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

March 8, 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)

Michael Berry
And, good morning, everyone, and thank you for joining the Interoperability Standards Workgroup. I am Mike Berry with ONC, and we are always glad that you can join us. As a reminder, your feedback is welcome to be typed in the chat feature throughout the meeting, or it can be made verbally during the public comment period that is scheduled at about 11:55 Eastern Time this morning. I am going to begin roll call with our workgroup members, so when I call your name, please let me know if you are here, and I will start with our cochairs. Steven Lane?

Steven Lane
Good morning.

Michael Berry
Arien Malec? Kelly Aldrich?

Kelly Aldrich
Hi, everyone.

Michael Berry
Hans Buitendijk?

Hans Buitendijk
Good morning.

Michael Berry
Thomas Cantilina or Jeff Ford? Christina Caraballo?

Christina Caraballo
Good morning.

Michael Berry
Grace Cordovano?

Grace Cordovano
Good morning.

Michael Berry
Steve Eichner?

Steven Eichner
Good morning.

Michael Berry
Sanjeev Tandon?

Sanjeev Tandon
Good morning.

Michael Berry
Raj Godavarthi? Jim Jirjis? Ken Kawamoto? Leslie Lenert? Hung Luu?

Hung Luu
Good morning.

Michael Berry
David McCallie?

David McCallie
Good morning.

Michael Berry
Clem McDonald? Aaron Miri? Mark Savage?

Mark Savage
Good morning.

Michael Berry
Michelle Schreiber?

Michelle Schreiber
Good morning.

Michael Berry
Abby Sears?

Abby Sears
Good morning.

Michael Berry
And, Ram Sriram?

Ram Sriram
Good morning.

Michael Berry
Good morning, everyone, and now please join me in welcoming Steven for his opening remarks.

Workgroup Work Plan (00:01:48)

Steven Lane

Thank you. And, Arien is in the process of getting online.

Arien Malec
I am here.

Steven Lane
He is here now! Terrific. Perfect timing. That is great. Well, thank you all, as usual, for your time and attention this morning. We really appreciate everybody logging on, and we are sure we are going to get some more coming on as we go. We are deep in our final run here to finish off our Charge 1 work, looking both at the draft USCDI V.3 as well as other Level 2 data elements that were not included, and trying to put together formal recommendations back to the HITAC. We are hoping to get our work done in the next few weeks in terms of collecting input and going through as much of it as we can. We have had such wonderful engagement with putting recommendations onto the spreadsheet that I truly do not think we are going to get through all of them, so the cochairs and the ONC leads are working together to try to prioritize the suggestions that have been submitted, and we will go through as many of those as possible.

If there are those of you who have put items in the spreadsheet that you feel particularly enthusiastic about and want to assure that we get to, please let us know directly. That would be fine. And again, we are going to try to use our time as wisely and fruitfully as possible. So, that is really our plan at this point. We have had a number of presentations to the group, which have been wonderful and which have led to a number of specific recommendations that have been entered into the spreadsheet, both by workgroup members as well as Al, who has captured some of those for us. We are hoping today to go through a number of those.

First, we are going to invite Hans to enlighten us about all the work that he did mapping the recommended new data classes and elements to the standards in FHIR and CDA. Then, we are going to ask Michelle to talk with us about the CMS recommendations that she has documented. We are then going to come back and look at the name standards that derived from our presentation from the US@ project, as well as the Gender Harmony recommendations that came from that presentation, so we are hoping to get through as much of that today as we possibly can, and then, probably next week, come back to the recommendations that came out of our discussions last week. So, lots to do. Our plan is very much to drive towards solid, completed recommendations, so as we go through these items one by one, while we appreciate diverse conversation and perspectives, we really want to drive to conclusions because the faster we get through each of these, the more of them we will get to and the more we will have an opportunity to impact the final USCDI V.3. Arien, do you want to add to that?

Arien Malec
No, I am good with that, thank you.

Charge 1a – Draft USCDI v3 New Data Classes and Elements & Charge 1b – Level 2/Other Data Classes and Elements Not Included in Draft USCDI v3 (00:05:17)

Steven Lane
All right. And, let's see. Mark sent me a chat. So, we do have a priority column that we have put in the spreadsheet that really, I think the workgroup leads are using to try to flag those things that we want to be

sure to get to. If you guys want to comment on that, feel free to throw it in a comment or send us an email, but ideally, you can leave that priority column to us just as a placeholder. All right. Hans, are you here?

Hans Buitendijk
I am here.

Steven Lane
Wonderful. Excel team, do you guys have Hans's slide that he shared with us? I know I am throwing you off here. There we go. There it is. Hans, please let us know how you have approached this and how we can take advantage of your work.

Hans Buitendijk
And perhaps also, if you have the Excel spreadsheet handy, because we are going to switch over to it. Basically, what we did last round and that we are trying to do again this time is to look at proposed USCDI data elements and classes and consider that in USCDI, there would be a statement about the vocabulary that would support that as part of the USCDI standard, but then, from an implementation/certification/adoption by HIT perspective, the question then came of is that supported? Is there work to be done that, if we propose this, that additional guidance is needed to make it happen?

So, when you look at that, and this picture is trying to summarize that a little bit, on the USCDI, we have Versions 1 and 2 that are currently in the green. They are published. They are currently being supported by FHIR US CORE Release 3.1.1, and in flight soon, we anticipate, Release 4.0.0. Version 2, currently from the last round, did not have all the support, and actually, what you see here with the lines is that Version 4.1.0 that is in flight is in ballot on the C-CDA site. Version 3 of the companion guides is in flight to ensure that Version 2 is being supported with the appropriate guidance.

So, the exercise was to do the same for Version 3, to look at what is already in FHIR US CORE, what is already in C-CDA and the companion guide to support us for that. There is unambiguous guidance, and it is in the standards that are referenced in certification that are to support USCDI progression. So, that is the intent because when you look at it, you go to the right-hand side of the picture, data may sit in FHIR R.4, or it may sit in C-CDA R.2. That does not necessarily mean that it is recognized in US CORE. There might be another implementation guide like Gravity, Da Vinci, or something else that does it, but FHIR US CORE is the one that is being called out that needs to support USCDI and that is therefore eligible for an update in SVAP in the next round. So, that is why we are looking very specifically at FHIR US CORE. Is it there? If not, then it is work. It could be thorny work, it could be very straightforward work, but it is work to ensure that standards are updated and published so that everybody can then use it correctly.

So, that is the exercise. If you switch over to the spreadsheet, where all of them are listed, we are going to look at Columns E and F, the question there was is it in the FHIR IG, is it in C-CDA? And, that really meant is it in FHIR US CORE, is it in C-CDA 2.1 and the associated companion guides? Do I have that? The legend there, which is textural and the coloring, is if it is green, for example, discharge summary notes, it is already supported in FHIR US CORE. There is notes guidance around that, and there is guidance there, so that looks green. As another example, in discharge summary notes, where there is the addition on "must contain admission," there are a couple of things in that would have to be clarified for locations and reasons,

and there is some additional text there. So, there is some work to be done, and that is the orange. I try to avoid red as being too strong.

So, what you will see is that when you get the general sense of that, for most of the proposed USCDI data elements and classes, there is work to be done, and that can range from fairly straightforward guidance that is already existing in other guides, but now we need to figure out how it is incorporated in FHIR US CORE, work that is currently going on, for example, for SDOH data that needed to go into Version 2 that was available in Gravity but not in US CORE, so it is work like that, as well as more thorny issues, like around coverage status, where what is being proposed, what is in the guides across FHIR C-CDA, is not totally in sync, and there is still a fair amount of debate of what is the right status that one would have to include, or the coverage type, I should say.

So, that is what is documented there, only meant to provide a backdrop to understand where things generally sit. We have to keep in mind that as USCDI comes out, there is more time available than what there initially was last year, there is more time available to say, "Okay, it can be in USCDI," but we have to remember there is still work to be done. If we feel it is too big, then it is probably too soon. If we think that it is reasonable, then it is something that can go into USCDI and aim for having that updated in the standards. I do not have an estimate of time. Some of those things can take longer or shorter, so it is just meant as background to inform us about are we okay to progress with this or not. I am going to stop there, Steve, and hand it back to you.

Steven Lane
Thank you so much, Hans, and I think it is important as we craft our recommendations back to the HITAC and on to ONC that we remain aware of the fact that if we ask for things to be added or recommend things to be added to V.3, we need to incorporate an understanding of the work that needs to be done by HL7 to support each of those new elements. Arien, you put your hand up.

Arien Malec
I did. So Hans, I think in some cases, you are talking about additional guidance, so when I look at the discharge summary note, it feels like all of the data elements that are in the definition have a place to go in, for example, the FHIR spec, and in other cases, we have data elements or concepts in FHIR that are just not there. Have you done that level of mapping in the difference between just guidance versus structural issues?

Hans Buitendijk
I generally looked at it. I do not see too many structural issues, and I can clarify that. It is more the types of elements where the data is available in, say, C-CDA 2.1 in the base implementation guide, it is optional, there is a lot of optionality in there. The companion guide provides more specifics on the binding to the vocabulary, and **[audio cuts out] [00:14:19]** that it is actually being identified as being tested. In FHIR, you will see there is a good use of "must support," indicating that there is clarity that you are expected to work with this field, and the underlying standard is just optional, and there is not much data there. So, those are the main things. If you look at some other ones, it is a little bit challenging to understand where exactly I have options on how to do it, so it is guidance about which structural option I need to follow to express it, and that we do so consistently.

I have not seen at this point in time yet a real structural **[audio cuts out] [00:14:59]**. Typically, they are being resolved with observations and otherwise, so it is possible, it is just we need to be on the same way of doing it.

Arien Malec

Got it, thank you. So, sort of in conclusion, a lot of the work that HL7 would have to do is the nitty-gritty, thorny work of putting together the implementation guidance, explaining what vocabulary standards, explaining where to put certain concepts, but you are not seeing, at this point, major structural issues where there literally is not a resource where this can go or the resource fields do not have the definition that is available.

Hans Buitendijk

No, the constructs that are available so far seem to indicate that it can be covered, but let's say in FHIR, it does not need an extension, perhaps. Yeah, that might be the case, but that is a structural, easy thing to do. I have not seen anything that we would have to go back and say it is just not possible in FHIR Version 4 and there is no way to create an extension for it to support it. So, I have not seen any of those types of major structural issues.

Arien Malec

Awesome, thank you.

Steven Lane

David McCallie?

David McCallie

Yeah, thanks, Hans, for putting that diagram up. It is helpful, but it raises some questions to me. What can you say about what the vendor community is targeting with respect to Release 4.0 and 4.1 and R.2/R.3? Is this something that they are committed to? Is this something years away? Is there an EHRA perspective timing-wise?

Hans Buitendijk

Yeah, if you can go back and show that slide, it is a little bit easier to then reference the different versions. So, it is a combination of some might already have support for this, where the guidance is available. Other ones are not, but overall, the perspective is that as long as we can get, in a timely fashion, the implementation guidance agreed to and published, at that point in time, there is the opportunity to then progress and implement it. You have to keep in mind the difference between SVAP, which is a voluntary adoption opportunity, so what you likely will see in this diagram, USCDI Version 2 you will see that as soon as R.4.1.0 of FHIR US CORE is published, which is still in the ballot process being reconciled, and then it has to be published over the next couple months, you will start to see that some are probably going to begin upgrading to that.

Most probably are still looking at Version 1 and R.4.0 to look at that and see how they can enhance their abilities given where we are in the certification timeline. So, I cannot give you an across-the-board, everybody is going to implement it with a particular date/time certain, but there is the desire and the participation that you can see that as we progress through Version 1/Version 2/Version 3 of USCDI that we

can get to the clarity, and that creates for everybody a path that they can follow at their appropriate pace and where their focus is. I am not sure whether that answers your question.

David McCallie

Well, it is a start, but let me ask from the other side. What are the obligations or impacts on the broad community when something is in USCDI, be it Version 2 or, at some point soon, Version 3, and there is no appropriate companion guide/standard implementation to use it? Is there an obligation that that creates for people to just make up a way to send it, or you do not need to use it until FHIR supports it? I just want to be clear who is pushing, who is pulling, and what obligations we might be accidentally creating that actually hinder interoperability.

Steven Lane

Hey David, Al has his hand up, and I suspect he has a perspective here on the way that ONC policy machinery works.

David McCallie

Please.

Al Taylor

Maybe not so much the policy, but more the process. So, because USCDI is invoked by six or seven different certification criteria, some with FHIR and some with C-CDA, it is our intent to ensure that those IGs update sufficiently to be able to accommodate changes to USCDI, such as USCDI Version 2, and it is for that reason, that amount of time it takes to update, why we adjusted the SVAP timeline, because in order for somebody to voluntarily update their systems to Version 2, they need to also voluntarily update their systems to US CORE and the C-CDA, the appropriate versions that reflect USCDI V.2 changes. And, that will continue to be our intent, to have those two IGs be able to accommodate changes in subsequent versions of USCDI.

Arien Malec

And David, just as a reminder, because we had this conversation earlier on in the workgroup deliberations, and not speaking for ONC or even implying any ONC policy, but we had the conversation about how the way that the policy wants to work is that the SVAP is the mechanism for standards advancement, and that there should be a natural way for the SVAP to flow down into deployed technology that is associated with incentive programs, and right now, there is a little bit of stickiness just in terms of the regulatory machinery where because of the Administrative Procedures Act, it is hard to put together a natural glide path that works the way that we want it to work and is consistent with the APA, so I know greater minds than ours who are thinking through the APA are trying to make sure all this machinery works, but early on in deliberation, as a workgroup, we were going to pretend as if the machinery works.

Our job is to feed the top of the machine for things that want to enter into the SVAP, and then, to the point that we are raising, we just need to be thoughtful about the timelines for getting something into the top of the SVAP, getting through the testing and implementation guidance work so that it can enter the bottom of the SVAP and be more broadly adopted in industry. And David, I think a lot of the questions you are raising are about the policy incentives for people to broadly adopt, as well as making sure that we have the implementation guidance before we have the broad adoption, and as I said, I think we just ought to pretend

as a workgroup that we have that policy machinery well oiled, and our job is to think through what goes into the top of the SVAP. Al, did I get that directionally right? You can wave your hand in a suggestive manner.

Al Taylor
How about if I lower my hand in a suggestive manner?

Arien Malec
Perfect, thank you.

Hans Buitendijk
And maybe, also to David's question, USCDI Version 1, and therefore the associated implementation guides 3.1.1, and Version 2 I do not see in the chart, but for C-CDA, they are required for certification to be certified for 2015 CURES update certification. As we get into USCDI Version 2 rolling into SVAP, Version 3 rolling into SVAP, and their associated guides, for base certification, you do not need to support that, but if you want to, you then need to certify to those versions if you want to certify the next version of USCDI or to those guides, so then, if that sense, it becomes if you want to be certified, you must then support those guides, but you do not have to be certified yet against SVAP. You can do that at whatever time you want to do that, recognizing that when the next certification edition comes out, whenever that might be, and it is going to raise that bar, likely the latest from SVAP is that now, you need to make that immediate jump.

So, for HIT that wishes to be certified and stay up with it, this progression allows you to spread that out over time, and depending on the HIT and the environment where you operate, you may want to stay up to date with that closely, or you may say you are taking your time for it, or you wait until the next certification round. That is the optionality of the volunteer part, but what we need to make sure of here is that all the pieces can work and that if somebody makes the decision to want to be certified against SVAP 2023, let's say, coming up, that everything is there, and we can unambiguously implement it. That is why it is important to understand if everything is already covered. If so, great. If not, if it is a reasonable effort, that is okay. We now have a little bit more time to catch up with that with standards. If not, then we really need to seriously think about the maturity level, whether it can go in.
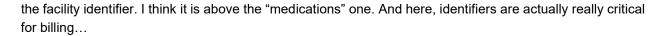
Steven Lane
Thank you, Hans, and I am going to move us along. That was a great review. For those of us who have been here in past years, we have covered this a number of times, and again, as we make recommendations, we just have to keep in mind which of them are going to require work on the part of HL7 to get things ready for us. All right, so, we want to move on to Michelle, we want to give CMS the mic so that we can talk through your recommendations. Michelle, I think most of yours are recommendations about Level 2 data elements that you would like to see included in Version 3, which is well within our charge, so if you can walk us through those as expeditiously as possible, we will try to come up with some recommendations one way or the other.

Michelle Schreiber
Thank you, I really appreciate the time today. Just to level set, we actually do talk across other parts of the federal government, and I am representing CMS, but there is agreement around some of these things in particular. So, I think the first one is above where you have us on the worksheet. It is the facility-level data,

the facility identifier. I think it is above the "medications" one. And here, identifiers are actually really critical for billing…

Steven Lane
Point us to the row, please. Sorry, I was finding your name, starting from the top, so I want to be clear.

Michelle Schreiber
I am sorry, I do not know.

Steven Lane
Okay. That one is Row 17, "facility-level data."

Michelle Schreiber
Hold on. Okay. This is really about a couple of things that identify facilities. These data are critical for public health reporting, again, for linking billing and clinical EHRs, they support data aggregation across multiple data sources, and in particular, what we are recommending, one is the CCN number, which is the unique CMS identifier for facilities that bill CMS, and two is the PTN number, the Provider Transaction Number, that uniquely identifies healthcare organizations. There we go, yes, you are right, Row 17, and I think we have that outlined. These are already well-established.

Steven Lane
Hans, can we lean on you to jump back and forth to your prior work and tell us if there is an HL7 challenge with regard to this data element that you are aware of.

Hans Buitendijk
This is the facility identifier?

Steven Lane
The facility identifier, yes, just so we do not dizzy ourselves going back and forth.

Hans Buitendijk
Okay, I am just jumping.

Steven Lane
That is fine, you are looking. Any questions about this recommendation? Any concerns on the part of the workgroup?

Arien Malec
When we get discussion… Sorry, Clem.

Clem McDonald
I have a concern. I do not know how **[inaudible – crosstalk] [00:28:38]** organizations NPI.

Steven Lane
Michelle, did you hear Clem's question?

Michelle Schreiber

I thought NPIs are provider identification.

Clem McDonald

Well, it is an organization provider, like a hospital would have an NPI, as well as individual physicians.

Michelle Schreiber

I do not know. I would have to go back and look, Clem, to be honest with you. I know that we use the CCN, the certification number. That is how we track hospitals.

Clem McDonald

Okay. We always ought to clarify why it is one or the other because it will cause confusion.

Steven Lane

So, this is a request, though, or a suggestion. We suggest the inclusion of facility identifier in Version 3 for these reasons. Any concerns?

Arien Malec

Yes, Steven. I just want to remind the workgroup that the last time we talked about this, we suggested that the identifier be a combination of authority and identifier so that we can accommodate multiple types of identifiers for the facility.

Clem McDonald

Yeah, we have always done that.

Hans Buitendijk

My question would be whether all HIT would have that data, those particular identifiers…

Arien Malec

Yeah, you would not have the CCN if you are not enrolled for Medicare fee-for-service. As Clem says, you would have a facility-level NPI in some cases. There are a whole host of identifiers that are payer-specific, so we just need to make sure that the way we set this up in USCDI accommodates the notion that there are multiple identifiers, and then makes it clear the CMS preference for CMS-based identifiers.

Steven Lane

So, would we need to include both the facility identifier itself as well as a specification of which data set this was being drawn from?

Arien Malec

Yes. I think what I am proposing is it is a combination of identifier and authority, and it is a multiplicity so that you can attach multiple identifiers for a given facility.

Clem McDonald

Can I just comment? I think the NPI may be the organization. Is the facility at the physical location? I am just not sure what that name is. That is not the same as the NPI. Does anybody know?

Hans Buitendijk

That is not clear to me either. I have tried to do some digging to get more clarity around that, but it is not clear to me either, and I echo the question that David has. Is it on the account of the individual where that sits? And, the added question to Clem and David's would be if we put it in USCDI, that means HIT can support it. Does any HIT support it, or is it more the administrative systems that would have the information as they pull things together, not necessarily the clinical systems where this number does not have any further meaning, so therefore, they would not be able to support it? So, from a standards perspective, if we find out where it sits, the underlying capability is there in principle. If it is a location or an organization, identifiers allow what Arien is indicating that needs to be done, so the basic building blocks would be there, but are the systems that we have to implement this…should everybody support this, or is this more if you do quality measures, you must, or if you do claims, you must, but if you do not, then this is not a **[inaudible] [00:32:52]** identifier?

Arien Malec

Yeah, and the other question that has been raised is if this is an organizational identifier or a sub-organizational, literal brick-and-mortar identifier, also a critical question to answer. Hans, is there an organizational identifier already in FHIR somewhere?

Hans Buitendijk

Effectively, yeah. The statement at the bottom of H17 says there is a FHIR resource organization, so it sounds like it is meant to be an organization. An organization has the resource and has an identifier that can include the value, the assigning authority, the type, and a number of other things, so the building blocks are there. The question is what is that organization associated with that this is relevant? So, that is the question that David has. Is it going to be against an encounter or against a patient? Was it that it is part of, in that regard? And then, the question is if it is within the scope the HIT that is trying to represent this or if it is a more administrative financial **[inaudible] [00:34:03]**.

So, I think there certainly would need to be work done to clarify where it is kept, and I think there is the larger question for the USCDI perspective that is meant to be supported by all HIT that wants to certify against it if we take that angle. I know there are other angles, but if you look at it from that angle, for example, is an EHR something that is relevant? If it is administrative, yeah, if it is a quality measure, perhaps, that sounds like it, but does everybody need to support this? That particular kind of CCN and PTN… Are those specific identifier types necessary to be supported by everybody?

Steven Lane

David is asking the same question in the chat, and the issue is putting something into USCDI does not require anyone to collect it. We have gone over this a hundred times. "If I add that, then I am adding burden to people, forcing them to collect it." You are not required to collect a head circumference if you are seeing a 90-year-old. It is as simple as that. You do not have to collect a blood pressure just because it is in USCDI if it has nothing to do with your workflow. USCDI tells us that if you have this data, this is the data element in which it lives and how it will be exchanged, and that you should be able to both send it and, ideally, to be able to receive it, but it does not mean you have to collect it.

Arien Malec

Steven, I think what the group is doing here is trying to make sure that this concept is as generally useful as possible so that we are not vectoring in with a specific CMS identifier that is not applicable for facilities or organizations that, for example, do not submit CMS claims or associate with other programmatics and other identifiers. So, maybe what I can propose back to the group is either that we amend this recommendation to be an organizational identifier with a combination of assigning authority and identifier consistent with FHIR, and that it should be attached to the encounter because I think that is what makes the most logical sense, or we remand it back to Michelle to address some of the questions that the group has raised.

Michelle Schreiber

Arien, I can certainly live with a more general identifier with a CCN and a PTN as something underneath that, as an example. To be honest with you, I am having a hard time envisioning a healthcare facility that is not identified or bills something in CMS.

Arien Malec

A pediatric practice?

Michelle Schreiber

Medicaid. Anyhow, we are not just talking about Medicare fee-for-service.

Steven Lane

Okay. Arien, help me craft your recommendation. Slide a little to the right, Al, so we can see the recommendation.

Arien Malec

So, the proposed recommendation is that we amend this to be an organizational identifier, that that organizational identifier be composed of an assigning authority and identifier, that there be a multiplicity of organizational identifiers, that the coding system accommodate CCN and PTN, and that it be associated with the encounter, and that it be in the category of "required if known," although I do not think we identify in USCDI the data requirements, the optionality modifiers, right?

Steven Lane

Okay, that is the recommendation. Is anybody uncomfortable with that?

Hans Buitendijk

Not with the overall intent, in a way, but the implication is that if this is included in USCDI, every HIT that wants to be certified must demonstrate that they can handle it, and for those two identifier types, that is where the question is. Is that really reasonable for all HIT?

Steven Lane

Certified HIT.

Hans Buitendijk

Correct, absolutely.

Steven Lane

When and if this is included as a certification requirement, so first, it is added to USCDI, then it is added to SVAP, then we have experience with its voluntary use, and then and only then is it added as a certification requirement.

Hans Buitendijk

Not true, because if this is in USCDI, then the standards need to be able to support that, so that means the moment those standards go into SVAP, which they will do at an appropriate time, then anybody wishes to certify against that must be able to demonstrate that because the scope is not part of USCDI, it is all of USCDI.

Arien Malec

Right, and to the point, this is already included in HL7 FHIR, probably is included in the consolidated CDA specs, and so, what you would be required to do is demonstrate that you can fill that slot out or receive that slot in interoperability.

Hans Buitendijk

With those values. That is the thing.

Arien Malec

So, I think we are more saying the assigning authority needs to accommodate the CCN and PTN.

Hans Buitendijk

Effectively, yes, and that means you need to be able to demonstrate that if you want to be fully conformative.

Steven Eichner

This is Steve Eichner, Ike.

Steven Lane

Go ahead, Ike.

Steven Eichner

I think we are running into some potential issues looking at the assigning authority and looking at reconciling that identification in terms of utility. Do we need to be concerned about what authority is assigning an authority ID? I am thinking from a public health perspective, for example, looking at validating that an organization is the organization that it says it is, and if I am using this ID, I need to know the assigning authority, and trying to index a myriad of assigning authorities could become really complicated.

Steven Lane

Thank you. All right, so, I have continued to capture this in a draft recommendation. Are we willing to call this final or not?

Clem McDonald

Steve, I like the proposal perfectly well, but looking on the web, it is very confusing. In one place, it says the PTN is the same as the CCN, in one place, it says that the CCN has replaced the NPI. We need somebody with knowledge to say what is what. What are these things?

Michelle Schreiber
You are giving me a homework assignment, I take it.

Steven Lane
All right, good, let's do that.

Michelle Schreiber
I personally cannot answer that question.

Steven Lane
So, let me take this recommendation out of the final column, and we will put it in a draft state, and we will go on, as we could get stuck here all day.

Michelle Schreiber
Okay, the next, which we had up before, and I do not know what row it is, is around medications. There we go. And, in particular, these had not been finalized before. You are right, they are Level 2, but they do get to the management of medications, which I think we all know is critical for patient care and coordination between the providers, quality, public health, patients need to know what medications they are actually taking, so here, the recommendation is around including the medications-administered code, medications that are dispensed, discharge medications, and dosages.

Steven Lane
Wait, are you on Row 12, which is discharge medications?

Michelle Schreiber
Twelve is discharge medications, 13 is dosage…

Steven Lane
Let's go one at a time.

Michelle Schreiber
Scroll up, too, because the first one we talked about is medication administration code.

Arien Malec
Steven, before we dive in, it might be worthwhile just noting the state of play for USCDI, FHIR, and consolidated CDA. So, right now, USCDI V.2 and V.1 say medications encoded by RxNorm, and that is it. I think the way this works out in the real world is that "medications encoded by RxNorm" is a shorthand for this really complex field of structural representation of medications, an Hans, you can correct me, but with respect to demonstration of interoperability, you are already required to demonstrate the variety of medications and medication concept representations that are expressed or implied in the consolidated CDA and US CORE FHIR, and to some extent, this is one where we either need to fully represent medications

in USCDI at the level of complexity that they are represented in those underlying standards or keep it at the hand-wavy "medications" concept, shorthand for all the ridiculous complexity.

If we include specifics here, but not the other kinds of representations that are available under medications in the underlying interoperability specs and their associated implied models, then we are missing a whole lot of stuff. We are sort of assuming, then, that all that other complexity is not included in USCDI. So, this is one where we either need to go whole-hog or keep it at the hand-wavy level. Hans, I wonder whether you could comment on how, in practice, the one-word medications in USCDI reflects its way through consolidated CDA and FHIR.

Hans Buitendijk

It really primarily focuses on the presence of an "order" or a "request," a prescription that is out there. That is really the primary focus, so you can get from a medication list that enables you to understand what is the patient on, but it is not going to the level of each administration recorded is now included in that set, in US CORE, and in the C-CDA. That does not mean that systems do not capture in the EHRs, that they do not capture administrations individually. It is just not, at this point in time, the scope of what certification is looking at to capture that level or demonstrate that level.

Michelle Schreiber

Arien, it is Michelle. I think that is actually part of the issue. We do not really know without probably a great deal of work what somebody, for example, is discharged on and what their medication list actually is, and that is why we are bringing this forward, but I think you are right. Within RxNorm, there is probably a lot of information and this is not all of it, and I guess if I had to vote for one thing, it might have to be whole-hog, as you say, because what we have now by waving our hand at it I do not think is giving patients the information that they need, or facilities, actually.

Clem McDonald

Could I clarify a little bit? I do not think there is any ambiguity in naming the medications with RxNorm. The issue is there is another layer, there is another dimension, which is really lists of medications, so they should all be coded. If you have the RxNorm code, you know what they have. The question is the dispense and this and that, and it is different for outpatient than inpatient. Inpatient, you actually dispense them one at a time, and you record it. Outpatient, they take the medicine home, and who knows what they are taking? So, I do not think it is a matter of throwing away the hand-wave one. That is really describing what the medication is we are talking about. There is another layer that says whether it is dispensed, etc., and I think some of those are in C-CDA as different categories, aren't they?

Arien Malec

The concepts are representable in consolidated CDA and in FHIR. Again, just to remind everybody, we talked about discharge medications, we talked about medications dispensed bedside. There is a significant difference between medications ordered and medications taken. There is a fractal complexity associated with medications, and it sounds like from Michelle's perspective, in USCDI, she would prefer to us to specify whole-hog the clinical representations or the ontology for medications that is sufficient to make clinical quality determinations in ways that allow us to disambiguate, for example, medications dispensed inpatient, versus medications dispensed on discharged, versus medications confirmed taking in a current medications list.

Hans Buitendijk

At this point in time, the focus is primarily on the medication list, when you look at the implementation guides, the focus of that. It would be a substantial amount of effort to align everybody to get the other parts of the medication area in play. Discharge summaries do include medication lists, so I think the question is, then, as we go through the more refined detail, what exactly are we trying to address at that point in time that would have to be in play? I think that is not totally clear from this description what exactly is intended so that there is clarity on how to then make it supportable. Is it just a list of medication administrations that you can show? What did **[inaudible] [00:50:12]**?

Clem McDonald

Well, Michelle, I think some of what you want is in C-CDA. I do not know whether you are able to look at that or if that is the place you are looking.

Michelle Schreiber

I am not sure I can answer that at the moment.

Arien Malec

Clem, I think the issue is not whether it is representable in FHIR or C-CDA, but whether it is literally part of USCDI. To Steven's repeated point, is it part of the set from which interoperability specifications can assume they can pull from so that we can create implementation guides that imply the existence of discharge meds as a structured thing? And, to Hans's point, we can get to a discharge med list with coded concepts if we include the discharge summary and its representation, both in consolidated CDA and FHIR.

Steven Lane

So, again, in the interests of time, Michelle has been talking about a number of medication-related data elements, some of them up higher, the discharge medications and dosage, some of them here down lower, the medications dispensed and the "medication administered" code. The proposal from CMS is to add these to USCDI so that they become part of the defined core data set that would be pointed to by the six to seven certification criteria that Al mentioned earlier in the future, and we would assure that they were included in C-CDA and FHIR US CORE so as to support that. So, is that a recommendation that this workgroup would like to carry forward for one or all of those four data elements, or do we have concerns about these and we want to leave them at Level 2 to relook at another day?

Clem McDonald

Well, I think the main problem is that if it is expecting that all of that is going to be in one code, it is not going to be feasible, but I am not clear that they are not aware of the other places to look for. Now, maybe it is specifically inpatient medication administration, which is the gap.

Arien Malec

I would say that it is the sense of the workgroup, Steven, or at least the sense of a vocal subset of the workgroup that says we either need to fully specify what we expect out of USCDI in the area of medications, and that is going to take some work to do, and that we do not have the level of specificity right now to be able to do that specification.

Steven Lane

All right, is that where we are going to leave this?

Michelle Schreiber

The problem that I have with this, though, is that the current concept of medications that we have, it does not differentiate what is active, ordered, actually administered, and not necessarily even dose and route, and I do not know how you can make informed clinical decisions, let alone having quality measures, without that kind of granularity.

Arien Malec

Yeah, dose and route should be fully expressible in the underlying specifications, so, fully expressible in NCPDP script standard, fully expressible in FHIR and consolidated CDA, and so, I actually do not think in actual practice that we are missing dose and route information relative to medication lists. I think the bigger issue is whether we have the lifecycle of medications expressed enough in USCDI sufficient to be able to say from an interoperability and future certification perspective that you can determine what is the discharge med list, you can determine what is the "medications taken" list versus the "medications ordered" list.

Clem McDonald

And Michelle, RxNorm distinguishes root and route, so it is all in the RxNorm code, that particular sort of thing.

Al Taylor

Well, Clem, it allows for the different routes, the most appropriate route for a given medication, and it can be that particular medication. If it says "intermuscular injection," we do not actually know that that intermuscular injection was performed. That would be handled by some other attribute of medication besides RxNorm. I think that is what Michelle is asking for, is having these additional attributes of a medication be a part of USCDI so that anybody who accesses medication data using a future version of USCDI could also get information about whether or not a medication was... Yes, it was prescribed, and it was prescribed using e-prescription, eRX, as a certification criteria, but that level of detail is not necessarily available to a patient accessing their record or a provider somewhere else accessing a record remotely. I think that that is what Michelle is asking for. Michelle, if you could verify that.

Michelle Schreiber

Yes, I think you are better at representing it than I am, so, thank you, Al.

Al Taylor

Sure. I think the recommendation is to add these attributes to the medication data class so that that level of detail is available to anybody accessing the record through USCDI exchange.

Arien Malec

Yeah, and Al, I think my perspective is if we do that, we have to really do it. Make sure that the medication class in USCDI fully represents the needed representational complexity of medications. And so, if we put in some, but not all, we are implying that the ones that we do not include are not required, and so, what we really want to do is import the implied medication model from, for example, FHIR into USCDI, and then we would also want to make sure that we have the representational model so that we can capture discharge

medications, medications administered, medications ordered, and the home med list fully in USCDI, and I think that is going to take some work.

Steven Eichner

This is Steve Eichner. Do not forget trial status. That is another missing element that we do not do very well right now.

Steven Lane

Sorry, what was that, Ike?

Steven Eichner

Whether the medication is being used as part of a clinical trial.

Steven Lane

Oh yeah, that is clearly a different data element. Again, to be clear, Michelle and CMS are bringing forward data elements that have been evaluated in detail by ONC and found to be Level 2. I appreciate, Arien, that we may have not done that work, but ONC has done that work, and each of these now four data elements related to medications have been determined to be Level 2, and are therefore ready for inclusion from a technical maturity, use in the real world perspective, so when you say a lot of work needs to be done, what work needs to be done beyond adding these four data elements to USCDI and letting it go through the process?

Arien Malec

Al, can you speak to whether we have fully mapped the implied medication data model in FHIR into USCDI, based on approving this work?

Al Taylor

That is not how it works. We do not take a FHIR model and apply it to USCDI data elements. If they already fit together, that is great. If they need additional work, like some other USCDI data elements are going to need or are currently undergoing to make them work in US CORE, then that work needs to be done, so to say to adopt the entire model, which is not what I think Michelle is suggesting, to say that every conceivable data element or attribute of medication should be included in USCDI's medication data class, I do not think that is what she is saying.

Michelle Schreiber

No.

Al Taylor

And, we do not necessarily need to, and by picking four out of probably 20 conceivable attributes and medications to go into USCDI in some future version, it is saying that these are the most important for a certain set of…

Clem McDonald

These are not attributes of a medication as an abstraction from patient care. They are all tied to other aspects of care, so they are lists, typically, and the medication codes within the lists are the same, regardless of what list.

Arien Malec

Yeah, and I am sort of triggered by the dosage. When we talk about dosage, are we talking about root strength, formulation, signum, additional instructions? Are we fully representing the data that typically goes along with an NCPDP script standard, or is it transmitted from a pharmacy bedside for med administration bedside, or are we talking about something else? It is dosage that sort of implies to me that maybe we are leaving out because there are a whole bunch of other things that are included in that medication implied model besides dosage that are required to fully cash out a medication into what is the chemical entity that the patient either was exposed to or was ordered for the patient.

Hans Buitendijk

Arien, I am looking at Column I, Cell 22, where it states that standards do not support the determination of current medication lists or medications administered. Actually, it does support medication lists, and actually, it does support medication administrations as well, just not in the implementation guides on the latter one that needs to be certified. But, to clarify, discharge summary is a good example. It includes medication lists. That is addressed and available. If you look at FHIR US CORE, medication lists are very explicit. I could drop in the URL to the page where it clarifies how you are supposed to do it, and that is supported.

But, administrations are not currently part of FHIR US CORE C-CDA more explicitly on how to further do that in context of certification, so I am wondering for USCDI, if we put in the medication list whether the current medication list, the ability to do that… It is effectively already in play, but for USCDI, that is probably a good thing to recognize. If we get to administration and other parts of it, I think that is where more work needs to be done to further address how to best express what is missing, but on medication list itself, I think there are already many parts that are in play to say that is what is being supported today.

Arien Malec

Got it. So, your counterproposal, Hans, would be to simplify this recommendation to medications and medication list, and specify that the medication list be applied at admit/discharge, and be sufficient to represent ordered and medications taken?

Hans Buitendijk

Yeah. That effectively would reflect what is happening in certification. Look at that, where we have the need to be able to support from C-CDA's medication reconciliation. That is because it is in the C-CDA medications that are part of a list that is being communicated. You need to demonstrate that you can reconcile those into your receiving system. So, I am not sure why "medication list" is considered not existing, because it exists. You will also see that there a number of systems that are already exposing this using FHIR APIs, but not necessarily the US CORE because administrations are not quite… Let me just double check.

Arien Malec

Michelle, I do not know if you are tracking this compromise position, but I think what we are looking at is let's reflect the real world to say that what we are talking about with medications is medications and medication lists, and that the medication lists should be capable of distinguishing between discharge meds,

medications currently taken, medications ordered, and that would really accommodate home meds on admit as well, and that what we are missing is meds administered in the context of an inpatient encounter, but medications currently taken would account for, for example, transitions of care from a SNF or stepdown facility to another facility. I think it is appropriate that USCDI is not in the nitty-gritty of communication from a pharmacy system to barcode scanning on-floor for meds administered. Does that make sense to you?

Michelle Schreiber

Arien, thank you. It does make sense, and by the way, thank you to all of you for interpreting some of these things. I feel like I am the instigator of an issue and you guys are helping to resolve it, so thank you. Let me ask a clarifying question, though. We have talked a lot about hospital and hospital discharge lists. What happens on the ambulatory side? Does this provide us with an appropriate medication list there?

Arien Malec

Yeah, so that is where I was trying to make a distinction between meds ordered and meds currently taken. Hans, maybe you can correct me in terms of what the implementation guides currently call that, but there is a critical distinction, as you know, between what has been ordered for a patient versus what is confirmed as the patient's med list associated with what the patient is currently taking. In some cases, the dose that the patient is currently taking is not the dose that has been ordered, or the patient may have voluntarily discontinued the medication, so that is a critical distinction to make in terms of understanding what is happening. And Hans, I believe that is already representable.

Hans Buitendijk

I would say the vast majority. There might be a couple nuances there, but the vast majority is there. It focuses on medication requests and the information that you can keep within a medication request, i.e., prescription or an order that is in some state of either being active or out there.

Arien Malec

Yeah, and we also need the literal med list, which is implied as the list of medications that the patient is currently taking. Hans, why don't you and I go offline and put together a proposal back for the workgroup?

Hans Buitendijk

Yeah, that sounds good.

Michelle Schreiber

Thank you.

Steven Lane

Okay, I think that is fine. I had a question for Al, which is since there are specific data elements that have been flagged as being Level 2, and these are the ones that Michelle requested bringing forward, are we in a position to rejigger those elements into this current medication list and make that as a proposal, or does it need to go through some other process to make it up to Level 2 before we can do that?

Al Taylor

I would need to talk to some folks in certification, but the concept of a current medication list goes way beyond a collection of vocabulary terms or a collection of data elements because it has to be formatted

together. There is the concept of current, which has all the date/time requirements, and then medication, and then the list, which is a compilation of it, so the concept of "current medication list" is more of a format or a function, which is outside the scope of USCDI. The additional data elements that would be required to compile a current medication list are in scope for USCDI, so we would just need to determine what data elements or what attributes of medication are required for something like medication lists. How we develop a new certification requirement for current medication lists? We used to have a problem list as a certification requirement, now we just have a problem as a certification requirement. I would say that creating this concept of "medication list" is outside the scope of USCDI.

Arien Malec

If it is outside the scope of USCDI, then I am confused by how to handle the disposition of the requests, which really are to make sure that we have a discharge list or a meds administered list.

Al Taylor

So, if it is Michelle that is proposing that for CMS's purposes, the data elements required are the data elements that go into medication lists, just determining which of the current 20 to 25 data elements under the medication data class that are not part of the USCDI version. And so, which of those are the most required for at least this particular use case, whether it is for all the reasons that CMS wants these additional data elements, or the use case of creating and exchanging a current medication list?

Hans Buitendijk

Al, if I hear you right in the way you are suggesting to frame it, let me see whether I understand that right. It is that since the medication list is made up of medication requests, not medication administrations, that you would then translate this suggestion more into focus on including medication requests as part of the data class, not medication lists. Am I hearing you correctly there?

Al Taylor

Yeah, because current medication list is future medication taking, right? So, that is the reason that you want the list, is to see what the patient is taking, or has taken up until now, and so, a current medication list would not necessarily include medications administered because it has not happened yet. Does that make sense?

Clem McDonald

This "administered" problem is really thorny because it really only applies inpatient. We are dealing with objects, not data elements. We are not dealing with fields, we are dealing with objects, so if it is administered in a hospital, they need a date and time. Who administrated, and what room was it? All kinds of other stuff. We cannot mix the elements or fields with data structures. We will not get anywhere.

Al Taylor

So, I think the concept of "medication administered," whether it is a data element or an object, may not be part of the requirement to create a medication list unless it is perhaps for billing, or reporting, or quality measurement purposes to make sure that something has been administered for those reasons, but I think that is different than the "current medication list" concept, or it may be. But, the question is what are the most important data elements for what we will call the CMS use case, which is obviously a very large use case, but are there other things that might be required for this new concept called "current medication list"? Not a new concept, but a new proposal.

Michelle Schreiber

So, to be honest with you, I thought this was going to be a more straightforward conversation, that we had elements that were in Level 2 that we were just looking to codify into USCDI, but what I am hearing is that maybe this is a separate workgroup, almost, that has to provide more detail to this to make a recommendation. Am I correct in that, or no?

Arien Malec

I thought we had a proposal that was workable, and Al said we did not.

Al Taylor

Well, I am not saying that the proposal is not workable. The list of data elements that Michelle is proposing to add may not be all of the same data elements that are required for this other concept, called "current medication lists." What Michelle is saying is that her proposal is to provide additional data elements that are part of a current medication list.

Clem McDonald

So, my worry is that this stuff is already there, at least 80% of it, but they are not defined as codes. It is just a list of fields with codes. I do not think it can be, which is causing huge upheaval in the recordkeeping.

Al Taylor

It does not necessarily have to have a code to be a data element.

Clem McDonald

No, but I think that is the mindset of a lot of administrative systems, and I just worry that we have a different worldview. Discharge medications are explicitly included in the discharge records. It is part of both C-CDA and FHIR. Now, for the administrative one, you might want a list of everything that has been administered. That is valid. I do not know if that exists, but we can make it exist. **[Inaudible] [01:14:12]** in a hospital or in a nursing home. Some are where there is a discrete control over the administrations, which does not happen in the outpatient.

Steven Lane

Okay. So, I have been trying to reflect our discussion in this field here. Again, we leave ourselves at a proposed recommendation that it sounds like requires more work. Michelle, I would suggest that you take this back to your friends at CMS and see if this is something that they would like to pursue and/or contribute to, but it does not sound like we are ready to move any of these medication-related recommendations forward as proposed.

Michelle Schreiber

That is certainly what it sounds like, Steven.

Steven Lane

All right, and I appreciate the discussion.

Michelle Schreiber

However, we are happy to work with anybody who has enough granular detail to move this forward.

Clem McDonald

I would volunteer, though I do not know if I could find the time.

Steven Lane

We have just a few minutes before we cut to public comment, and Michelle, the other one that you were specifically recommending including was surgical notes, operative notes. Those were not called out in Version 1. As Clem pointed out in the chat earlier, last year, our taskforce did recommend that we simply include all notes that have a LOINC code associated with them, and Al, I do not believe that you brought that recommendation forward as part of draft V.3. We could look at adding specific notes incrementally, and operative notes clearly is one with a high value, or we could look at recommending, as we did last year, the inclusion of all LOINC-coded note types. Al, I am curious how you see this would move forward most meaningfully.

Al Taylor

So, a recommendation to add a clinical note type to USCDI is a perfectly valid recommendation, as is adding all LOINC either doc type or NAIR type LOINC codes to USCDI. They are both valid recommendations.

Steven Lane

This is Row 29, by the way, if you can scroll down to it.

Al Taylor

They are both valid recommendations, and we did hear that recommendation from not just the HITAC last year, but we did not add any additional clinical notes to USCDI draft V.3, or to Version 2. That recommendation came in before, during the V.2 cycle, and ONC did not add them. **[Background noise]**

Steven Lane

Someone needs to go on mute. Someone is listening to the news.

Arien Malec

Steven, I think I would double down on the recommendation. If we are going to do this, we should do it, and we should add LOINC-parametrized notes as the thing that is in USCDI so that we do not have to keep revisiting the question note type by note type.

Steven Lane

Well, I guess my question back to Al is we recommended that last time, and it was not included. If we recommend it this time, is it likely not to be included, or would we be better off simply adding surgical notes?

Al Taylor

I cannot say one way or another, but I can say that the more… We have a limit to the number of data elements that we can require, just a practical limit of the number of data elements we can require of anybody in any version of USCDI, and so, our decisions are based on that aggregate lift, which is one way to put it, for not only developers, but implementers/providers, and so, we continue with those priorities about not

only breadth of applicability of each individual data element, but also the total aggregate lift as a prioritization criteria. So, more data elements would obviously be a higher lift for everybody involved.

Steven Lane

But again, this is not a new data element per se. The data element is already there as clinical notes, right?

Al Taylor

Well, "clinical notes" is a class.

Steven Lane

A class, okay, so this would be one additional element. So, can we agree, before we cut to public comment, that once again, this year, we would like to recommend to the HITAC and ONC that all LOINC-coded note types be added to USCDI, but failing that, at the very least, add the surgical operation LOINC, 11.504-8, to USCDI. Does that sound good?

Arien Malec

Sorry, do we already have discharge note called out specifically?

Al Taylor

Discharge summary note is a clinical note required in USCDI V.1, V.2, and draft V.3.

Arien Malec

Got it, thanks. That sounds like a reasonable request to me, Steven. **[Inaudible – crosstalk] [01:20:08]** formulation of the rest.

Al Taylor

You were talking about two separate recommendations. One is all LOINC clinical note codes, and then, a separate recommendation is surgical note.

Arien Malec

Yeah. So, I think the recommendation that Steven is framing is the recommendation that USCDI include all notes expressed through LOINC codes, and that if ONC deems that not an appropriate USCDI recommendation, then the fallback recommendation is to specifically add the surgical note.

Al Taylor

Yeah, my suggestion is to leave them as two separate recommendations, and not have one be a sub-recommendation.

Michelle Schreiber

And ONC would choose, Al?

Al Taylor

Well, we would consider a recommendation to add all LOINC codes, or we would consider the other recommendation of adding surgical or operative note.

Clem McDonald

So, Al, there is a specific subset called the note ontology or something like that. I can get you the right name.

Al Taylor

Right, the category in LOINC.

Clem McDonald

Yeah. And, the thing is, there are some institutions that use the ones they want. I think the VA and Mayo are the ones I know about that use them widely. But, having that list does not mean you have to use them, it just means you have the option to use them.

Al Taylor

It would mean something different if it were part of USCDI. It would mean that the system has to support any of the LOINC document ontology codes if it were part of USCDI.

Clem McDonald

Oh, okay. Thank you.

Al Taylor

So, a developer would be on the hook for being able to represent any of the LOINC codes, and it is hundreds for sure, possibly thousands. I think it is in the many hundreds.

Clem McDonald

It is at least many hundreds, yeah.

Steven Lane

So, we have two recommendations. One is the same from last year, to include them all, which seems to have not gotten the traction it needed in the past, and the other is specifically to include the surgical operation note in the current list.

Hans Buitendijk

Steven, I think one of the reasons why there might be hesitation on everything goes back to what is the expectation from a certification perspective. Would that then translate into an HIT that wants to be certified and needs to be able to generate any clinical note of any of those codes, or does it just mean it should not throw up an error when it receives one for display purposes? That is where the USCDI and the standards underlying it get very murky continuously on these kinds of questions.

Steven Lane

And, you are not going to let us forget that, Hans.

Arien Malec

Yeah, it is receive versus generate. Does a pediatric EHR need to send a discharge note? That does not seem like it makes a lot of sense, but it certainly should be able to receive a discharge note.

Hans Buitendijk

Right. So, I think in a way, it goes back, and I put in a note down the list, and I am not sure whether we will get to it at this round, and I will pose this question, no answer expected: Should USCDI really become more of a library where it makes sense to include these kinds of thing, but really find a better way on the implementation guides to not have one monolithic approach where everything needs to be supported in FHIR US CORE, but that we can stratify better? What is the stratification strategy to avoid that all HIT must do all capabilities rather than "Yeah, you need to receive it, but you do not need to generate it, or you do not need **[inaudible] [01:24:18]** administrate it."

Steven Lane

All right, that was a great conversation. We are going to public comment. Mike, do you want to do the honors?

Public Comment (01:24:35)

Michael Berry

Yes, thank you, Steven. We will open up the call for public comment, so, if you are on Zoom and would like to make a comment, please use the hand raise function, which is located on the Zoom toolbar at the bottom of your screen. If you are just dialing in only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. Let's pause for a moment to see if we have any public comments. I am not seeing any hands raised, Steven, so I will turn it back to you and Arien.

Steven Lane

Excellent. Thank you so much. So, this is a lot of work. We do not have a lot of time. We are only going to get as far as we get. I personally would actually love to have more time, either stretching out the time that we dedicate to this work by a week or two or potentially even adding additional meetings, if that were a possibility, because I think we are doing good and important work, so I will ask Al and Mike to comment on whether that could be done, but out of today's discussion, we have a draft recommendation on Row 17 related to facility identifiers, which I think we have a commitment for someone, I forget who it was, to go back and work on and bring back, perhaps as a way that we can actually move that one forward. I think on the medication side, I captured our discussion in Row 22. It sounds like it is less likely that we are going to get that done for this year's cycle to be able to move towards the presentation of a current medication list, though I share the desire for that. Sorry, Arien. Go ahead.

Arien Malec

So, on the facility, I think we have a proposal to look at that as organizational code, and I think the specific request was for Michelle to flesh out whether there is a preferred "must support" from CMS relative to the variety of codes that CMS currently uses, then I think we need to better specify, to Hans's point, whether the intent is "must send this from an interoperability perspective" or "must be able to receive any" if they are variably coded.

Steven Lane

Okay, so that is an action item for Michelle and the CMS team to come back.

Michelle Schreiber

I will take it, and we will bring that back.

Steven Lane

Perfect, all right, thank you, Arien, for that clarification. Okay, and then, I was just trying to summarize. Is anyone planning on going and working on the current medication list presently, or should we back-burner that and maybe come back to that during the second phase of our workgroup effort?

Hans Buitendijk

I would be happy to touch base with Michelle and run through some of the things there, if that works.

Michelle Schreiber

That would be great. I would be happy to have a conversation. It sounds like, though, this may become back-because it is so complicated.

Hans Buitendijk

But, maybe we can figure out a path or something there.

Michelle Schreiber

Thanks, Hans.

Steven Lane

And, we did finalize a recommendation regarding the procedure notes to reassert our interest in the full LOINC document ontology, but at the very least, as a separate recommendation to recommend the addition of a surgical operation note. So, that is where we got today. Does anyone want to add any comments before we close? All right. I think we are going to come back next time… Oh, go ahead, Mark.

Mark Savage

Steven, I will vote for more meetings. This is important.

Steven Lane

Okay. So, Al, do you want to give us your off-the-top response to that idea?

Al Taylor

My initial response is to talk about it on the cochair meeting.

Arien Malec

Yeah, why don't we talk about it in just a bit?

Steven Lane

Okay. But, at this point, we have weekly meetings scheduled. I think we said that we were going to entertain this Phase 1 work through the March 29 meeting. Is that right, Al? Do I have that right?

Al Taylor

Yeah, so that includes a deadline of, I think, March 25th for member input, and then, we are doing finalization on the 29th.

Steven Lane

And, when you say "member input," you mean to say new comments or recommendations in the spreadsheet. I am just thinking how much work can we get done on what has already been submitted in the next three meetings?

Al Taylor

Yeah, we could conceivably push that closer to the HITAC if the goal is to get the HITAC recommendations finalized by the HITAC meeting.

Steven Lane

Okay. So, we are going to start back in next week with hopefully a follow-up on the CMS recommendations, and then, I think Arien and Mark are going to try to help us finalize the US@ project recommendations, and then we will hopefully be able to move on to recommendations related to health status. So, we will see you all next week.

Al Taylor

Thank you.

Michelle Schreiber

Thank you.

Adjourn (01:30:05)