That fit in two minutes.

Al Taylor
I think it was a good discussion.

Unidentified Speaker

Thank you for the kickoff.

Arien Malec

Thank you. All right, maybe we should give back everybody a couple of minutes, and then, we look forward to meeting with you frequently and often, and as much as you can bear.

Steven Lane

Thank you all for your time and participation. Have a good day.

Arien Malec

Thank you.

Adjourn (01:26:57)