HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) INTEROPERABILITY STANDARDS WORKGROUP MEETING
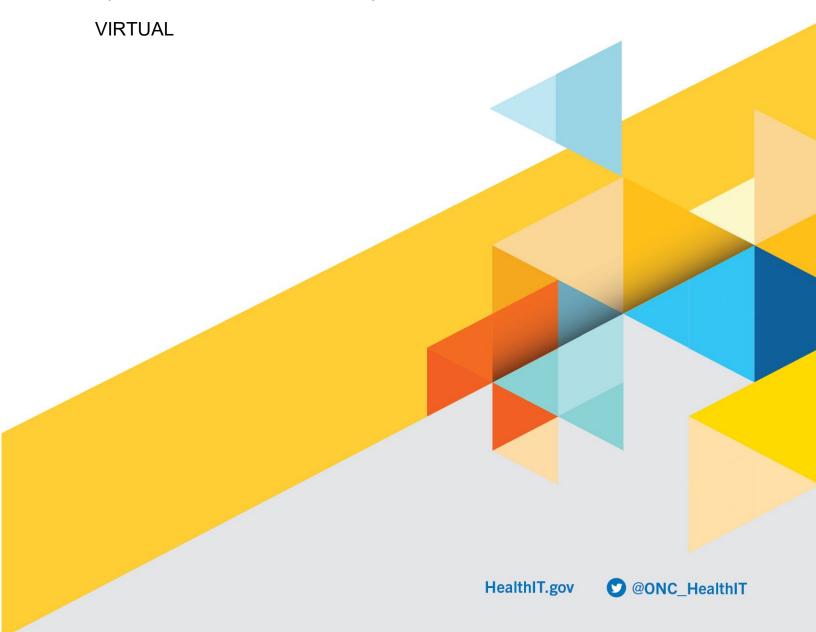
April 5, 2022, 10:30 a.m. – 12:00 p.m. ET

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
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 could be with us. I want to do a shoutout to the workgroup and our cochairs for getting us to this point and getting ready to finalize our recommendations on draft USCDI Version 3. We really appreciate the hard work that you all put into this. As a reminder, your feedback is welcomed throughout our call today, which can be typed in 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. So, I will begin roll call with 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? Hans Buitendijk is not able to be with us today. Thomas Cantilina or Jeff Ford?

Jeff Ford
Hey, this is Jeff Ford.

Michael Berry
Thank you. 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?

Raj Godavarthi
Good morning.

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

Hung S. Luu
Good morning.

Michael Berry
David McCallie?

David McCallie
Good morning.

Michael Berry
Clem McDonald? 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
Great, thank you so much, everybody, and now, please join me in welcoming Steven and Arien for their opening remarks.

Co-Chair Remarks (00:02:08)

Arien Malec
Well, let's get to it. I think we have a nice draft ready for the workgroup's consideration. We took all of the workgroup deliberations that had been memorialized already as recommendations, took a few others that we discussed, and drafted them as recommendations, and then, Al very nicely put them together in the official recommendations letter format. So, from this point forward, for the material that we are presenting at the actual HITAC, the recommendations letter is the format we are working off rather than the Google docs. If we have time after reviewing the workgroup report-out or recommendations, then we will take forward our ISA portion of the taskforce, review our charge, and start thinking about testimony, deliberation, etc. there.

So, that is generally how I think we are going to proceed today. As Mike noted, it has taken a lot of work to get here, and we really appreciate the workgroup's time, energy, and attention. Sometimes, when we are in the thick of the deliberations, it feels like we are only going to recommend a few things, and I think we have a good, healthy set of recommendations for V.3 that has reflected the input and deliberation of this group. Mark, you look very snazzy today. So, Steven, anything more you want to add?

Steven Lane
No. I would have introduced it the same way, had I gotten myself off mute fast enough, so again, thank you, everyone, for your time. I do want to always remind members of the public that you are welcome to join us in the chat. I know Mike mentioned this, but there are quite a number of members of the public who are here, so, join us as we discuss things as well as take advantage of the opportunity for public comment at the end. As you can see in the agenda, we want to take feedback regarding the draft recommendations report that has been prepared and distributed. I think there was one item that we still had some open questions about because our recollections of the discussion were a little different, specifically having to do with average blood pressure, so we want to come back to that one, and then we do want to shift our focus as soon as we can. Really, as soon as we are done with receiving your feedback on the draft report, we want to switch to the Phase 2 work to get ourselves oriented to that so we can really dive into that in earnest next week. Al, did you have anything you wanted to add before we jumped in? If not, that is fine.

Al Taylor
Sorry, just like you, it took a minute to get off of mutes, plural. Not for this part. I think I am going to have some remarks as we begin the Phase 2 portion of the agenda, but I have both the letter and the editable spreadsheet in case we need to reference that. It is available. **[Inaudible – crosstalk] [00:05:52]**

Arien Malec
Yeah, I think so.

Steven Lane
Wonderful. It seems like pulling up the letter makes sense at this point. I think we should pull that up.

Al Taylor
Yup. I have them both available. I will put up the last letter that went out.

IS WG Report to the HITAC – PHASE 1 – RECOMMENDATIONS ON DRAFT USCDI VERSION 3 (00:06:05)

Arien Malec
It feels like the suggestion, Steven, that you made about having a little blanket recommendation would be helpful to discuss as a full workgroup, as well as the recommendation on average blood pressure, just make sure that we actually reflected… You and I have different recollections of the workgroup's deliberations, so let's just make sure that we get that correctly, and then, I am sure that other folks have read the recommendations and may have some edits, or may wonder where X or Y went.

Steven Lane
Exactly. So, the first comment that Arien made, a suggestion that I actually made after this was distributed to all of you, was that we include at the top here a statement that the workgroup reviewed all of the recommendations from ONC for new items to include in V.3, and that we support them across the board with the following modifications, which are simply intended to make them more understandable and to support the logic and structure of the USCDI in response to the input of our stakeholders.

Al Taylor
So, Steven, would that be a bullet under the recommendations or under the intro?

Steven Lane
Frankly, I see it as an intro to the subsection called New Data Classes and Elements because what we are saying is that we support all of the new data classes and elements that ONC proposed. One of our charges was to see if there was anything in there that we felt was not ready that we wanted to remove or suggest the removal, and I do not think we had any of those. We suggested some resorting, keeping elements in

its original class, and renaming of certain classes and elements, but my understanding of all of our discussions to date is that there were none of the proposed new data elements or classes that we were suggesting not including.

Arien Malec
So, we had an extensive discussion about medications. I think we have that already in there. I think the only person, who is unfortunately not available today, who might have some alarm at that statement would be Hans because he has done the analysis with HL7 and FHIR about elements that are not yet ready, so that would be the one check.

Steven Lane
That is a good point, and it is probably also worth including an acknowledgment to that effect in this intro to the subsection to say that the workgroup is aware that some of what has been proposed may be a challenge for HL7 to ready all of the appropriate implementation guidance that we continue to believe is required in order for something to move forward into a new version. I do not think we got down in to the level of detail of that discussion, since it started a little late in our process to be able to say specifically, "We understand this one here is going to be really hard, and if you cannot do it, we get it." I think just acknowledging that reality and knowing that ONC and HL7 have a process that they are going to go through to assure that HL7 is ready to support all of this. There is a question in the chat from Matt whether the document is available for public view. Al, why don't you comment on that, or respond to it?

Al Taylor
At this time, it is not available for public review because it is still part of the deliberations of the workgroup, which then have to be forwarded to and presented to the HITAC. Once it is presented to the HITAC, it will be part of the public record.

Arien Malec
Yeah, even once it is drafted.

Steven Lane
It will be posted on the HITAC website, probably by the end of this week.

Al Taylor
Yeah, as meeting materials ahead of the meeting.

Arien Malec
As meeting materials.

Steven Lane
Exactly. Welcome, Kelly. There was another question from Ike, some wordsmithing suggestions and spelling errors, and thank you for that. I will let Al read those. All right.

Arien Malec
We are not going to give Al a hard time for typing furiously during the meeting itself.

Steven Lane
No, and rest assured…

Al Taylor
Why should today be any different?

Arien Malec
Exactly.

Steven Lane
Rest assured we will go through this again with a fine-toothed comb for spelling and language.

Arien Malec
Why don't we go down to the blood pressure recommendation? So, as a reminder, both the AHA, not the hospital association, but the heart association, and the AMA put together public comment into the workgroup that suggested the addition of the calculated average of systolic and diastolic blood pressure.

Steven Lane
No, of multiple measurements of both systolic and diastolic.

Arien Malec
I am trying to be precise, and I messed it up in being precise. So, the calculated average value of the diastolic and the systolic calculated across multiple readings with some recommendations for how those readings are to be taken to address measurement error in blood pressure readings. I believe when we discussed this, we discussed that our recommendation was for ONC to work with LOINC to better assess how that should be captured, whether that would be a new set of LOINC codes for the systolic and the diastolic, or whether that would be an observation modifier that notes that the systolic and the diastolic respectively are the average of multiple values. So, I think the sense is we support the sense of the medical societies that this is an important clinical value that should be available for interoperability, and then, we think there is more work to be done to figure out the appropriate representation.

Steven Lane
And, I think the other point that came up in our discussion was that there are other vital signs where ONC has been compelled to accept calculated values, such as certain ratios within pediatric vital signs, but that in general, there is a sense that that calculation can be done by a given system whether or not it is defined as a specific data element. As a patient who measures my blood pressure at home, I have my blood pressure cuff on my desk behind me here, and I have a machine which generates an average of three measurements, and that is the only number that it shows me, and I could imagine systems being able to receive that.

I could also imagine that if you have a dermatology system or an ICU system that does not really care about averages of multiple blood pressures that they could just receive it as an external blood pressure and probably make full use of it, but be that as it may, Arien, your point that even though this seems like it could be a desirable thing for some systems, the question of exactly how it is defined has not been clarified, as far as we understand, even though it was accepted by ONC as a Level 2 item. Arien, I think your suggestion on the table is that we would encourage ONC to work with LOINC and stakeholders to get a clear definition and perhaps bring it back next year. So, we have a couple hands up.

Arien Malec
Or add it, but let's make sure that when we talk about adding it, we know what we are recommending adding. We are not necessarily recommending adding a literal data element. Clem has his hand up.
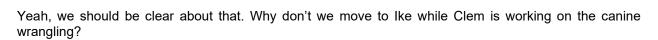
Clem McDonald
Firstly, I think the calculated issue is not relevant, whether we make it data or not. There is all kinds of stuff that is calculated behind the scenes, of which BMI is a classic example, and because it is calculated, it does not mean you have to necessarily send it that way. Corey Smith is one of the AMA/AHA people who I have just communicated with when that closed. They actually have already requested a term back in the fall, a set of *n* different repeats of the pressures. We keep dropping what they actually say… Sorry about the dog.

Steven Lane
While Clem is coming back, I will just respond to Kelly's point. This is not mean arterial pressure.

Arien Malec

Yeah, we should be clear about that. Why don't we move to Ike while Clem is working on the canine wrangling?

Steven Lane
Oh, Clem, you are back.

Clem McDonald
The real issue is everybody keeps dropping it. They said this is for n **[inaudible] [00:17:09]** visit, and if the first pressure is high, then repeat some more. So, it is pretty well defined, and the question is whether one should make a general term that has multiple blood pressures and have a protocol, but I do not know if there are any other recommended protocols, or whether that is important, rather than just having a panel that says this is this average blood pressure, and do it when the first blood pressure is high. The whole theory is that you will get more accurate measurements when you have **[inaudible – crosstalk] [00:17:44]** you are doing.

Arien Malec
Documentation, yeah. Ike?

Steven Eichner
Two things. I will go fast. I just want to clarify that we are doing systolic and diastolic separately, which you all know to be true, but just make sure the notes reflect that clarity.

Clem McDonald
They are proposing that, three separate measures of both.

Steven Eichner
I know that, it is just that in the language earlier, it could have been interpreted that you were averaging the systolic and diastolic, and that is obviously not what we want to do.

Clem McDonald
Correct.

Steven Lane
And Al, perhaps you can clarify that in the text of the document we are displaying.

Al Taylor
Because we have separate data elements for systolic and diastolic blood pressure, the question to the workgroup is whether this is a recommendation for the existing systolic pressure and the existing diastolic blood pressure plus the average systolic blood pressure and the average diastolic blood pressure. That is a question that can be clarified in the recommendation.

Steven Lane
Right, and Al, I think what the workgroup is saying is that we have no reason to disagree with the AMA and the AHA that interoperability of computed mean systolic and computed mean diastolic would be helpful to improve the quality of blood pressure care for Americans. What we also believe, based on our deliberation, is that ONC should work with LOINC and other stakeholders to establish the correct coding and data representation, again, as we have talked about, whether that should be a collection of underlying data elements where the computation can be made on the fly, or whether there is a modifier or specific LOINC code that represents that this is a computed value. I think we generally support the inclusion for the purposes of interoperability. We do not know at this time what the right representation is, and we are recommending that ONC work with LOINC and other bodies to figure out the representational issues.

Clem McDonald

Arien, I think we could do that overnight if that is what you want, but there is no option for a modifier in any of these contexts. What you either do is you put an extra term in and say by what protocol in your panel or you have a panel that says what it is, and that is something separate, to just have a panel with multiple blood pressures and have another variable that says this is the AHA protocol, but I do not know if there are any protocols that you need to get that extra box.

Steven Lane
It needs to be spelled out, and we are not going to do it between now and next week.

Arien Malec
We are not going to do it now, not going to do it as a workgroup.

Steven Eichner
Just to round out my thought earlier, is there really a need to share whether the blood pressures were taken multiple times or not, and laid on top of that, another layer about why it was taken multiple times? In other words, did I just get a really bad measurement the first time because the blood pressure cuff was not attached properly? Well, yeah, I am going to get an odd number there, but does that count as one of multiple attempts to take blood pressure or not? So, are we better off looking at the clinical practice that says yes, you should take multiple valid blood pressures, and report the single number, and leave it to the clinical side as to how many iterations you need to get there? Is there clinical value in communicating that there are multiple iterations?

Arien Malec
Again, just the sense of the workgroup is we do not know what the right answer is. We support the medical societies in including this element for interoperability, but we think there are representational issues that ONC should sort out with LOINC and other stakeholders.

Steven Lane
I agree, and I think we can leave it at that. I do want to go to the comment about clinical notes from Grace just below this, looking for some clarity there. I think Grace is reminding us that we did have a discussion about tumor board notes in particular, and I guess the question is whether that should be called out as a specific recommendation in the same way that we have called out surgical operative notes.

I must say, it is interesting, Grace, in that in my organization, there has been a parallel conversation about tumor board notes and focus on tumor boards, feeling that those are actually the sort of notes that are going to be particularly challenging to make available to patients unexplained because sometimes the tumor board meets even before options are presented to the patient, so it is kind of like the unanticipated abnormal imaging result. The patient may not even know that all of this is going on yet, and of course, one could argue either way about whether that is a good thing or not and how much of that is paternalism, but I think if we choose to call out tumor board notes, it is a pretty big deal, whereas I think the surgical operative notes are not so contentious.

Grace Cordovano
Steven, I can appreciate the concerns, but from the patient and care partner perspective, there is no transparency or documentation that is shared, so what happens is a phone call is given to a patient, a possible virtual meeting, and they are told recommendations, and we cannot follow up or ask any questions, and then we are supposed to go to a local community oncologist that we are seeing to relay the information. There is no documentation, and it is quite tragic and unfair to not have these rich, robust conversations recorded and shared with the patient. I did post a link. I am not sure if that is the appropriate LOINC code, but there is information there, so I would appreciate if the workgroup would really consider encouraging this.

Arien Malec

Thank you. My understanding would be that it is not specifically excluded from the designated record set. Unless it is anonymized, it is PHI that is used for the care of the patient. Well, it is never going to be anonymized because it always has to be mapped back to the care of the patient, and so, it should form part of the designated record set.

Steven Lane
And, looking at that LOINC link, that looks like the right one, Grace, that you have found. Clem, your hand is up.

Clem McDonald
I just wanted to comment on that one too. I guess you already said it. There is already a code for that, and I think you have described that for all the notes, LOINC is the record set for it, so it is kind of covered. I do not know if it matters much if you call it out because it should be there by the broader definition, but I think that is more up to the patient advocates. If they really, really want it, it is them that we are talking about, so I would not mind calling them out either.

Arien Malec
I agree. I think it is included there in our overall recommendation. If it is captured, it will be represented as a LOINC code and will be available for interoperability.

Steven Lane
Al, can you go to the top of Page 8? Because the way we phrased it is, as we have said, the general recommendation, which we had last year, is that for any LOINC-coded note, you should be able to receive the LOINC code along with the note, and then have the notes be findable using that. But then, we do call out surgical operative notes independently, so I think Grace is proposing that in that last sub-bullet that we call out that this recommendation includes both surgical operative notes and tumor board notes, and if you do not follow the recommendation above, please at least include these. So, I think that is the request here. Does anyone object to that addition?

Arien Malec
I am looking it up in the background, but just from a process perspective, was it in Level 1 or Level 2?

Steven Lane
Remember, they did not level individual note types. In Version 2, they added clinical notes, and they called out a few specific ones, so we are saying either Version 3 should be updated to identify all note types that are captured or your short list should be extended by at least this much. Any objections to the addition as noted?

Clem McDonald
Steve, I do not object at all, but I think the way that those two things are proposed, it sounds like they could choose not to send notes with a code if they did those two. Is that what you mean?

Steven Lane
Well, the way it is now, and David, I think you have it right in your comment, is that it says you must share this short list of note types, and a lot of organizations, my own included, went through all of the note types in the EHR and said, "Which ones map to the short list that needs to be shared? Let's make sure we share those," but then, that is how they went about interpreting information and sharing requirements. Now, we all appreciate that later this year, USCDI no longer becomes the scope of information-sharing requirements, so in a certain sense, these notes will, by definition, be available with the shift in October. Having said that, I think we have identified, again, the surgical note as particularly valuable to patients, and Grace is arguing that this is another one that is of particular value and should be called out. And, I think by calling it out and listing it in USCDI, if they do not take our first recommendation, it does really assure that that short list is still short, still single digits, and one could expect that certified EHRs would test against all of those specific note types. Al?

Al Taylor
I wanted to just clarify a point that you just made, Steven, or maybe correct it. There is a difference between the scope of information blocking being USCDI, and once USCDI is no longer the limit of information blocking, that information would have to be exchanged in whatever format available to fulfill the requirements for information blocking or to avoid the penalties there. But, outside the scope of information blocking, the addition of a particular clinical note would have the effect of requiring EHRs to be able to create, identify, and exchange clinical notes of that type or that tag, so it would not mean that all clinical note types would be required to be captured, it just means that anything that is captured would have to be exchanged to avoid information blocking, if that makes sense.

Steven Lane
It does. Thanks for the clarification. And, to David's question, again, I think if ONC took our first recommendation, then the second recommendation is not really necessary. All right, any concerns about this as Al has represented it in the draft?

Arien Malec
Mark, right now, we are treating the document as the standard, so we already did the reconciliation back to the spreadsheet. We are not going to backwards port the comments we are doing here back to the spreadsheet, so if you are looking for something…

Mark Savage
Thank you, it is the other way around. The things that were in the spreadsheet that I am not seeing in the letter, and I am not trying to jump into any process, but I am mindful that we have an hour left, and I am wondering what you want us to do.

Steven Lane
So, that is the process. So, we have translated it from spreadsheet to letter, and the letter is what is going to move forward, along with an accompanying slide deck, so if there is something that stands out to you that we missed in the translation, this is the time.

Mark Savage
Okay. So, wherever you would like to put me in the queue, I do have some items, thank you.

Steven Lane
Go ahead. You have the mic.

Mark Savage
Sorry if I am barging in. The first one is on Recommendation 6, pregnancy status. I may have missed this at the very beginning, but when we talked about it, we talked about saying explicitly yes, we do recommend adding pregnancy status as a data element. That was on the spreadsheet. It did not seem to be explicit here, though certainly implied.

Steven Lane
That was the purpose of my original comment, that we should start this section saying we support all of it.

Mark Savage
Moving to Recommendation 9, on disability status, I believe it is the ICF functioning query. Somebody may have had a reason for putting it here, but query whether it should be connected to disability status, Recommendation No. 23, it sort of stands out here. I am just seeing this now, so there may be a perfect explanation that was not immediately occurring to me.

Arien Malec

Just as a guide, the way this letter is structured is that it takes the new elements, so it takes the data elements that were in draft V.3, and then it goes towards the recommended adds, and in some cases, that has the effect of splitting logically related items across multiple sections, so there are a few sections where we talk about it.

Steven Lane
Okay. But, I think, Mark, your suggestion is good. Since this did come up in the context of our discussion of health status and disability, it would make sense to make this a sub-piece of the broader recommendation for that data class. Before we shift, I want to make sure that Al is capturing that, and maybe you could just do a quick, sloppy cut and paste, and then we could clean it up later.

Al Taylor
So, we are cutting from where?

Steven Lane
Taking what is now 9 and making that a part of… What is the other one, Mark?

Mark Savage
Twenty-three.

Steven Lane
No, 23 is Gender Harmony. It is 25. Yeah, it would be a part of 25, which is already a very long recommendation.

Clem McDonald
Could I just make a comment that is not as supportive? So, I see F as a vector. You have four different variables. It does not fit into FHIR. If FHIR looks for answers, it is not an observation in the definition of FHIR. Some have told me from the disability area that the upper level is great, but trying to flesh out all the lower levels is hard. I just think we have to be careful.

Steven Lane
So, I think what we intended in our language, and perhaps we can refine it somewhat, Clem, in response to that observation, is that ONC explore naming ICF as a useful tool in the documentation of disability because it is broadly used. The fact that it has not gotten on the FHIR train, if you will, is probably relevant, but I think our goal is to recommend that ONC consider, which is how we phrased it, using a value set based on the ICF.

Clem McDonald
Fair enough. I retract my comment.

Mark Savage
So, second comment on Recommendation 9, we know that that is appropriate.

Steven Lane
Hold tight. Al, get us reoriented here.

Al Taylor
Just real quick, since the recommendation, which I think is 23, correct me if I am wrong, is specifically the support for inclusion…

Steven Lane
No, it is 25. That is the long recommendation regarding…

Al Taylor

I am looking at the wrong version of this.

Steven Lane
Maybe I am, sorry. It is possible that I am looking at the wrong version.

Al Taylor
The one that I have was the last email that we sent around.

Mark Savage
And, that is what I was working off.

Arien Malec
Twenty-three is correct.

Steven Lane
I will close the one I was looking at.

Al Taylor
Now that I look at this, this recommendation looks like the first section's recommendation, and so, I would recommend moving Recommendation 23 up instead of the other way around.

Steven Lane
That is perfectly fair.

Al Taylor
Let me get on that.

Steven Lane
Do not renumber everything else, so that everyone can work off the version that they have in their hands.

Al Taylor
I am not rearranging the numbers yet. I have not automated it that much.

Steven Lane
And, I am pulling up the right version, so that is good.

Arien Malec
And, I think it is good that it also puts this ICF model in its proper context because it really is a "We do not know, but ONC might want to consider it," as opposed to "We support/we recommend," which is what the rest of these recommendations are actually saying.

Al Taylor
Something for us to look at is there is a little bit of a disconnect between the broad ICF model and adopting the list of specific data elements or terms. I just throw that out there as a thought.
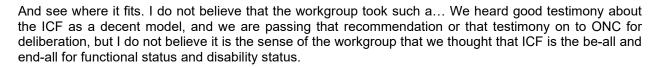
Arien Malec
I think the way that I would state the workgroup's recommendations in this area is that 23 are the workgroup's recommendations, and the ICF comment is a comment to ONC that ONC might look at the ICF in addition.

Steven Lane
And see where it fits.

Arien Malec

And see where it fits. I do not believe that the workgroup took such a… We heard good testimony about the ICF as a decent model, and we are passing that recommendation or that testimony on to ONC for deliberation, but I do not believe it is the sense of the workgroup that we thought that ICF is the be-all and end-all for functional status and disability status.

Steven Lane
And yet, we appreciate that there are a number of stakeholders that are utilizing it to good purpose.

Arien Malec
Exactly.

Steven Lane
All right, Mark, where do you want to go next?

Mark Savage
I think that is what Recommendation 9 says. So, on what was Recommendation 9, the very last bullet says, "The ICF can be used to describe both functioning and disability." We had a specific recommendation around disability status that came from our subject matter experts, so I think ICF is not really about disability.

Steven Lane
I do not think we need this sub-bullet, frankly. I do not think it adds tremendous value, so we can strike that last sentence.

Al Taylor
Which sub-bullet, please?

Mark Savage
The last one.

Steven Lane
"The ICF can be used to describe," right there, yeah. We may be overreaching there.

Mark Savage
I think "both" is the keyword there. The word "both" is the important part of that bullet, not the whole bullet.

Steven Lane
Mark, do you want to respond?

Mark Savage
Your suggestion was fine. I think if you take out "disability" and just say "to describe functional status," that makes sense, but it is just a recommendation to ONC anyway.

Steven Lane
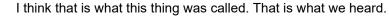Yeah. I think it is easier to leave it out. It will just avoid confusion.

Al Taylor
The name of the model itself explains that it includes functioning, disability, and health, so that is sort of self-defining.

Steven Eichner
This is Steve. Just a purely technical question. Is there a different acronym? Because in government and public health, ICF often means something other than what we are using it for here.

Steven Lane

I think that is what this thing was called. That is what we heard.

Al Taylor
It is. It is a common abbreviation.

Steven Eichner
Okay, just to differentiate it from care facilities, because that is often what ICFs are in public health and state government kind of stuff.

Al Taylor
Inpatient care or inpatient rehab?

Steven Eichner
Rehab. It does not make a huge difference. I am just trying to avoid confusion.

Steven Lane
Carmella put in a nice link to a document that the CDC has posted about this, so CDC is well aware. All right, Mark, where did you want to go next?

Mark Savage
Going up to what was 23, and probably still has that number on it, but it is immediately above where we are looking right now. So, to the third bullet point, we made a separate recommendation about defining disability status data element. It is now combined in a sentence that says "recommending to work with stakeholders to specify value sets." I think we should be breaking that bullet point up and remain specific about disability status, which is what our experts recommended to us as those seven self-reported questions.

Arien Malec
Oh yeah, got it. So, we do not formally say we support the inclusion of disability status.

Mark Savage
I think that is up at the header, Arien.

Arien Malec
Well, it does not say "we support the inclusion of," it now says "we recommend the following changes or definitions for."

Steven Lane
But again, we now have a note at the top of this whole section saying we support the inclusion of everything that was recommended in draft V.3.

Clem McDonald
Cool, okay. So, is this edit what you were looking for, Mark?

Mark Savage
I think so, because we did talk about working with stakeholders on some of the value sets for cognitive mental status and functional status, so I think this tracks what was in the worksheet, and I know we are working off this document now.

Steven Lane
Also, Al, my comment to the right there, that we spell out the seven questions, either in this document or via a link, but at the very least, include that in the presentation to HITAC so that they know what we are talking about.

Arien Malec

I think a link would be appropriate.

Mark Savage
So, to your question, Steven, the next item is at the very bottom of this recommendation, when AI is ready. There is the addition of a functional capacity evaluation under disability. I am not sure if that is a typo, but I do not think we talked about that. We talked about the seven questions.

Arien Malec
Sorry, this came from Holly and Terry.

Steven Lane
This was part of their specific recommendation.

Arien Malec
Their recommended value set. Again, I just want to be precise because I think Holly and Terry did fantastic work. Here, we are not making recommendations that ONC literally include all of these codes in a value set. We are saying, "Here are some codes for a prospective value set that you might want to consider."

Steven Lane
And, I think that we could address your concern, Mark, by simply moving that functional capacity evaluation up as an item in the list just above it, which now has 13 items, and make this 14.

Mark Savage
Okay, that makes sense.

Al Taylor
But, those items above are in different categories than…

Steven Lane
No, no, I understand, but the list of 13 is under functional status, and the functional capacity evaluation certainly sounds to me like it has to do with functional status, so I would just move that one up as 14 in the list above. And then, we could probably lose both of those bullets. This one says, "Disability status may consider the following." Do we still need that? Yes, I think we could get rid of the whole disability status and expand items if we just move that one up.

Al Taylor
Like this?

Steven Lane
Like that, exactly. Thank you. Okay, Mark. I want to remind everyone Mark is an accomplished attorney who has been at this for a long time, so he knows from fixing documents before they go out the door.

Mark Savage
Recommendation 22, which was gender identity, one specific item there. Keep going down, please. So, what we talked about as a workgroup and what was in the worksheet was on that bullet now at the top of the page, that recommended sex or gender and sex for clinical use might be clinical values derived through clinical assessment, and therefore consistent capturing the source and the method. I am not sure why clinical use is deleted.

Arien Malec
I will take the action. I broke this one out, and recorded sex or gender is a clinical value that is derived through clinical assessment or legal documentary status, and sex for clinical use is context-dependent and should not be interpreted as a singular assessment. That was clarification that I made. The way that it read felt to me to not distinguish the notion that sex for clinical use is not a value. It is something that is context-

sensitive, content-specific, and representing a biological fact, not a legal documentary fact, so it is intended as a biological fact that is relevant for the procedure, activity, or assessment that is being performed only the in the context of that assessment.

Mark Savage
I think the contextual statements in the last bullet point are great, but then, I would just copy that we want to also track source and method for sex for clinical use.

Arien Malec
Got it.

Mark Savage
That is my primary focus. It does apply to both. It might not be individual self-report, but just identifying the source and the method for clinical use as well.

Arien Malec
Yeah, or we can pull that clause out, Al, into a separate paragraph.

Al Taylor
From where? Sorry, I am not seeing it.

Arien Malec
We can pull out "Therefore, consistent with…" We can say that for both sex and gender and sex for clinical use, we recommend consistent with other data elements or recommendations identifying the source.

Al Taylor
We will turn that into an English grammar sentence.

Mark Savage
Last item on the ones I just did a quick hunt on at the beginning of this meeting: I did not see anything on the health insurance information topic. I may have missed it. I was just searching for key words, so it may be there, because I did not read the entire letter. I searched for the words "coverage type" because that definitely should be listed as a data class. I could not find coverage type. Is it accidentally dropped from the letter?

Al Taylor
Was it part of our final recommendations?

Mark Savage
Yes.

Arien Malec
It was, yeah.

Al Taylor
I think I know why I did not put it in there. It does not seem to be on the final spreadsheet.

Steven Lane
It might have gotten inadvertently deleted.

Al Taylor
I am looking, unless someone can point to it on the worksheet. I do not even see the words "coverage" or "insurance" in the spreadsheet, period. I do not understand that.

Arien Malec
It would be hard to delete a whole row.

Steven Lane
It should be in the data element list. Google is still opening it for me. Here we go.

Mark Savage
I am looking at Entry. I do not know if I am in the one you are in. Yes, it says last edit was made. So, Entry 19 is the one where we have the recommendation to include.

Arien Malec
Yes, here it is, big as life.

Mark Savage
Row 20, Entry 19.

Al Taylor
Sorry. I could have sworn I put that in there somewhere in some version.

Mark Savage
It may be, sorry. I did a search and could not find it. I just wanted to raise that.

Al Taylor
No, I am saying I think I put that in there, but I will make sure…hold on. Give me a second.

Arien Malec
Yeah, I am doing the same search that Mark did, and I am not seeing it.

Mark Savage
I have to go look at my older versions of this. So, this is part of the first group of recommendations. I do not see it either, but we will make it happen.

Arien Malec
Yeah, why don't we just make sure we do a second pass to make sure that everything that was a formal recommendation on the spreadsheet did end up in there? It would be useful as a secondary check.

Mark Savage
Steven and Arien, thanks. That is it for me for the ones I was quickly trying to spot. Thanks so much.

Steven Lane
Thank you, Mark. Clem wanted to discuss specimen type. Which recommendation is that, Clem, in the document that was distributed? Clem, you are on mute.

Clem McDonald
ISWG 2022 Phase 1, Recommendation 10. I sent the actual URL in the chat. I just want to clarify that currently, HL7 recommends an HL7-specific code set. I think this is fine as long as it is clear that it does not replace it because lots of places are using the existing code set happily.

Steven Lane
Yeah, the wording specifically says "as an applicable vocabulary standard." That was certainly the substance of our discussion.

Clem McDonald
I would say "in addition to the current HL7 data set."

Steven Lane
Yeah, that seems fine.

Al Taylor
Which HL7? So, specimen type is typically codified by SNOMED, according to LIVD.

Clem McDonald
Say again?

Al Taylor
According to the LIVD file format, specimen type uses SNOMED, not HL7. HL7 generally will sometimes reference… So, I do not know which HL7, if it is HL7 FHIR, V.3…

Clem McDonald
Well, I included in chat the actual URL to the site, and I think this has been used in V.2 and V.3 for decades, so if it is considered a replacement, there should be some discussion with laboratories along the way. I think it is fine in LIVD, but it just does not mean it cannot be used for the other things. I am afraid that is what this suggests, and it will be very disruptive.

Steven Lane
Yes. So, Clem, you found it in Version 3.1.0; I found it in 2.8. HL7 clearly has specimen type defined in its various versions, so yes, this would be in addition to.

Al Taylor
ONC did not identify that particular specimen type value set as the standard. We were instead referencing the way that the lab in vitro diagnostic process defines specimen type, and there may be some correlations to…

Clem McDonald
I think it is fine, but I think if it replaces this other one, you are going to create a world of woe for a long time.

Steven Lane
Yeah, I do not think it was meant to be a replacement. And, you said it was not in FHIR, but I see a FHIR page here.

Clem McDonald
I just meant to say it is widely used in HL7.

Steven Lane
But, you are comfortable with the terminology as an applicable data set? So, Al, I think rather than specifically pointing to the HL7 3.1.0, we might just be more broad. Okay, fine. And then, there was a V.2 version I put in there also.

Al Taylor
What USCDI typically does is lowest common denominator, especially when there is a discrepancy between FHIR, V.2, V.3, and C-CDA value sets. We will look for a common ground, and if that happens to be SNOMED, if the values in those value sets are all SNOMED codes, but they are just captured within an HL7 value set, typically, what USCDI will do is identify the commonality, which may well be SNOMED, because USCDI is, among other things, at a core, exchange standards agnostic.

Clem McDonald
Well, I think you will find the same one in all of the… It is the commonality right now. I am for the other one as a good code. Let it gradually replace it, but if it does it as a sudden thing, I do not think that will be

healthy. Of course, the other thing to remember, too, is that the specimen is typically embedded for common tests in the name itself, like serum glucose, and is not required for the specimen.

Steven Lane

Yeah, we discussed that. Okay, good. I wanted to raise an issue, so my hand is up, and that was in Recommendation 24, and Arien, I think you crafted this one, but you put in unit of measure and interpretation as laboratory data elements, but I did not see those, so they are in CLIA, but they are actually not in USCDI.

Arien Malec

They are. So, interpretation is in USCDI, and unit of measure is noted as either Level 1 or Level 2 associated with results. As a structural element, the only thing that was not mentioned in Level 2 or Level 3 was reference ranges, which was obviously a miss by somebody because that is in CLIA.

Steven Lane

Right, and we added that as the bottom sub-bullet there.

Arien Malec

The bottom one, right. So, if you just give me a moment, I can go find the sources.

Steven Lane

Okay, but you think it is reasonable for us to include those two?

Arien Malec

Yes.

Clem McDonald

A comment. I have checked with one of the big labs. They said they would like to test the unique identifier, but I still think it would be a good idea to talk to the laboratory association and see how easy it would be to use, but anyway, it is on the positive side.

Arien Malec

So, test interpretation is in Level 1, and then, if you go under result value in Level 2, there are recommendations to… Oh, it might be somewhere else. It is another one under result value, where there is a recommendation to add UOM.

Steven Lane

So, if interpretation is in Level 1, I think it is out of scope for us to suggest it for inclusion in Version 3.

Arien Malec

I thought we were including stuff from Level 1/Level 2.

Steven Lane

If you go back to our charges, our charge is to look at items in Level 2 that were left out of draft Version 3, so we have repeatedly declared out of scope things that are at comment and Level 1.

Arien Malec

Fair enough.

Clem McDonald

So, 1 comes before 2, but I guess it does not.

Steven Lane

Level 1 is less mature than 2, but it all depends on whether you are talking about levels or versions. Version 1 came before Version 2, but Level 1 is less mature than Level 2. So, I think we need to take out interpretation. If we want to put it at the bottom as a list of things that we are recommending ONC work with stakeholders to see if and when interpretation can be added, I think that is fine.

Clem McDonald
Arien **[inaudible – crosstalk] [01:00:12]** getting it in there though, anyway.

Arien Malec
So, UOM coded as UCUM is noted as an APHL comment to V.3 under the result, and so, interpretation is in Level 1, so we should move it to the section where interpretation and reference range are in "ONC should consider for future revisions to better align with CLIA."

Steven Lane
You could just add it in that sentence right there, "reference range and interpretation." We all support it.

Arien Malec
No, I got it. We have to go with the process.

Steven Lane
We have to play by our own rules.

Arien Malec
It was my mistake for misunderstanding the underlying process we were following.

Steven Lane
Hung, why don't you chime in?

Hung S. Luu
I think one recommendation that was missed was that we also specified adding SNOMED CT as an applicable standard for qualitative results.

Arien Malec
That was in the spreadsheet.

Hung S. Luu
Yes.

Steven Lane
So, we could do that in the second-to-last bullet, "recommend that USCDI V.3 specify SNOMED CT as an applicable vocabulary standard for specimen type and qualitative results."

Hung S. Luu
Yes.

Al Taylor
Not "and qualitative results." "Specimen type for qualitative…" Oh, "and result values, qualitative."

Arien Malec
Yes, exactly.

Hung S. Luu
Yes.

Al Taylor
Since "result values" is already part of USCDI, we will list it first.

Clem McDonald
That was actually explicitly spelled out two years ago, in one of the…

Al Taylor
That is right, Clem. Because of the numerous applicable standards depending on the result type, we decided not to add all of them. So, LOINC, SNOMED, UCUM are all reasonable applicable standards depending on the result type, so, because there were so many, we added none.

Arien Malec
It is there. It is Recommendation 18.

Al Taylor
I thought I remembered seeing it.

Clem McDonald
Thank you, Al.

Al Taylor
You are welcome.

Steven Lane
So, we potentially shorten the list by taking it out of 18 and putting it down with its brethren and sistren below.

Arien Malec
As everybody knows, you measure the complexity of a set of recommendations by the number of underlying recommendations, or by the number of pages of the resulting federal register submission.

Al Taylor
So, this probably belongs in the first section, with suggestions.

Steven Lane
Up above. Good point, yes.

Al Taylor
It is already in there.

Arien Malec
Yeah, it is duplicative.

Al Taylor
It is not duplicative, but we just refer to it for specimen type.

Arien Malec
No, it is duplicative because under specimen type, we also recommend SNOMED CT as the code system.

Steven Lane
That is under Recommendation 10.

Al Taylor
Yeah. "…and SNOMED for specimen type."

Arien Malec
Yeah. So, if you go up to Recommendation 10, it is already there.

Steven Lane
Let's collapse 10 and 18 into one.

Arien Malec
Ten is where we say "include specimen type," so we have a recommendation…

Al Taylor
This is getting shorter and shorter. I love it.

Steven Lane
Short is good. Brevity is the soul of wit.

Al Taylor
That is funny, Steven, and well said. I will combine these two.

Steven Lane
So, David McCallie made a comment. "Are there any systems that do not include interpretation?"

Arien Malec
There are no systems that do not include interpretation. There are no systems that do not include reference range.

Steven Lane
So, why is it at Level 1? Who knows?

Arien Malec
So, why is it in Level 1 and not in Level 2? I do not understand. I think it was because it dawned on people very late. People just assumed it was there, and it is not there, and so, it is always a surprise to people that it is not there.

Clem McDonald
So, Arien, the HL7 FHIR spec and the V.2 spec is also specified by ONC as required, and those data elements are in those specs.
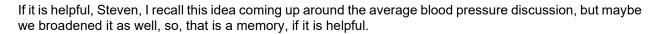
Arien Malec
This is my underlying point. It is the same issue for medication. My underlying point is the NCPDP script that is already certification guide includes all the detail around medication that you would ever need, and so, the work is basically to realign these classes and their data elements with the actual certification criteria. We also have to follow the mechanisms that were laid out for Level 1/Level 2, and it is a little bit of a mess right now.

Steven Lane
So, if you scroll down to the bottom of Page 12, we captured these concepts in additional workgroup recommendations, and we have done this historically in prior task forces. We have to address our charges and the tasks that we were given, and then we take the liberty of adding to that with some additional recommendations, so this is where those are. And, Al does have this question about LOINC vital sign qualifiers, which, I think, Clem, came from you. So, this is where we are essentially asking ONC to extend our charge and our support so that we could do a third task in anticipation of the Version 4 work.

Mark Savage

If it is helpful, Steven, I recall this idea coming up around the average blood pressure discussion, but maybe we broadened it as well, so, that is a memory, if it is helpful.

Steven Lane
I think, as Arien clarified earlier, the average blood pressure where we said we think it is probably a good idea and ONC should go work on that, as opposed to asking us to work on that. Clem?

Clem McDonald
Just in terms of the qualifiers, I want to explain what is meant by that. Those are things like body position when you are doing a vital sign, standing or sitting, things like the cuff size, 10 centimeters, 20 centimeters. There are four or five of them that apply to a lot of vital signs, and they are available, and we have proposed them in the past, but I think it would be nice that clinical systems could be more specific if they wanted to be, but would not be obliged to be.

Steven Lane
Yeah, and I think that comes through in this recommendation. I will just say, speaking as a clinician, I find this to be more valuable as an addition to the core data for interoperability than calculated averages, but that is just one man's opinion.

Arien Malec
As a person who has had many a blood pressure reading taken, walking out of the lobby into the blood pressure cuff, interpretation of blood pressure readings out of an EHR seems like a little bit of a mystery. I guess nobody cares if it is normal.

Clem McDonald
So, how many cuffs do you now own?

Steven Lane
And then, there is the whole issue of finger pressures, wrist pressures, and arm pressures, right?

Clem McDonald
Yeah, where it is taken. That is one of the qualifiers.

Steven Lane
Exactly. Okay, have we addressed all of the comments that were in the distributed document? I think there was one, Arien, with your name on it in Recommendation 13. Did that get taken care of?

Arien Malec
I do not believe so. So, the comment that I had is that we make specific that we recommend the following Level 2 data elements to capture important patient-generated health data be added, and in all of these cases, these can be both clinical and patient observations. I guess family health history is always elicited through interview and assessment.

Steven Lane
Actually, not always. There is this current functionality that allows one to link multiple medical records.

Arien Malec
There you go. Then, let me amend this. In all these cases, there are objective sources as well as patient self-reported sources for this information, and I do not think we are saying that substance allergies can never be clinically observed, for date of onset of a problem that can never be clinically observed.

Mark Savage
I agree with that. We are not making that statement.

Steven Lane
Should this be a sub-bullet under Recommendation 12 above, having to do with author? That is to say that author is particularly relevant for these data classes.

Arien Malec
So, I was a little confused. Which of these are in USCDI V.3, and are we making recommendations that we include that they be patient generated, or are we recommending that they be included in USCDI, and then, for these that have been included, we are also making the recommendation consistent with our recommendations that it can be clinically observed or patient generated?

Al Taylor
None of the data elements are in USCDI, draft V.3 or any. They are all Level 2.

Arien Malec
Got it. So, I think what we are recommending is they be included in USCDI, and we are also recommending that, being consistent with our other recommendations, we include both clinical observation and patient-generated health data as sources.

Mark Savage
This is Mark. I agree.

Steven Lane
And, I do not personally think that the EG square bracket's text are necessary. You could ditch those.

Al Taylor
Yes, that is right. So, I just wanted some clarity about how to phrase. I personally do not think that these five listed are clinical observations other than the allergies or the diagnosis of an event.

Arien Malec
Date of onset of a problem is a clinical observation if it happens in a clinical setting.

Steven Lane
It can be.

Al Taylor
If it happens in front of the doctor, but how often does that happen?

Arien Malec
A lot.

Steven Lane
It happens. Anaphylaxis happens in front of the doctor all the time.

Arien Malec
Exactly. I have been in the hospital, and I have had plenty a problem that has been clinically observed.

Al Taylor
So, the suggestion is to scope the recommendation to define these data elements as both clinical observations and patient reported?

Arien Malec
That is right, and to Steven's point, if I link family health history via familial status, it can be a direct read-off of the chart as opposed to patient self-reported.

Al Taylor
The original source of family health history is always patient-reported.

Clem McDonald
In FHIR, observations have a special definition, and the date of onset would be an attribute of the problems resource, not the observation resource, just for the record.

Steven Lane
I think the point in all of this, to David's comment, is that for any of these, we want to be able to be clear through the provenance metadata or some other means whether the data was reported or observed, or, as Arien said, imported from another source. All right. Well, this ended up taking the time allotted. I sort of anticipated we might go through this a little more quickly. There are a lot of people on the call who have been very quiet. Anybody else have any specific thoughts or observations that they would like to share?

Arien Malec
Maybe just to close out of this, I think we have captured all of the workgroup comments. I think we are also going to commit to doing a secondary last pass to make sure that everything in the spreadsheet is addressed in the recommendations letter itself, but this is by matter of last call, because we have the majority of the time on the 13th.

Steven Lane
Yes. That is to say, for the presentation to HITAC. Arien and I will be ringmasters of a lively conversation, I am sure, and all of you who are on HITAC, please come with bells and whistles and give your support, and those of you who are members of the public or members of this workgroup but not on HITAC, please attend. I think there is public chat at HITAC too these days, right? So, I think you can root for things in the public chat there as well. I am just trying to keep up with the chat here. Great, all right. We like praise. Al and Mike in particular, thank you guys for all of your support that you have been giving to this process. We obviously could not do this without your help and the help of the entire ONC team to help us bring these together.

Arien Malec
Indeed.

Michael Berry
It is a woo-hoo moment.

Arien Malec
All right, shall we celebrate for a nanosecond and then move on to thinking about our second charge relative to the ISA portion?
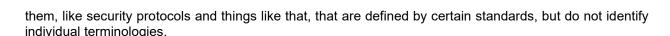
Establish Phase 2 Workplan (01:15:52)

Steven Lane
Al, I think you were going to introduce this. Just a quick reminder, our charge is to identify opportunities to update the ISA, ONC's Interoperability Standards Advisory, to address priority uses of health IT, including related standards and implementation specifications. So, a number of items have come up in our discussions thus far that people have wanted to bring forward. This is our chance, so, go ahead and take us through this, Al.

Al Taylor
This is a real quick introduction to the Interoperability Standards Advisory. It has been around now for eight years, and every year, we make updates to it to identify a broad compendium of standards in health IT, and that is not just vocabulary standards, which is primarily the focus of USCDI, but also things that identify standards around content and structure of data, so that could be how to put individual terminology into a structure of, say, a report or an exchange package. There are services that have standards associated with

them, like security protocols and things like that, that are defined by certain standards, but do not identify individual terminologies.

The ISA combines not only the standards that are required in certain things like certification and, in particular, USCDI, so it is not just about what the requirements are going to be, which is the focus of USCDI, in certain. The flexibility that the ISA allows is significant, especially compared to anything in certification or, in particular with USCDI, the ability to add something to this compendium is, in my opinion, the strongest part of the ISA. We go through a process every year to update the ISA. Three or four months ago, we published the reference edition, and the reference edition really is a point in time, a fixed document that is the update as of the time of publication, but that does not change the fact that the ISA is a living, breathing thing. It can change in a matter of minutes. At any time, if somebody identifies a new standard or identifies an old standard that addresses a particular interoperability need, as we call it, then those changes can be made immediately, so then it becomes there for the public to review, to comment on, and to maybe even recommend changes or improvements to those particular interoperability standards.

And so, the ISA can be used in a lot of different ways. It can actually be used as a reference. There are some examples of where different agencies or entities had said not because it is in certification or not because it is in USCDI, but because it is in ISA, that folks that want to take advantage of whatever benefits that entity points to have to use the standards that are listed in the ISA, so it becomes a little bit of a lever to promote the use of some of these standards that are different. Those levers may be different than the regulatory levers that USCDI and certification offer. So, for areas that are underdeveloped, this workgroup can make recommendations and changes, and I was not around for the Interoperability Standards Priorities Taskforce last year or the year before, so I am not as familiar with all of the things that were done to feed this, to offer up the standards priorities from last year, but I do know that the ISA stands ready to receive these changes and be acted on very quickly without a long implementation timeline that USCDI and certification have.
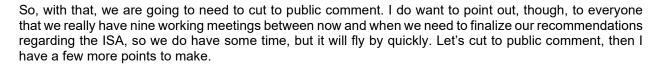
Arien Malec

Yeah. So, David and I were the cochairs of the ISP, Interoperability Standards Priorities Taskforce, and the other thing I would add is that the ISA… So, we have USCDI that is certification relative to data. There are certification criteria that name standards and implementation guidance, and the ISA would be the prospective place to pull new certification criteria relative to interoperability, so not only is it a holding ground for the state of the art relative to pilots and implementations, it is also the place where standards and interoperability specifications and implementation guidance can be matured for future certification associated with those elements as well.

And then, in terms of areas of focus, I think we walked in with some additional SDOH standards, we contemplated whether we should take on expansion of race/ethnicity vocabulary subsets, so, as a reminder, the current USCDI names the CDC race/ethnicity vocabulary list, which is extensive, and then a subset list, which maps to the OMB classification, which is tiny, and there may be some need for something intermediate.

There is a tremendous amount of work that is going on with SHIELD, and so, we really wanted to contemplate taking on the SHIELD work and looking at whether there are additions that we can recommend to the ISP. There is, I think, a pretty obvious set of fixes to the ISP associated with evolution and ECR, and then, in the previous workgroup, we named additional future work as warranted that we did not have time to get into on care plans **[inaudible] [01:23:10]** management, data sharing between federal and commercial entities, portal data aggregation across multiple portals, occupation and location of work, which I think we did actually take up here in USCDI, which I think is useful, data exchange formats for price transparency and associated standards, and then, I think we have heard from a number of people on the workgroup, as well as externally, that there is work going on in standards that enable patient use of HIPAA rights as a self-correction that we might want to contemplate.

Steven Lane

So, with that, we are going to need to cut to public comment. I do want to point out, though, to everyone that we really have nine working meetings between now and when we need to finalize our recommendations regarding the ISA, so we do have some time, but it will fly by quickly. Let's cut to public comment, then I have a few more points to make.

Public Comment (01:24:13)

Michael Berry
All right, thank you, and I just want to note that 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 the 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. So, let's pause for a moment to see if anyone raises their hand.

Steven Lane
I see a hand up.

Michael Berry
We do. We have Debi Willis. Please go ahead for three minutes.

Debi Willis
Hi. I do not think I will need three minutes. I just want to ask quickly logistically how to move forward in getting the patient requests for corrections to become part of standards. There are so many errors in charts, and I am a cochair of the Patient Empowerment Workgroup and a co-lead on the project Patient Requests for Corrections, and we are now going to go to ballot in May, but it is really important that we move this forward to actually get implemented, and getting it in front and noticed in the standards is really critical. So, are there recommendations on what we should do, and are y'all looking into this? Is there anything we could do to help?

Steven Lane
Yeah, I can respond quickly, just saying that we have Grace as a great voice on this workgroup, as well as the public comment process. Certainly, anybody can jump on to the ISA and put input there, but I do not think there is any question that we will be addressing this. As we have in the USCDI phase of our work, we have the opportunity to hold hearings, to invite subject matter experts, etc. I anticipate that this may be one of those situations where we will do that, and probably at our meeting next week, we will talk about what are the areas that warrant that kind of laser focus. It is going to happen.

Arien Malec
Just to repeat, our first activity will be to prioritize the list of things we will narrow down on, and this is clearly part of the set that we will contemplate and consider.

Steven Lane
Wonderful. I do not see any other public comment hands up, but we will still watch for those if people have other ideas. Arien and David did a great job managing this process last cycle. I had the opportunity with Ken Kawamoto to cochair the group for, I think, the two cycles before that, so we have a lot of experience working through this. We used a methodology a couple of years back of a spreadsheet similar to what we have been through with USCDI, and I sent that to the ONC team, where we can collect ideas much as we have before, and I think we will try to get that up and available to all of you in the next day or two so that these sorts of specific suggestions can be captured, much as we did in the USCDI portion, and then work through it in there. Christina?

Christina Caraballo
I know we are at time here, so I will just be really quick. I see that the recommendations or the focus areas are very specific. I think one thing we should also look at is the connection to the USCDI. So, ISA is a really important document, and I think there are opportunities for ISA to kind of map to USCDI. USCDI lets us see

what is coming up and what is being considered for USCDI, but there is a lot of work happening that is not being identified in USCDI. So, I will put together a thought and send it to both of you for looking at that area. Sorry, I was trying to be really quick on that.

Arien Malec
Fantastic, and I think that is the reason that ONC wanted to combine these two workgroups, because there are obvious points of connection.

Steven Lane
And, that brings us to the top of the hour. Thank you, everyone, for your time and attention. We will see you next week and we hope that you will also join us at the HITAC meeting subsequently.

Michael Berry
Thanks so much. Bye.

Arien Malec
Thank you all.

Adjourn (01:28:48)