Health Information Technology Advisory Committee

The Office of the National Coordinator for Health Information Technology

Transcript

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

March 15, 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
Medell Briggs-Malonson	UCLA Health	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
Terry O'Malley	Individual	Discussant

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 happy to have you with us. As a reminder, your feedback is welcomed, which can be typed into the chat feature throughout the meeting, or can be made verbally during the public comment period that is scheduled at about 11:55 Eastern Time this morning. I will begin roll call of our workgroup members, so when I call your name, please indicate that you are here, and I will start with our cochairs. Steven Lane?

Steven Lane
Good morning.

Michael Berry
Arien Malec?

Arien Malec
Good morning.

Michael Berry
Kelly Aldrich? Medell Briggs-Malonson? Hans Buitendijk? Thomas Cantilina? I know Christina Caraballo is not able to join us today. Grace Cordovano?

Grace Cordovano
Here, good morning.

Michael Berry
Steve Eichner?

Steven Eichner
Good morning.

Michael Berry
Sanjeev Tanden?

Sanjeev Tanden
Good morning.

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

David McCallie
Good morning.

Michael Berry
Clem McDonald? Aaron Miri? Mark Savage?

Mark Savage
Good morning.

Michael Berry
Michelle Schreiber? Abby Sears?

Abby Sears

Good morning.

Michael Berry
And, Ram Sriram?

Ram Sriram
Good morning.

Michael Berry
Good morning to all. Now, please join me in welcoming Steven and Arien.

Workgroup Work Plan (00:01:51)

Steven Lane
Thank you so much, everyone, and thank you for your time and attention today. Arien and I have each been challenged in our own ways just in terms of other things going on in our lives over the past week, so I apologize if we are not as prepared as we might otherwise hope to be. Al, are you on the line?

Al Taylor
Yes.

Steven Lane
Wonderful. Can we ask you to update the spreadsheet as you drive today with regard to our recommendations? Because I am working off a laptop, it is going to be hard for me to bounce back and forth and do that work while leading the meeting.

Al Taylor
Sure. I will do my best, but I would appreciate a look over my shoulder as I go, or afterwards, to make sure I am getting it right.

Steven Lane
Absolutely. Maybe put whatever changes you put in another font color, and then I can get back after the fact and look it over. Thanks. And, thank you all for those who are commenting in chat that you are joining. I do want to remind members of the public that you are welcome to join us in the chat, and I want to remind members of the workgroup that if you want your chat to be made a part of the public record, you should direct the chat to everyone as opposed to the hosts and panelists. It is a subtle difference, but worth noting at the beginning of each of our meetings.

So, today, we are jumping back into our work on Task 1, focusing on our recommendations for USCDI V.3, both recommendations related to the items that were proposed as part of the draft V.3 as well as those recommendations related to items that were leveled as Level 2 that we may feel should be added. I want to thank Hans again for the work that he did helping us to clarify where each of these data elements is in the process of being supported by the C-CDA and the FHIR US CORE, and I want to remind all of us that when we make suggestions for additions to V.3, we have to be sure that the HL7 implementation guides will support that going forward, so that will be a key consideration for us.

What we want to do today, and then again at the same on Thursday of this week, is to pick up where we left off last time, looking at issues related to the CMS recommendation throughout medications and facility data, to the patient demographic information that has come forward for our consideration, as well as health status. So, we are going to go there, and then we are going to try to get to other recommendations that workgroup members have put onto the spreadsheet. I really want to thank people for the thoughtful additions to the spreadsheet. There has just been a lot of really good input, and I would love it if we had the time to meet every day between now and our HITAC meeting to get through every one of them, and we are not going to do that, so we are going to do the best we can. So, Arien, do you want to add to that at all?

Arien Malec
No, let's just get to it.

Draft USCDI v3 IS WG Recommendations (00:05:32)

Steven Lane
Great, okay. Michelle, are you here? Michelle Schreiber? Well, if we do not have Michelle, we are going to save some time at the front end. If Michelle comes later, we can come back to that. So, not hearing Michelle, we wanted to jump into the patient demographic issues first that were related to Rows 2 and 3 on the spreadsheet. So, Al, can we bring that up?

Arien Malec
And, while you do that, Steven, I will just give a little background to where we are. So, as a reminder, I think we agreed to use the US@ specification as a content specification for USCDI because we have content that was created pre US@ spec. We indicated there should be a content metadata flag that indicates whether the data was collected pre US@ or collected in accordance with the US@ spec. And, after some back and forth, I think we determined that that recommendation was not quite inclusive or complete enough, and in particular, we did not fully specify that the going-forward content model for USCDI should also include the metadata flag for Project US@.

For those who have not read the US@ spec, there is a metadata flag that can contain a set of modifiers for the address. It really just indicates the role or the interpretation of that address, and it allows, for example, that you can specify that the address is a private address, or an apartment, or that it is a multi-living facility, and you can also indicate that it is temporary, that the person is experiencing homelessness. And so, as I said, it is a flag that indicates the meaning of the address, and a way to think about the implicit bias that we have in health IT is that we all assume that in the absence of any good metadata about the address that the address represents a single-family residence that is a permanent residence, and that is not quite true because we accommodate apartments, but we implicitly assume that that address is a single-family address. And so, it is a useful add to the content spec to recommend that as we move forward with the address that we include the metadata spec.

And so, if you go to 4, the text in bold is my recommended addition to our already approved recommendation, so the first text in bold, which actually has bad formatting because I didn't include the "I" in the text in bold, so, including the address metadata specifier list. So, I am going to pause there. That is the proposal that I have for addressing Mark and Abby's concern about our recommendation as it stands, and it is pretty simple. Today, per USCDI V.3, we have got this unprincipled address collection. Going forward, we recommend that address information in USCDI include the metadata specifier for the US@ spec, and that it include this content metadata spec that indicates whether the data is collected pre US@ spec or in accordance with US@ spec. So, I will pause there.

Steven Lane
So, I think the key question is does anybody have concerns regarding Arien's suggestion?

Arien Malec
Mark has got his hand raised.

Mark Savage
Not a concern per se, but the discussion that Arien, Abby, and I had about the metadata element occurred after the text was written under Column J… Sorry, the metadata element is there. So then, the other thing I would raise is that Abby and I, in our recommendation, talked about the fact that these considerations illustrate that address is not the only element to be looking at for patient matching, and OCHIN kindly offered to actually test some combinations, so in Row 3, we laid out what Arien just laid out, but also added a recommendation that ONC, in the nearish future, invite some consideration of the best several patient-

matching elements and that OCHIN would be willing to test those within the next six months, so that is in addition to what Arien was describing. Again, not a concern.

Steven Lane
Right, and I think that is a great recommendation. It is a bit outside of the scope of, as we have been calling it, our remit, insofar as it is not a specific recommendation regarding V.3 data elements, but we could certainly include a sentence or two to that effect in our recommendations back to HITAC. Would anyone object to that inclusion? If not, whoever is editing the spreadsheet, maybe make a comment above in the "workgroup decision" column that we will include said recommendations along with our specific recommendation about the V.3 data element. Is that good, Mark?

Mark Savage
Sounds good. And, Abby, does that sound good to you?

Abby Sears
Yeah, that sounds fantastic, thank you. And thanks, Mark, for being so eloquent.

Steven Lane
All right. I will ask again whether CMS is in the house. Michelle? I guess not. Now, we were going to have Terry O'Malley join us for the health status discussion, but he was going to be a little delayed.

Arien Malec
Maybe we could go to the recommendation for sex assigned at birth. It is a super geeky technical recommendation.

Steven Lane
Yeah, let's go there. Which row is it, Arien?

Arien Malec
I have no idea, sorry.

Steven Lane
That is fine.

Al Taylor
I got it. I will figure it out.

Arien Malec
Okay. So, again, I will give a recap and reminder to the workgroup. When we heard from the Gender Harmony team, their presentation initially looked at whether we should include sex assigned at birth because it has, as they described it, some administrative and legal issues, particularly given the interpretation of what sex assigned at birth is, and then, when they deliberated and got to the recommendations, sex assigned at birth is a current USCDI field. Sorry, there is a different recommendation that I put together. There we go, this one here. In accordance with the recommendation, I am drafting a member recommendation to align the definition of this field to indicate this is a recorded sex or gender as recorded and valid at date of birth.

As I said, it is a highly technical and super geeky recommendation, but what it does is clarify the meaning of this term to indicate this is effectively what was recorded on, for example, a birth certificate or other administrative record at the date of birth with no additional baggage around the interpretation or meaning of what that field is. So, I am going to pause there. There are administrative issues sometimes, there are issues associated with sex assignment surgeries sometimes, and what we are trying to do with this recommendation is take the meaning of this field, not have it imply anything more than what it is, which is

a simple reflection of administratively what was recorded at the date of birth. So, I am going to pause and see if there is any additional commentary, and Mark has his hand up.

Mark Savage
So, Arien, if I am reading this correctly, this seems definitional, and I am checking on that because I think the Gender Harmony Project's recommendation went beyond the definitions and looked at other sources that might be used for recording sex or gender, not just birth certificate.

Arien Malec
Yeah, there is no word "birth certificate." We interpret this data element as a recorded sex or gender as recorded a birth in accordance with the Gender Harmony data model.

Steven Lane
And, I think that that addresses the concern that Ann Philips raises in the chat, about the fact that some people do get their birth certificates reissued after gender reassignment.

Arien Malec
That is right. This is literally what was recorded at the date of birth.

Mark Savage
Whether or not we want to change the wording of the recommendation to state "sex assigned at birth is an observation made at time of birth" or just "recorded at time of birth"? A recorded observation or a recorded sex?

Clem McDonald
This is Clem.

Mark Savage
Can I just finish?

Steven Lane
Clem, hold on. Let Mark go. He has his hand up.

Mark Savage
So, I think what we heard from the Gender Harmony Project, and I have been talking with them since, is that that approached to sex assigned at birth would be one example of recorded sex or gender.

Arien Malec
That is exactly right. So, the Gender Harmony team has the notion of a recorded sex or gender. The recorded sex or gender has a date collected and date valid. This interpretation of sex assigned at birth is a special type of recorded sex or gender whose collection date and validity date are fixed to the date of birth.

Mark Savage
Okay. So then, that answers my question. I think Abby and I have a broader recommendation at the appropriate time.

Steven Lane
Does it conflict with this one, Mark, or should we complete this and then go on to that?

Mark Savage
Abby may have another thought. I do not think it conflicts, but we were looking at broader alignment. Even recorded sex or gender would go beyond just whatever is recorded at birth, and some other elements too. So, I do not think there is a conflict, I am just flagging that I think it goes more broadly than this.

Arien Malec
So, I am trying to do a technical fix for the fact that sex assigned at birth is an existing USCDI field, and so, we want to fix the interpretation. I think Clem was trying to raise his hand verbally, and then Ike, and then Abby.

Clem McDonald
I just want to say that I cannot get on the web. I do not know what is going on. I am on voice only. Also, I hope we get to the point where we think about observational realities. How in the world is the checking clerk going to record these things? They are not going to have access to the birth certificate, etc.

Mark Savage
But, that will come up, I am sure.

Steven Lane
Clem, as with everything, just because we have included it in USCDI does not specify that it needs to be collected or in what manner. It means that if it is collected operationally, then it is available, then it shall be exchanged.

Arien Malec
That is right, and this one is a routinely collected field, so what we are trying to do is at least remove ambiguity about what that routinely collected field is supposed to mean with respect to USCDI.

Steven Lane
All right. Ike?

Steven Eichner
Good morning. Can we just make sure the language clarifies that it is observed at the time of birth, but not necessarily recorded at the time of birth?

Steven Lane
Well, we cannot exchange it unless it is recorded. It does not become data until it is recorded, and that is our focus here.

Steven Eichner
Right, and I am just trying to distinguish…

Arien Malec
Yeah, I am trying to find the actual Gender Harmony presentation in my records so I can pull out the actual text that Gender Harmony recommended.

Steven Lane
But, I see your point, Ike. It is observed at time of birth, and it could be recorded then, or minutes, or hours, or some other time.

Mark Savage
Gender Harmony does not get into what was the basis of its being recorded. They do not touch that because they treat it strictly as a recording. And so, this is a recorded observation, as I think Ike and I were saying. At least from ONC's perspective, what we mean by that or what we want to clarify that it means is that it is based on an observation. I think that is an important distinction because it is not simply an administrative thing that fills a box on a birth certificate. Our belief is that it has always been based on an observation.

Arien Malec
Okay, cool. Let me go see if I can find the actual presentation, and then we can decide how we want to interpret that field.

Mark Savage
Arien, I will send it to you.

Steven Eichner
It obviously cannot be exchanged until it has been recorded, but we have gone through several iterations of clarity on language about how you may not have to put it in immediately upon observation for it to "count." Obviously, you cannot use it until it is put into a system.

Steven Lane
Right. How would you like "observed and/or recorded at time of birth"?

Steven Eichner
I am not sure about the exact wordsmithing. I will leave that to other experts **[inaudible] [00:22:39]** focused on the goal and challenge of just working that through, if that makes sense.

Steven Lane
Okay, we will work on it. Abby, your hand is up.

Abby Sears
Yeah, I just wanted to clarify. Are you suggesting this definitional update because it is additive to the additional requests, or once we make an agreement on this, then this will finish this conversation? My impression is this is Step 1, and then we have the rest of the conversation, which is Step 2, and that you are cleaning up something related to the data, Arien.

Arien Malec
This is purely cleaning up the definition of sex assigned at birth, correct.

Abby Sears
Okay, thank you.

Steven Eichner
Maybe it needs a footnote rather than changing the definition in terms of time of entering.

Arien Malec
Mm-hmm. Okay, Mark?

Mark Savage
Steven, were you calling on me?

Steven Lane
Yeah.

Mark Savage
Okay. Since we are paying attention to words here, the point that birth certificates can be changed at a later point in time, I wanted to check to make sure that we do indeed want the words "recorded at time of birth" as opposed to the legal source of the information, which is the birth certificate, which might be changed at a later time. I am just checking on what the intention is here.

Arien Malec
That is right. We already have an administrative sex or gender field. This is not that. Let me present, if I can, the actual text. I cannot share a screen.

Steven Lane

I have to stop. Hold on. Go ahead, Arien.

Arien Malec
I am going to share…here we go. Can you all see this? Okay. So, these are the recommendations for sex assigned at birth. Again, very neutrally, we are not, in this field, making any assertions about biological sex in clinical observations. We are saying this was an observation that has a validity period of the date of birth. So, the intent here is that this is a very neutral description of a recorded sex or gender that has a specific validity period at date of birth.

So, again, the point that Gender Harmony makes is that sex assigned at birth is not useful as a clinical sex characteristic observation. It has never been the perspective or point of a sex assigned at birth to be clinically sophisticated enough. In most cases, it does not need to be. In some cases, it does, and may be misleading as an observation. And so, the Gender Harmony recommendation is to treat this very neutrally, get out of the overload in meaning and variation by jurisdiction. Because it is in records, needs to be in records, and is part of USCDI, the recommendation is let's make sure that it's clear, that it is a recorded sex or gender that has a validity period at the date of birth.

Steven Lane
So, Arien, I understand, and your description of it made it very clear, but I just wanted to distinguish the way that this is represented on this slide and how that differs from the original intent of sex assigned at birth as a data element, and the fact that the original intent of it is to base the reported sex on an observation, and not to distinguish it from what is put on a birth certificate in some legal record. So, if the recommendation is to change the scope of the original intent of ONC's use of sex assigned at birth, then the recommendation should say to change the scope of it from an observation to a recording.

Arien Malec
Yes, I think that is correct.

Steven Eichner
This is Steve Eichner. Really quickly, I am not trying to change the language, but thinking from a provenance perspective, with a single observation, is there an opportunity for a technical correction to correct a data entry issue if somebody miscued it? I am not looking at changing an interpretation, but just in terms of a technical error, is that permissible in this space or not? Again, thinking from a provenance kind of perspective, not reinterpreting the observation, but just…

Steven Lane
I think I can answer your question, Ike. From a certification perspective, the ability to record demographics data elements, including sex assigned at birth, the certification requirement is "access and change," so there is some specification in certification on access and change of any data element.

Arien Malec
Just to be clear, there is no specification that the data entry is…99.999% of data collected is collected by means of saying, "What was your sex as it was assigned at birth?", and that is it. The instrument that is used to collect this field is not highly principled. There may be cases in birth records where it is highly principled, where it is based on an observation, and it is a little hyperbole to say 99.99%, but I think that is useful as a rough approximation that is has purely existed as an administrative field as opposed to a clinical observation, and that this definition is in no way inconsistent with data that has been collected, but again, I think the recommendation, as Al notes, is to change the interpretation of this field to be a more neutral recorded sex or gender with validity period of date of birth, period, and any interpretation as to whether that is an observation or has clinical validity is redefined as not what that field is intended to be interpreted as.

Steven Eichner
This is Steve again. That is probably a good thing, looking in terms of managing birth certificates, updates, and amendments, and the like, and tracking that all the way through can become rather complex.

Steven Lane
I want to be sure that we do not burn too many hours on this topic. I think we covered it in pretty exhaustive detail. Does anyone have any objection to the recommendation as it stands? Terrific, all right. Well, luckily, we now have both Michelle and Terry in the house, and as promised, I want to go back to Michelle and CMS and pick up where we left off with the facility data and organization identifier. There was a pretty straightforward proposal on the table last time. Michelle, you were going to go back and revisit what with your team. If we could go, Al, to Row 17, what do you have to say, Michelle?

Michelle Schreiber
Well, I think at a minimum, Steven, we really need a facility identifier group or whatever we would call it. We still advocate for CCN because CCN is the way that most facilities are identified, although we recognize that there may be other identifiers that, over time, would need to be added to that group.

Steven Lane
Well I think on Row 17, if you can pull it Al, we have wording for a recommendation that will accomplish that.

Al Taylor
Steven, I do not think it is 17 anymore.

Steven Lane
Sorry, I hate that.

Al Taylor
I think it is 27. People are adding stuff at the top, so it is messing it up.

Steven Lane
Oh. People, add things at the bottom, please. Where do you think it is now?

Al Taylor
Twenty-seven.

Steven Lane
Twenty-seven, okay. Can we go there?

Michelle Schreiber
My gosh, 10 whole rows.

Al Taylor
It could have been an alphabet sort that did that.

Steven Lane
Yeah. I know people are all well intentioned here. Yes, it is in 27. I am seeing it here.

Arien Malec
All right, I can go back to sharing.

Steven Lane
So, the draft recommendation is “USCDI V.3 include an organizational identifier with a combination of identifier and assigning authority, which would need to accommodate both CCN and PTN. It should allow multiple identifiers, and the identifiers should be associated with an encounter, and it should be required if known,” again, not assuming changes to operations. So, that was the recommendation at the end of our discussion last time. Michelle, it does not sound like you have said anything that is going to change it. Does

anyone have an objection to us moving that over into a final recommendation? Terrific. That was the easy one. All right. Oh, Clem, your hand is up.

Clem McDonald
I am happy with the definition, but I thought we were going to get a formal definition of what the facility and these various things were so we avoid confusion in the future.

Steven Lane
So, you are saying a formal definition of CCN and PTN?

Clem McDonald
No, not the coding systems, the things they are talking about. Is it the geographic location? Is it the organizational structure? Is it the legal organization? I do not think that is clear.

Arien Malec
Hey, Clem, I think in our recommendation, we are clearly saying organizational identifier as opposed to facility identifier.

Clem McDonald
Okay.

Steven Lane
All right. Michelle, that was the easy one. The harder one is medications. We had a detailed discussion last time about a couple of medication-related data elements that you were recommending adding, and it led us to a really interesting discussion about how health IT systems might represent a current medication list and whether adding the ones that you requested would be appropriate as an iterative step forward or whether there needs to be a more full-sail reevaluation of medication data. I think that is really the key philosophical question, is can we make small, iterative, valuable changes, or do we need to be in an all-or-none approach to this? And, you were going to take that back to your team and bring us input.

Michelle Schreiber
I think at this point in time, our input is that we are probably not at a point where we can make these recommendations, and we need to take it back and look at it in more detail. So, in other words, although we actually thought that these data elements were standardized enough to bring them forward, last week's conversation seems to indicate that that is not the case, and so, we are willing to table this to the future.

Steven Lane
Well, I find that a little disappointing, but not inappropriate.

Michelle Schreiber
We are happy to push if you would really like. It just did not seem feasible.

Steven Lane
Yeah, I hear you, and I will let Arien speak to this as well, but there was a discussion last week about possibly putting together a small task group to look into this in greater detail to see what might be an appropriate iterative change to medication-related data to move us from where we are to a greener pasture, and I just wanted to keep that thought out on the table that perhaps even after our ISA work, if people still had the fortitude to move forward, that we might dedicate a few meetings to that topic, perhaps bringing in appropriate subject matter experts. Arien?

Arien Malec
No, I completely agree with that, and Michelle, I think one of the things that has come out of the discussion is a recognition that maybe what we thought or what I naively thought was in USCDI is not, in fact, in USCDI, and that USCDI has no way of capturing the notion of a medication list that is structured or interpreted in

any particular way, and that that creates, I think, issues related to interoperability where the No. 1 useful thing that people hope to get out of interoperability is a medication list, or if it is not No. 1, it is in the top three, and it sounds like it would be a useful activity for the Interoperability Standards Workgroup to contemplate what it would look like to have medication lists as data classes inside USCDI.

Michelle Schreiber
Arien and Steven, we completely agree with that, we just did not think now was the time that we could push this forward. It did not seem right. But, we are completely supportive of a small group working on this because, Arien, I completely agree. This is one of the main advantages of having interoperable data, is that we can have an appropriate list of medications so that everybody knows what the patient is actually taking.

Steven Lane
And, it seems to me that if one were going to propose a group to take that up, it would be a group called the ONC Interoperability Standards Workgroup, so perhaps, Al, you can take back to your team our suggestion, request, and volunteerism to potentially take that up later this year after our ISA work is done.

Michelle Schreiber
Steven, I do not want you to think that we do not believe this is important. We believe that this is critical, but the reason to not push forward for a recommendation at this time is that it seemed like there were too many issues that need to be discussed first.

Arien Malec
Yeah, I think that is exactly right, and I also want to note that at least one of the reasons why structured med lists are not a thing in USCDI is that historically, we had certification requirements on EHRs to do certain things. I think we have dropped those certification requirements on EHRs and on providers to do certain things or maintain certain things to better let providers practice medicine. There may be a fear that including more structured things like med lists in USCDI creates a reciprocal obligation on clinicians to do or maintain, and I would imagine that our future intent would be that when medications are managed in organized lists that they be available for interoperability, and we will see that as a common theme going forward. As I said, if there is one thing we should be pretty good at, it should be exchanging structured lists of medications.

Steven Lane
All right. Any other comments on that? I do not see any hands up, but I want to take full advantage of our time. Thank you so much, Michelle, for those follow-ups. I think now, we can turn our attention to health status. Is that true, Arien?

Arien Malec
I believe so.

Steven Lane
And, I know that we were supposed to pick that up on Row 11, but I have no idea where that is now that things have moved, so, Al, help us out here.

Al Taylor
Sorry, which data element are we talking about now?

Steven Lane
I would say we would take them in order in the hopes of getting through them all.

Al Taylor
Order of what?

Steven Lane

Just numeric.

Al Taylor
Well, the current first one is No. 17. I guess we will be discussing disability status first. There are four recommendations related to disability status on these lines based just on disability status.

Arien Malec
I wonder whether we go for the uber one first as opposed to going into the…

Steven Lane
Is that No. 18, whether it is a demographic or a health status?

Arien Malec
So, maybe there are bunch of uber ones. The uberest of all of them, in my head, is the one that makes the recommendation that we support the concept of assessments, that we move, for example, SDOH assessments into a generalized assessments category, and that we classify these statuses as assessments.

Steven Lane
Okay. Terry, that was your recommendation. Would you like to speak to that? And again, I think like the question of whether this is a demographic or a health status, this is kind of a categorization issue, so, not central to the question of whether and how the data will actually be exchanged, but I do think that part of our work is making sure that the architecture and the structure of USCDI is logical to participants.

Arien Malec
And, the reason that I am proposing taking this one up first is that if we make a decision here, it may end up simplifying the rest of the decisions that we make, and if we do not make a decision here, it will also make it clear how we assess the future considerations. So, Terry, over to you.

Terry O'Malley
Thank you. So, I guess the actual issue there is no place in USCDI for assessments currently, and as Clem noted, there are thousands of assessments, not only just for physicians, but therapists, nutritionists, and nurses. Everybody has assessments, and so, it seems to be a very important data set to capture in USCDI, and the question that Holly Miller and I raised was why don't we put it into the health status bucket and call it health status/assessments? But, we also read Clem's comment that used to be in Workbook Line 6 that assessments could also fit under the lab results category, and we have no problem with either of those. Our main goal is to get assessments into USCDI. Where it ultimately rests, we leave to the wisdom of the committee.

Clem McDonald
Could I say something?

Steven Lane
Yes, go ahead.

Clem McDonald
I do not think it belongs at WEBS. I do not know if I said that or if my mouth said it wrong. But, I do think along the line of the thousands of them, we should find some way to call out the best ones or some way to reduce the numbers because it does not help much for statistical analysis to have thousands of different ways of saying the same thing. Maybe tens, maybe hundreds. What do you think, Terry?

Terry O'Malley
It would be great to do that. My thought is that clinical medicine is just so diverse, and the folks who are doing the assessments are doing them for somewhat different reasons, that I would be happy with a

standardized assessment, one that has been demonstrated to have validity and reliability, and take the number as what it is, whatever that is. Unfortunately, as you said, it is going to be a big one, but standardized assessments are in wide use, and we can support that.

Steven Lane
Mark?

Mark Savage
Thanks. I just wanted to both check and observe that many of the recommendations and presentations we have had have talked about the importance of self-reporting a value rather than having an external, clinical, or other observation reporting, and the way I look at this as an approach to an assessment would also mean, and this is where I am checking, that values that are self-reported would, as people have recommended, go into patient demographics, for example, and would not fall under assessments because they do not fit that definition of being externally validated. Is that correct? I am raising it also because I think that might have some downstream effects, but I am not sure.

Steven Lane
I will take a little bit of cochair prerogative to respond. I think that there are a number of ways that we can deal with the notion of self-reported data. I think that definitely overlaps into provenance and data source, as you and I have discussed. Personally, I cringe at the idea that saying if it is self-reported, it is demographics, and if it is professionally or otherwise captured or recorded, it goes into a different bucket. I personally think it would make more sense for us to categorize the assessments as living somewhere logical, and then have a method whereby we identify whether, for any given assessment, it was captured as self-reported data or by a provider-type person.

Arien Malec
So, Steven, would that mean, then, that assessment is not just constrained to an external observation, but it might be from various sources?

Steven Lane
That is how I would see it personally, and I am interested in others' thoughts. Why don't we go to the next hand up, which is Ike's?

Steven Eichner
Good morning again. I think that there are some opportunities to do three or four things with respect to assessments including both structured and unstructured data in the framework. There are some general assessments that may be useful and have good vocabularies behind them, potentially LOINC codes and the like, associated with particular data elements, and those are wonderful to capture. I think there is also huge value in including the ability to support what is currently more realistically unstructured data in the sense of looking at support for rare disease, assessments that are specific to that particular condition that could then be attached to the patient's record as an unstructured document until such time as there are LOINC codes and such developed around those specific assessments. I think there is huge value in that, both from a pure data perspective and in terms of looking at addressing the need of actually providing useful care to the patient in that sense of the assessment.

For example, identifying that I have a mobility issue is not really identifying what my needs are, or helping you as a provider get into the office, or address the narrow need of what you need to do to help me to get into the office successfully, where unstructured data might support that. I do think it is also a little challenging to say who administered the assessment and using that to distinguish what bucket you might put it in. As an example, I have done a bunch of clinical trials as a patient, as well as several in other capacities, and I cannot tell you the number of times that I have answered on a paper assessment if I can reach my back pocket. And, I have filled out the form, and then handed it to the nurse, who puts it in the record. So, is that a self-assessed component because the nurse was sitting right there when I did it, or is that administered

by a professional? That is just an example of trying to thread that needle if you are trying to say administered by one goes here, self-administered goes there. So, I hope that is helpful.

Steven Lane
Arien?

Arien Malec
All right. So, first of all, I completely agree that assessments as parameterized by a LOINC code do not imply that all such assessments must be externally administered, that a validated self-assessment is indeed a self-assessment, is definitionally an assessment. I also want to point out that I think one of the critiques in some cases from ONC in including this notion of support assessments with the accompanying LOINC code is that historically, we have believed that that led to a presumption of EHR workflows, and that ONC has had a policy in USCDI of adding elements slowly so that we could work out the certification requirements.

So, I think it would be useful as we think about an assessment's category to be able to make it clear that what is required for the purposes of interoperability is not the requirement that an EHR would be able to produce any possible assessment, because that would be a little insane, but that any clinically relevant assessment that is captured in the EHR be exposed as an assessment with its associated LOINC code, and that when data are received through a specification that is mapped to USCDI that the expectation is, with respect to interoperability, that a system can accept the notion of an assessment with its accompanying LOINC code, again, with no presumption or assumption in terms of interpretation, clinical workflow, etc., simply the fact that it can receive an assessment, labeled appropriately, that this is a Glasgow Coma Scale.

And then, just to sell this feature a bit, I think if we go this direction, a lot of the additional discussion that we have becomes a lot simpler. So, for example, a disability status is a subclass of assessments, and we can use the validated instrument that has been recommended with respect to collection of data for disability status, we can use any number of functional status assessment instruments, and we have a principal place for it to go, so a lot of the future discussion, I believe, becomes conceptually simpler upon adopting this recommendation.

Steven Eichner
This is Steve. Just real fast, thank you so much for that. I think it is also important to consider from the "included in the EHR" end of it that it is not necessarily included in the EHR as a structured document, that it might be also included in the EHR as an unstructured either scanned or PDF document as well.

Arien Malec
That is exactly right, and going forward, we might want, for example, FHIR questionnaire to be an interoperable specification that is included as part of EHRs. That might be one place where assessments could be captured, but this is logically divorced from the notion of what technology is used to capture the assessment.

Steven Eichner
Wonderful, and thank you for that. I guess the other thing that I would add in passing is thinking about that structured data and coming back to the back pocket question, it is off a standardized assessment, but from my personal perspective, it is a lousy question because it does not specify left back pocket or right back pocket. I can reach my right back pocket; I cannot reach my left back pocket. Six years later, no one has been able to explain to me how to answer that question appropriately, given my circumstance. Again, I am not looking for a solution here and there, just putting that out as an example that that is difficult. The final thing that I would add is rather than looking and using language about disability assessments, if we look for the idea of determining functional assessments, including addressing individuals' health conditions, so you are not really assessing my disability, you are assessing my ability, if that makes any sense.

Steven Lane

All right. Thank you, Ike. There is a lot of lively discussion going on in the chat. Clem, your hand is up.

Clem McDonald
Yeah, I would just like to endorse what Arien said, that we should not subdivide them anymore, and the self-assessments are the same or as equal status, in fact, often better. I think the key is "validated," so we would like to highlight and distinguish validated assessments from unvalidated assessments, so the promise is that they are all self-assessments and they are all validated, or most of them are validated. And, I do not know if continually subdividing is going to be a very productive activity.

Steven Lane
Dave McCallie, you had a number of comments in the chat. Did you want to put voice to any of those?

David McCallie
Thanks, Steven. No, I am comfortable with Arien's broad notions. The thing that I have learned off-cycle in discussions with you two and Al is USCDI is really about some "should" more than anything, if you had to reduce it to one word, and by calling out a particular type of assessment and possibly a particular instrument associated with that assessment, we are really pushing a "should," "You should consider doing this, and if you do, here is how to exchange it." So, I think there is some value in that, but obviously, the record contains hundreds of different assessments captured from the patient, by the clinician, by instruments, so, listing all of them is not in scope. We cannot do that. We should just call out ones that we think are especially worthy of "should" status.

Steven Lane
Great. All right, so, we have a proposal on the table that came originally from Drs. Miller et al, and we have discussed it at some length. The proposal, again, is to change our terminology to health status/assessments, with the understanding that this would include structured, standardized, validated assessments with the proposal of adding lists of specific examples that could and should be exchanged within this data class and data element when that data is collected, and here, we are showing some examples of these assessments that have been included, and I think we have a couple of those in that Column H, "justifications," some of which were brought forward from work that we did in the taskforce last year. So, does anyone object to us moving that into a final recommendation?

Arien Malec
Steven, not an objection, but I think we should be clear that it also includes self-assessment. We just had this conversation. There is a risk of it being lost if we do not say so explicitly.

Steven Lane
Agreed, and we will try to capture that in the language of the recommendation that we will bring back to you all before bringing it forward to the HITAC. All right, so, Arien, you had a sense of how we would flow from that decision to the subsequent decisions regarding health status.

Arien Malec
Yeah. Let's just pick them up, but for example, whichever one we are on right here, the "expand mental status" subelements with instruments and a whole set of LOINC instruments becomes conceptually very simple. We are saying in this recommendation that mental status is a subclass of assessments under the overall assessments category, and then we have a principled way of knowing what how to interpret a mental status with regard to its inclusion in this overall category. So, we know, for example, that mental status has been assessed using the Glasgow Coma Scale, using the MACE, etc.

Steven Lane
This is mental cognitive status.

Arien Malec

Mental cognitive status, but what we are doing under Row 67 is saying that mental status is a subtype of assessment, and that it is the subtype of assessment that deals with mental and cognitive status.

Steven Lane
And could utilize this list of examples…

Arien Malec
And could utilize this list of example assessments, correct. That is what I mean by adopting this high-level recommendation makes the subrecommendations conceptually a lot simpler.

Al Taylor
May I ask a question about that? This is Al.

Steven Lane
Go ahead, Al.

Al Taylor
So, the recommendation on Column G says, "Expand mental status, or just examples." So, the question is which is the recommendation I am going to state?

Arien Malec
In this case, I think we would want to say that we would include mental and cognitive status as a subclass of assessments.

Al Taylor
Is it an element in health status and assessment?

Arien Malec
Yes.

Al Taylor
Isn't that the same thing? Does anything need to say?

Arien Malec
Yeah, it is a subclass or subtype.

Steven Lane
It is an element, not a subclass.

Arien Malec
That is true.

Al Taylor
And, there is no such thing as a subclass or subelement?

Arien Malec
Yeah, I am speaking CS type theory here, but conceptually, what it is is a subtype of assessment that is constrained or confined to the assessments to assess mental or cognitive status.

Steven Lane
Yes. I think the specific change that is being suggested is the addition of the word "cognitive," so it would not just be "mental status," it would be "mental/cognitive status," and as you suggested, Al, it would fall as a data element within the newly renamed health status/assessments data class, and then, we would include, again, a relatively short list of examples.

Arien Malec
Yup.

Al Taylor
Would those examples be in the form of a value set, like we had recommended, and then adopted for clinical tests?

Arien Malec
It certainly could. I do not know if, in this work, we want to be the ones to define the appropriate value set, but with respect to certification, for example, one could, in the future, point to a constrained value set as the "should," to David McCallie's point.

Al Taylor
The previous form of the taskforce already has set that precedence of defining what the value set would contain. I do not see any issue with recommending a particular value set, or working with ONC to define it, or saying among this list, last year, Clem recommended a list that was adopted as part of the appendix and the final recommendations. The same thing could be done for this particular set, which understandably has maybe a not so intuitive list of things, and to define them or to at least provide uses and examples, that could help with certification for this element, adoption/implementation of this data element, as it did with clinical tests.

Arien Malec
That makes a ton of sense.

Steven Lane
Al, are you using the term "value set" differently than the way I have used the term "examples"?

Al Taylor
Yeah. So, a value set versus an example is a value set is a curated list of examples that has an ability to reference a particular… So, in my world, value sets have a URL that can be used as a reference for that value set.

Arien Malec
Yeah, so again, logically, with my computer science hat on, we are saying assessments are a combination of a LOINC code and the output that is intended to be the response to that LOINC code. It could be structured or unstructured. We are saying that mental status, which we want to modify to "mental and cognitive status," is a type of assessment that is constrained to be mental and cognitive status, with the same structure, and that we recommend pointing to a specific value set that includes a set of standardized assessments for the purposes of common core interoperability.

Steven Lane
Okay, back to the hands. David?

David McCallie
Yeah. So, does listing this set of instruments have an impact on certification? Do they all have to be demonstrated to be certified? Do none of them have to be demonstrated?

Steven Lane
David, we cannot say what it is going to look like, what the final test method is going to look like, but a value set could be used as a reference to guide developers to develop the content, so, at a minimum, it is likely that developers would be able to capture these particular coded assessments, and then, presumably, the test method would test an ability to capture at least this minimum set.

Arien Malec
Yeah, and David, I do not think we in this workgroup are finalizing the specific sublist for the value set because I do not think we have the qualifications. You may be rare among us as the only one who has the qualifications to be able to contemplate what that value set looks like. I think what we are recommending here is that there be a value set of validated instruments commonly in use for capturing mental and cognitive status.

David McCallie
Obviously, I am not in a position to make those assessments of these assessments, but I would say, back to the notion of "shouldness," if someone like ONC ends up listing some of these things, it is because someone of authority believes they should be capable of being captured and transmitted for interoperability, and that has a big impact on what developers have to go do, so we have to be careful with these lists.

Steven Lane
Also, Al, I have a question. What I heard you say is that certification might require vendors to prove the ability to capture and exchange every example or every member of the value set, and it seems to me that that would not be necessary as much as "one or more of these."

Al Taylor
That is definitely not what I said, Steven. What I said is that ONC wants to provide guidance to developers to develop in accordance with the data element/data class version of USCDI in general, and in order to do so, we can provide to assist the developers in developing according to the way we think it ought to be done. We can provide guidance in either the certification companion guide, the USCDI reference document, in the test method, or some other mechanism to say what we mean by that is… Let me give you an example. There is a list of clinical tests that we publish in the VSAC, and that link is available in the USCDI document that says, "Here are some of the codes that we mean when we say 'clinical tests.'"

And, the test method has not been developed yet for Version 2 data elements, but when it is, it will likely say to developers that the test data that we send you to prove that you can conform to the clinical tests data element will include this list that is a value set, so developers can go reference that value set, make sure their systems can at least be capable of capturing those codes, and then, they would be able to prove that in certification to the new requirement. We usually do not say everything that falls under a particular category, whether it is everything in LOINC or everything in a value set.

Steven Lane
Okay, good. Mark?

Mark Savage
Yes. I am unclear how this recommendation about "mental status" relates to the USCDI V.3 data element "mental function." Somebody, please help me.

Steven Lane
I would say this is a renaming of that, that it is the same thing.

Clem McDonald
Hear, hear.

Steven Lane
So, I guess this is a question for Terry. Is the recommendation to change the name to "mental status," or are you just referencing the same thing?

Terry O'Malley
I am referencing the same thing. What is more commonly used clinically is "mental status."

Arien Malec
Should we call it “mental or cognitive status”?

Clem McDonald
There are lots of names. We can just declare them **[inaudible] [01:11:17]**.

Terry O’Malley
Yeah. I have no preference.

Steven Lane
Mark, are you comfortable with that response?

Mark Savage
Yeah. It makes things a whole lot clearer and easier to understand how this fits into some of the other recommendations we will be considering. Thank you.

Steven Lane
Yeah, and it was odd that in draft V.3, it was called “mental function” as opposed to “mental status.”

Mark Savage
Agreed.

Steven Lane
So, I like making them more consistent.

Mark Savage
And, we had proposed last year that it be “cognitive status.”

Steven Lane
Perfect. Well, now it is “mental and cognitive status.” Clem, you still have a hand up.

Clem McDonald
I think we maybe ought to think about at least making clear that there are multiple names for some of these, and maybe even including them as alternative names, just to keep people being aware. They may have their own favorite in mind. But, the second thing is, Al, I am just not clear on why it is easier for a vendor to take 12, 20, or 30 specifically named LOINC codes rather than a whole class of LOINC codes. They install all the ICD-9 codes and 10 codes every year once a year. It is just a big install. They are all the same kind of technical things. Now, granted, you want to call it a class, but I do not know why there is labor per term.

Al Taylor
The feedback we have gotten from developers is that they need examples, and so, we provide them.

Clem McDonald
I take it back. I am all for examples. No, absolutely. Never mind. If that is all you are talking about, you are right.

Al Taylor
You can call this a minimum set, or you can call it an example set, or you can call it just “mental function value set,” but it all has the same intent, to provide examples to people, because we have specifically gotten the question “What do you mean by ‘clinical test’?” And so, our response was “This is what we mean by ‘clinical test.’”

Clem McDonald
Okay, I take back what I said.

Steven Lane
Also, we can go back to the folks at LOINC once we have clarified this in USCDI and suggest to them that they add to their hierarchy where any given LOINC-coded assessment fits within the USCDI hierarchy. All right, we have another 10 minutes before public comment. Are we ready to tackle disability? That was a question to either Terry or Arien, I think.

Arien Malec
I am going to defer to Terry, but I guess my perspective is that we should treat disability status in exactly the same way we just contemplated treating mental and cognitive status.

Terry O'Malley
Agreed.

Steven Lane
And, that includes the earlier discussed notion of self-reporting and needing to specifically identify the source of the information. Shall we touch on this question of whether disability status in particular should be categorized under the demographics data class or under the data class we have been discussing regarding health status and assessments.

Arien Malec
I would move under the health status and assessments. The issue is that disability is a temporary point-in-time assessment, not a permanent or semipermanent status, nor is it associated with the human in the same way that the demographic elements are associated with the human. It is one day, as I think many of us know all too well, I am disabled in this way, the next day, I am not, the third day, I am disabled in a different way, so it logically makes more sense to consider it a health status assessment, and that allows us to think about, for example, making a recommendation of a value set for the ACS Washington group survey instrument as one of the value set instruments for collecting data into this proposed assessment.

Steven Lane
And, I think that by capturing the source of the data, we address the real underlying concern, which was the notion that most of the time, this is going to be patient-reported.

Arien Malec
Exactly.

Steven Lane
Ike?

Steven Eichner
This is Steve. I think it would be useful to consider using the word "condition" rather than "status" here. The term feels a little friendlier in terms of looking at what is my current condition, perhaps a little less technical that "status." It feels like I am giving a report of the day if you are using the word "status" in that context versus looking at what your condition is. It might be a little friendlier and more human of a term, if that makes sense.

Steven Lane
I think those are important considerations, and the way these recommendations are perceived, especially by communities of individuals to which they may particularly pertain is important. We have also certainly set a precedence here of suggesting these two terms separated by a slash as a way of expanding the vocabulary that we are using. So, I would not personally object to saying disability status/condition. I do not think it changes the meaning of the data element that we are discussing. I am curious what others think. Mark, your hand is up.

Mark Savage
We had a discussion last year about the "disability community" not really liking the phrase "disability status" at this point in time, sort of an evolving understanding, and I think our presenters worked within what the governmental policy workflow has been and did not raise any concerns about that, but I am just reminding us that that was a topic of considerable discussion last year.

Steven Eichner
Just building upon that idea, and the utility of the USCDI overall, and the evolution from CDA and the like, where historically, there has been much more focus and utilization in "hardcore" medical users than broader communities. We are really looking at trying to leverage the USCDI, not produced exclusively in medical environments, but in surrounding supportive activities, as well as thinking about things like personal access to data and making information available through personal portals, or other applications, or other services. I think it is very helpful to pay, perhaps, a little more attention as to how terms are perceived going forward, rather than looking where we were historically. There is nothing wrong where we were historically. It is speaking to the audience. I think our audience is changing and will continue to change, and it may be very helpful to adapt terminology that they are more familiar with or more comfortable with.

Steven Lane
Al, your hand is up, and I would invite you, in the next five minutes, to try to bring us to a final recommendation that you think would satisfy for this line item.

Al Taylor
Okay. I think we started off the discussion on a pretty good note. I will get to that in just a second. So, I wanted to address Ike's point about status versus condition. We deliberately added the status as a new element or class in USCDI because the need to evaluate each of these categories, which are the elements in the status data class, is something that we felt like was missing from USCDI in the past. The difference between a status or an assessment and a condition is the same as the difference between a vital sign and a diagnosis. So, there is the blood pressure vital sign, and then there is the diagnosis or condition of hypertension. The reason it is called "vital sign" is it is an important thing to check, which may or may not lead to a condition of hypertension, may not indicate a condition of hypertension, but it is important to check. Same as health status or assessment, it is an important thing to check.

Steven Lane
Good point.

Al Taylor
So, with respect to bringing us to a recommendation, I think what we started with when talking about…

Arien Malec
Mental and cognitive status.

Al Taylor
Yeah. So, we said "structured assessment" includes patient-reported and could be guided by a value set or a list of examples?

Steven Lane
Correct. Carmela raised the terminology issue of "ability" versus "disability," again, a sensitive topic for the affected community. I do not think it has a meaningful impact on the data, how it will be collected or shared, but could have a public-facing impact. I am curious whether anybody on the workgroup would want to take that up.

Mark Savage

Steven, I will. I have been in conversation with Sylvia and others. I would be happy to raise that question with them. Just like the change from "disabled people" to "people with disabilities," I think the notion of ability is probably going to resonate, and I will take it on to check that.

Steven Lane
I think similar to our use of "mental/cognitive status," which sort of tries to get at similar concepts from a couple different perspectives, we could certainly consider "ability/disability status" as the name of this data element to capture that important concept.

Arien Malec
Steven, I do not know where we are in our timing. Not much more time left. I wonder whether, at this stage, we propose consolidating a bunch of these subrecommendations into these larger categorizations, coming up with a more holistic set of recommendations, and then reviewing those in our next meeting.

Steven Lane
Your audio is breaking up a little bit for me, Arien, but I think you are talking about putting together some overarching recommendations that might apply to this health status/assessments data class that could be addressed separately, so let's take that up between now and our next meeting and come back with a recommendation, as it is time to cut to public comment.

Public Comment (01:24:26)

Michael Berry
All right, Steven, thank you. We are going to pause our workgroup meeting and go to public comment. 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 happen to be on the phone only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. I see one person in the queue, Michael Rakotz. I hope I said your name correctly. You can go ahead for three minutes.

Michael Rakotz
Yes, thank you. My name is Dr. Michael Rakotz. I have been a family physician for 25 years and am the Vice President of Health Outcomes at the American Medical Association. I want to first thank the Interoperability Standards Workgroup and ONC for their efforts to advance and expand the USCDI. Access to a common standardized set of health data classes and elements will help me treat and care for patients, will ensure individuals are engaged and empowered with data, and support much-needed information exchange across the healthcare community.

High blood pressure impacts more than 120 million people in the United States. It is the leading modifiable risk factor for preventing death from cardiovascular disease. The accurate measurement and interpretation of blood pressure for diagnosing high blood pressure and assessing effectiveness of treatment. With over 20 years of clinical evidence and guidelines, it is clear that proper estimation of an individual's blood pressure requires multiple blood pressure measurements, in other words, obtaining two or more BP readings and then averaging. This is true regardless of whether a patient is in an office setting or measuring their blood pressure at home. Moreover, consistent communication of average BP is critical for addressing hypertension nationwide.

Including average blood pressure in the USCDI would make it easier for physicians and other healthcare providers to diagnose high blood pressure and assess BP control more accurately. Physicians need health IT systems that can store and exchange average BP separate and apart from individual readings. This can help with documentation and enable physicians to use this specific information in their clinical decision making. The Centers for Disease Control and Prevention and the National Association of Community Health Centers agree with AMA, and support a standardized average blood pressure data element. Our organizations ask that the Interoperability Standards Workgroup include the Level 2 average blood pressure data element in its recommendations for the inclusion in the USCDI Version 3. Thank you.

Steven Lane
Thank you for that comment.

Michael Berry
There are no other comments in the queue, so, go ahead.

Steven Lane
That is great, and again, I will note that that average blood pressure data element does, as the speaker suggested, exist in Level 2 and was submitted by the AMA, and we really do appreciate that comment. I also note that it is officially now on the public record for ONC consideration whether or not our workgroup has time to take that up, so, thank you. If there are workgroup members who would like us to take that up, please identify that in the spreadsheet for us, and we could come back and discuss this. Otherwise, the ONC will consider that, again, as I said, with or without our input.

Arien Malec
And, I would just want to note that speaking with my computer scientist hat on, I think this is all properly encoded in the LOINC code, so the systolic/diastolic elements of blood pressure would then want to point to the appropriate LOINC code that this is an average of two or more measurements.

Steven Lane
Great. Clem, you have your hand up.

Clem McDonald
Well, I would just like to elaborate on Arien's insights. I think it should be clarified that average is the same as mean, first of all. That is not clear to everybody. But, there is some clarity needed. What they are really talking about is the practice in an office practice and in research studies to take one or more, typically three, blood pressure readings at some space apart and average them to mute the effects of anxiety or whatever that give you a higher blood pressure than needed, and that needs to be distinguished from the average diastolic and systolic, an average or mean blood pressure in a given cycle, so there is just some additional clarity needed to keep people from getting confused about what is really intended here.

Steven Lane
Great. All right, we are at time. We have had an incredibly successful meeting today, and I want to thank everyone for your contributions. I think we may have a bit of additional work to be done on the health status and assessments data elements when we come back on Thursday, but as your leadership, we will put together a list of where we are going to go from here with regard to the other submitted data elements, and look forward to your engagement.

Arien Malec
Thank you very much.

Steven Lane
Everyone have a wonderful day, and those of you at HIMSS, I will see you later.

Arien Malec
Enjoy HIMSS.

Adjourn (01:29:51)