# Transcript

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

February 7, 2023 10:30 AM – 12 PM ET

VIRTUAL

# Speakers

| Name | Organization | Role |
|---|---|---|
| **Sarah DeSilvey** | **Gravity Project<br>Larner College of Medicine<br>at the University of Vermont** | **Co-Chair** |
| **Naresh Sundar Rajan** | **CyncHealth** | **Co-Chair** |
| Pooja Babbrah | Point-of-Care Partners | Member |
| Shila Blend | North Dakota Health Information Network | Member |
| Ricky Bloomfield | Apple | Member |
| Hans Buitendijk | Oracle Health | Member |
| Christina Caraballo | HIMSS | Member |
| Grace Cordovano | Enlightening Results | Member |
| Raj Dash | College of American Pathologists | Member |
| Steven Eichner | Texas Department of State Health Services | Member |
| Nedra Garrett | Centers for Disease Control and Prevention | Member |
| Rajesh Godavarthi | MCG Health, part of the Hearst Health network | Member |
| Bryant Thomas Karras | Washington State Department of Health | Member |
| Steven Lane | Health Gorilla | Member |
| Hung Luu | Children's Health | Member |
| Meg Marshall | Department of Veterans Affairs | Member |
| Anna McCollister | Individual | Member |
| Clem McDonald | National Library of Medicine | Member |
| Deven McGraw | Invitae Corporation | Member |
| Aaron Miri | Baptist Health | Member |
| Aaron Neinstein | UCSF Health | Member |
| Kikelomo Oshunkentan | Pegasystems | Member |
| Mark Savage | Savage & Savage LLC | Member |
| Michelle Schreiber | Centers for Medicare and Medicaid Services | Member |
| Shelly Spiro | Pharmacy HIT Collaborative | 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 |

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

**Michael Berry**
Good morning, everyone, and welcome to the Interoperability Standards Workgroup. I am Mike Berry with ONC, and we are glad that you could be with us today. All of our workgroup meetings are open to the public and your feedback is welcomed, which can be typed in the Zoom 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 rollcall of our workgroup members, and when I call your name, please indicate if you are here. I will start with our cochairs. Sarah DeSilvey?

**Sarah DeSilvey**
Here.

**Michael Berry**
Naresh Sundar Rajan?

**Naresh Sundar Rajan**
Here.

**Michael Berry**
Pooja Babbrah?

**Pooja Babbrah**
Good morning.

**Michael Berry**
Shila Blend?

**Shila Blend**
Present.

**Michael Berry**
Ricky Bloomfield?

**Ricky Bloomfield**
Good morning.

**Michael Berry**
Hans Buitendijk?

**Hans Buitendijk**
Good morning.

**Michael Berry**
Christina Caraballo?

**Christina Caraballo**
Good morning.

**Michael Berry**
Grace Cordovano should be joining us in a little bit. Raj Dash?

**Raj Dash**
Good morning.

**Michael Berry**
Steve Eichner?

**Steven Eichner**
Good morning.

**Michael Berry**
Nedra Garrett?

**Nedra Garrett**
Good morning.

**Michael Berry**
Raj Godavarthi?

**Rajesh Godavarthi**
Good morning.

**Michael Berry**
Bryant Thomas Karras?

**Bryant Thomas Karras**
Present.

**Michael Berry**
Steven Lane?

**Steven Lane**
Good morning.

**Michael Berry**
Hung Luu?

**Steven Lane**
Good morning.

**Michael Berry**
Meg Marshall?

**Meg Marshall**
Hi, good morning.

**Michael Berry**
Anna McCollister? Clem McDonald? Deven McGraw?

**Deven McGraw**
I am here, thank you.

**Michael Berry**
Aaron Miri? Aaron Neinstein? Kikelomo Oshunkentan?

**Kikelomo Oshunkentan**
Good morning.

**Michael Berry**
Mark Savage?

**Mark Savage**
Good morning.

**Michael Berry**
Michelle Schreiber? And I think Joel is with us today as her alternate. Is that right, Joel? I see Joel on the line. Joel is from CMS. Shelly "Spy-ro"? Or "Spear-o," sorry.

**Shelly Spiro**
It is "Spy-ro," here.

**Michael Berry**
Oh, thank you. And Ram Sriram?

**Joel Andress**
Sorry, this is Joel. I am on the line. I just could not get off mute in time.

**Michael Berry**
Thank you, Joel. All right, well, thank you so much, everyone, and now, please join me in welcoming Sarah and Naresh for their opening remarks.

## IS WG Charge (00:02:39)

**Sarah DeSilvey**

I will first welcome everybody. It is great to be back with you all to further our work on our charge from HITAC and the ONC. We do hope to get to work today in analyzing elements on the spreadsheet. There has been some work on that asynchronously since our last meeting. I am hoping to move toward some recommendations from the committee and some identification of missing Level 2 elements by the end of the meeting and ongoing. Naresh, any other thoughts?

**Naresh Sundar Rajan**
Thanks again, Sarah. I think that is pretty much what we are going to move forward with today, and I am looking forward to this session. Back to you.

**Sarah DeSilvey**
Thank you. So, next slide, please. Hopefully, this is now becoming so thoroughly ingrained that it need not be said, but I am just reminding us collectively of the charge for our time, remembering our recommendations are due by April 12th, but in order to finalize, again, our recommendations and collate a formal recommendation, we need to complete our work well in advance of that. Our work, again, is twofold: Reviewing new data classes and elements from draft USCDI V.4 and recommending any Level 2 data classes and elements not included in draft USCDI V.4. Again, I want to make sure that folks are leveraging the shared Google document for this work, adding any Level 2 elements at the base of the spreadsheet. Again, there is precedent from our colleague Grace on that, and then, collectively, I am hoping to review the new data classes that are on the top of the sheet with the submitter, ONC. Next slide, please.

This is just the rationale we created for review. As elegantly mentioned at our last meeting, this is different in the prioritization that grounds our work for new data classes. This is just prioritization for the purposes of our timeline, not prioritization for inclusion. One of the principles that we identified early was just wanting to make sure that we created time to address some of the sticky or more compelling elements that we might have to address with public comment and trying to get those on the agenda in the middle of our work, which is enough time to get public input but enough time to do the work itself, again, right now, leaning into the elements related to advance care planning being the most critical in that area.

We did receive some feedback via email and, I think, on the spreadsheet regarding possibly including our colleagues working on the FHIR physical activity implementation guide for public presentation when we are addressing that work, given the headway that IG has made in that space, so we would not have time to include that in this meeting, but again, I am hoping to get our colleagues working on the physical activity IG to the next meeting in order to have them share with us their work. Any questions on this? Okay, I do see a pretty important comment from Hans regarding an element that might be missed. Thank you. Next slide, please. Oh, Al, do you have something you want to say?

**Al Taylor**
No, I was just going to say I saw the comment, and ONC is on it.

## Comments and Recommendations – New Draft USCDI v4 data elements (00:06:32)

**Sarah DeSilvey**
Thanks. Again, Hans, thank you for your careful review on the now tab in our work, which talks about alignment with FHIR and C-CDA, and thank you for that comment as well regarding the missing element.

**Steven Lane**
I have a hand up.

**Sarah DeSilvey**
Sorry, Steven. Yes, my apologies. It blended in with the paint on your ceiling.

**Steven Lane**
It is all good. The facility data elements really track back to some needs that have been identified by CMS in particular, and we have not discussed those original needs this cycle, but we have discussed them in the past. I just think it would be nice, when we get to those data elements, to have CMS remind the group and all the new members of why this is so important to their workflows and to have the chance to discuss why these are appropriate for USCDI itself as opposed to USCDI Plus, just so we can all be on the same page there.

**Sarah DeSilvey**
That sounds great, Steven, and I think Mark and I have both commented also on possibly bringing in experts from the social care taxonomy ecosystem, especially given the advancements in creating the human services directory IG over the last six months, which directly relates to some identification and similar elements to facilitate identifiers. So, CMS, one critical voice, absolutely, and then, should we be interested, members from the social care taxonomy ecosystem might be helpful as well.

**Steven Eichner**
This is Steve Eichner, Sarah. I just want to interject really quickly that I am very supportive of Dr. Lane's comments, and from a public health perspective, it makes sense if we can use a common data element or common field rather than collect similar information in two different methodologies. It would definitely be preferable to collect one single data point that can serve those purposes, so I want to make sure we get the right people engaged in that conversation so that we are not unnecessarily duplicating work on the provider end or having to supply duplicative data if there is an easy way we can go in with a single submission or a single data element, perhaps submitted in two different ways to meet different purposes. That would apply to both the facility data and SDOH information as well.

**Sarah DeSilvey**
Wonderful, Steven. As a terminologist, I 100% agree in the simplifying and sharing definitions.

**Steven Eichner**
So, I just want to be sure that as we have presenters coming into the space, we are getting good representation from both ends in that space, and perhaps CDC as…not a co-presenter, but if we are going to explore the facility information, also look to CDC for what they are looking for for facility information so we can balance those interests or consider those interests.

**Sarah DeSilvey**
So, just to encapsulate, Hans, let's actually go to you next, but I am just going to hold space for the voices I hear being relevant for facility information, and then, Hans?

**Hans Buitendijk**

I would just like to underscore the comments by Ike and Steven for USCDI Plus in general. Where we have data that is referenced in both, where there are good reasons to be referenced in one, the other, or both, but where they are referenced in both that it is very clear that it is the same because as we get into the standards that are needed to support those, that is where we are looking to make sure we are not ending up with different interpretations of what that might mean, then leading to what Ike's concern is as well, that we might end up collecting in two different ways where it is meant to be the same. So, in principle, it is not a problem that it is referenced as long as it is very clear that is truly the same concept or it is truly not.

**Sarah DeSilvey**
Okay. So, what I hear us saying is that we should start specifically with voices being important for physical activity, and we will work that into a meeting, but I heard us identify a few different voices that would be important for standardization, both in meaning and in data elements and recommendations across CDC, CMS, and some of the social care taxonomies, and maybe trying to include them in the next meeting to ensure we have all voices at the table. Is that a correct summary of what I heard?

**Steven Eichner**
This is Steve. I think it is close. I think the idea is if we are looking at having expertise come in and discuss any of the new elements, it might be very useful to have presentations from both potential or all potential user groups so that if you are looking at a research use for the data and there is a different expert or different use of that data, we are getting input from all of the potential users of that data, just to ensure that we have got harmony going on.

**Sarah DeSilvey**
Fantastic. Again, we will communicate to the public that we are addressing facilities, but if we can note any additional stakeholders we feel need to be represented in the Google doc, that would be helpful, and we agree on the need for including as many voices as possible.

**Steven Eichner**
Or at least as necessary.

**Sarah DeSilvey**
Thank you. Nedra?

**Nedra Garrett**
Yes, hi, good morning. So, I just wanted to add that I most definitely concur. CDC and CMS have worked together to provide joint support for a lot of the data elements related to facilities, so for those that are related to that, I can make sure that we have the right persons at the table to express that need and the priority. This is my first time participating, so I do not know if there is a schedule for when particular data elements might be addressed or if they would be identified in a given meeting for the next meeting, but if you let me know ahead of time, I can make sure that we have those representatives from our respective programs at the CDC to discuss those.

**Sarah DeSilvey**

Naresh, Mike, and Al, tell me if I am wrong, but if we can try to leverage necessary voices in time prior to the meeting next week, that would be wonderful, but if not, we can move it to the following week. Al, Mike, and Naresh, does that seem reasonable?

**Al Taylor**
Yes. We have done this in the past, where we have scheduled certain things, even as far out as a few weeks. We know that we are going to talk about it on a different date, whether it is next week, two weeks, or three weeks down the road, if it meets with everybody's scheduling requirements.

**Sarah DeSilvey**
Maybe a two-week buffer is more appropriate, giving better lead times? I guess that leaves us plenty of time to accomplish the task prior to submission of recommendation.

**Mark Savage**
Sarah, it is Mark. Sometimes, the people in the community need even more than two weeks in order to coalesce, agree on what they are recommending, and get it to a slide deck that gets to ONC in advance so it can be published for the public. I think we just try to do the best we can, and sometimes it fits a good timeline and sometimes it is a little fast, but it is sliding.

**Sarah DeSilvey**
All right. So, maybe we can state at least that we are aiming for the meeting on the 22nd or 21st, and we will do the best we can. That seems like a good step forward. Any other comments on the facility data elements?

**Naresh Sundar Rajan**
This is Naresh. I have a quick comment to iterate what Steve Eichner has mentioned. Would it help the workgroup to have a separate column on the Google document that explains the other data stakeholders from a user perspective, or the data utilizer perspective?

**Sarah DeSilvey**
It seems like it would.

**Al Taylor**
Sorry, Naresh. Who was that question for?

**Naresh Sundar Rajan**
It is for Al and Sarah. Based on the feedback from Steven, would it make sense for us to have a column in the Google document that refers to similar standards pertaining to the comments that were made on similar elements with other standards, to just capture that?

**Sarah DeSilvey**
I think that is a good idea. Right now, we are including some of those elements in workgroup discussion. I think the FHIR physical activity IG element was elsewhere, but that is an interesting idea. It would not hurt to ensure that we are thorough in that process.

**Naresh Sundar Rajan**
Sounds good. I see Mark's hand is up.

**Sarah DeSilvey**
Mark? Thank you, sorry I missed you.

**Mark Savage**
Thanks. I am also just bringing us back to Ike's point, that we also want to make sure we are not putting different standards on the chart and thinking that they can all be used. The important thing is to agree on which one is referred to, and that the others are not. And so, having multiple standards, some of which are relevant to our work and some of which are not, risks a little bit of confusion, but I think it is helpful to have the catalogue, bringing us back to Ike's comment, thank you.

**Sarah DeSilvey**
Thank you, Mark. Ike?

**Steven Eichner**
I am not sure that we want to identify stakeholders for every data element from a public health perspective in particular. There may be some that we use more regularly that are more of a focus, but looking at response to a public health issue, outbreak, or pandemic situation, there may be a floating need for substantially different data, again, depending upon a particular situation. So, I am not sure we can put it quite that way. We can certainly do things that are of primary interest or usual interest to particular users, but I am not sure we can be as specific or want to go to a place where we could be casting a potential "Hey, this is a limitation on who is accessing or who might use a particular element or class."

**Sarah DeSilvey**
Thank you, Ike. Pooja?

**Pooja Babbrah**
Going back to Mark's comment, this brings up a question I had, and I put this in the spreadsheet on the pharmacy side. So, if you have a long-term care facility-based pharmacy, it is very different than an ambulatory and community-based one in terms of the standards and code sets that they are using, so that was one of my questions. I understand we cannot use everything, but I am assuming we really want to be looking across different settings in all the spaces, but particularly in medication. I would just love some thoughts on that as we move forward.

**Sarah DeSilvey**
Pooja, that is a good point. I wonder if it is appropriate to apply that in particular to the collective work of this group when we move to the spreadsheet and we can just lean into it. We do have Shelly here as well, and I may have neglected one of our other pharmacy reps, but I just want to note that those are really good discussions to have on the spreadsheet so that we can discuss it in particular. Does that sound like an okay plan?

**Pooja Babbrah**
Perfect, yes. Thank you.

**Sarah DeSilvey**
All right. Any other comments before we actually move to the spreadsheet and start analyzing some of the elements and discussion points people have put there so far and try to start applying at least some initial recommendations to start moving forward in our charge? It looks like Shelly has her hand up.

**Shelly Spiro**
Yes, thank you. To address Pooja's concerns, the Pharmacy HIT Collaborative, which sets up the coding for the pharmacy profession, does take into consideration all practice settings that pharmacists are in, including the LTPAC and am-care hospital oncology, so we are very well covered in that particular arena, and through our comments, we will make sure that the coding terminology standards that we recommend are applicable to all practice settings.

**Sarah DeSilvey**
Thank you so much, Shelly. All right, any other comments? We put this here just as a reminder, that this is the general prioritization criteria that are applied to identify elements that are eligible for USCDI. Again, this is the important prioritization criteria. The prioritization criteria on the other side was just, again, in consideration of public comment, trying to create time for people to come to elements that might need more time. Next slide, please. I believe we now go to the doc to try to do some collective work and maybe move some elements along that may be able to be moved along at this time.

**Al Taylor**
Does everybody see my screen?

**Sarah DeSilvey**
I believe we can now, yeah.

**Al Taylor**
All right, let me zoom in so people with small computers can see. Let me find my zoom button. Here we go, sorry. That might be too much.

**Sarah DeSilvey**
I think that probably is too much, unfortunately.

**Al Taylor**
How about this?

**Sarah DeSilvey**
That seems good enough.

**Al Taylor**
Before we do, I think you may have touched on this, Sarah, but just in case, I wanted to orient members and the public to some changes we have made to the spreadsheet. No. 1, we did discuss the original list of data elements that are new to draft V.4, and these are listed here. A component of this tab is current thoughts on how these may or do map to both the FHIR IG and the C-CDA IG, and some work that was done by Hans and some others, and it serves as a reference for workgroup members to take into

consideration when they make recommendations. It is not meant to capture comments, just as a reference for consideration.

And then, second, this is, again, as a reference on the current prioritization criteria, and as a reminder, the prioritization criteria are what are used to select amongst the Level 2 data elements to add data elements to USCDI, new versions, so the first bar they have to clear is that they are Level 2 data elements before the prioritization criteria are applied to select for USCDI. So, with that in mind, we will start with the spreadsheet. These are listed in an order that correlates to the list that is on the slides, not alphabetical, not in order of anything other than that we think these are going to be more straightforward and get less straightforward as we go down, or require more comments, input, or adjustments. So, we are starting here. Sarah?

**Sarah DeSilvey**
Yes, thank you so much, Al. Again, the hope is to just get some early wins. So, in respect of the fact that we do have a lot of new members, one of whom is myself, I do not want to default to lack of comment meaning approval, so if the assumption is that we should be approving, in some sense, building off the work that ONC has done prior to us, so, really raising and just diving into elements that need the collective wisdom of this group. I have seen no comments yet regarding… Oh, it looks like Hans has a new comment regarding allergies and intolerances. Can we go over? Hans, can you help us understand your comment for contextual grounding, just as we work down the list, please? Thank you.

**Hans Buitendijk**
When looking at the intended definition of the proposal, it is not totally clear what level of granularity is intended here. Within the standards, US CORE in particular, there are a couple different places where that could occur, so if there is additional guidance beyond what is currently stated to help clarify that, that would make it a lot easier downstream, when this is being used, and whether an update to FHIR US CORE, implicated in this case, would need to be made or not, that that could be assessed. At times, we have seen that the description in USCDI would allow for different interpretations on how you could do it or what is really meant with it. The more that we can do that up front as part of USCDI, the more crystal about that…

Substance is one example where you could go a couple different ways, either as a result of it already being there or as a result of some additional guidance needing to be provided, and particularly in the second case, a general comment that you may hear me make and that those who have been in past discussions have heard me make, which has been clarified as well, is that any HIT that wants to be certified must be able to support, and the support has a particular meaning what that is, particularly one part of it, that it has to be able to create documents and otherwise accordingly at the granular level of that data.

That may or may not always be appropriate, but this would also help understand what in USCDI we are actually asking certain HIT to support that might not be relevant, not that we can solve that right now here, but it is relevant for both parts on what kind of implementation guidance is already there or may need to be made, as well as understanding if we are asking more HIT to support it, not just EHRs, but HIT, that wish to be certified to support that. So, if there is any other guidance from those who submitted it on what they meant with it, that would be very helpful.

**Sarah DeSilvey**
Hans, that makes a lot of sense. Shelly, any further thoughts?

**Shelly Spiro**
Yes. Hans is actually correct, but what we are trying to do within pharmacy, and we are not quite ready for it yet, though we have a project going on with the United States Pharmacopeia, but what we have in the data class now under allergy and tolerance is strictly for observation. So, there is an allergy, and it is observed, and this is the criticality and severity of that allergy. What we are working on is more of the potential adverse drug events that could take place, which would be codified using pharmacogenomic information, not only what interventions took place in SNOMED, but also, using LOINC, some of the laboratory data that would come from a pharmacogenomic test, as an example. And then, there is the process of the investigation that takes place to assure that the allergy intolerance that was observed is actually an observed allergy intolerance, all the way, then, to reporting to the FDA for FAERS reporting, and all of those points will hopefully come in in future versions of USCDI as we flesh it out within pharmacy.

**Sarah DeSilvey**
Thank you, Shelly.

**Steven Eichner**
I just want to note something really fast for Shelly. This is Steve Eichner. One of my curiosities in the space is that we have done a really good job with allergens for vaccinations and immunizations, but there is always an outlier, and I am probably the outlier there. I am not allergic to any medication, but intramuscular injections create a real problem for me, but there is not a way of reporting that as a risk factor with respect to immunizations and vaccinations.

**Shelly Spiro**
Yes, I am definitely with you, Steven. This whole aspect of what we are doing with allergies within EHR documentation is an emerging area, and I agree, it has to be attached to immunization.

**Steven Eichner**
So, the other piece there is that in the bigger scope, as you are looking in that space, we need to figure out a way of incorporating other risks as a note without duplicating those records or without duplicating needs or having physicians have to go search in notes files or other places for it. So, that is another little wrinkle.

**Shelly Spiro**
I totally agree with you, and those are on our roadmap to figure out.

**Steven Eichner**
Wonderful. Thank you, and thank you for allowing me that brief redirection.

**Al Taylor**
This is Al. I can address Hans's question as well. As far as clarification goes, Hans, the intent of this particular data element, if that is what you are asking about, is that there is a list of substances… So, the individual allergy and intolerance to a substance that is not a medication would be a set of values represented by some applicable standard code set, likely SNOMED, but the intent is to capture a category or a type of allergy and intolerance that is not represented by medication or a medication class, like we

currently have, so it is just an extra one, things like food and environmental. It is in that. That is the intent of this data element. I hope that helps.

**Hans Buitendijk**
I think that helps, and I put it in the text that it sounds like, if I hear you correctly, it is more the first interpretation than the second interpretation, if I hear you correctly.

**Sarah DeSilvey**
Hans, you mean a specific substance? Is that what you are saying, as opposed to a pharmaceutical product?

**Hans Buitendijk**
Yes, from a substance perspective. It is more the first thing that I put in the chat than the second.

**Al Taylor**
So, regarding your first definition, which, just to say it out loud, is a code that identifies the allergy and intolerance. Now, if you mean the reaction that happens after exposure to an allergen, that is not the intent. It is to identify the substance that causes the reaction. That is the intent of it. Just like allergy to medicine, it is not the reaction you get when you are exposed to a medicine, it is the medicine that causes.

**Sarah DeSilvey**
Yeah, so it is the nonpharmaceutical substance. The example in this submission was eggs, latex, etc.

**Hans Buitendijk**
That would be helpful to clarify because there are couple different **[inaudible – crosstalk] [00:32:54]**.

**Al Taylor**
Whether it is egg or pollen, yes.

**Sarah DeSilvey**
Hans, the submitter was Diameter Health. It looks like the use case for the rationale was specifically focusing on instances like latex and eggs, which are very important for clinical care, but are not represented currently in the pharmaceutical set. And then, it is important to get the submitter here to give further information. I want to hold that up because, Hans, that might be important. Ricky, it looks like you might have a thought.

**Ricky Bloomfield**
Yes. Building on what has been said, I think some of this has been covered already, but I just wanted to highlight that right now, the coding system that is recommended for use within US CORE is SNOMED, as was mentioned. There are two specific categories within SNOMED. There is both the pharmaceutical biological product and then the substance, and this would fall into the substance. But, I think one of the things that would be useful to hear from either Shelly, who has experience in this, or Diameter Health is whether the use of SNOMED here is sufficient for the categories and the examples that we are looking at, or whether we need to consider other CODING systems. I know LOINC was mentioned as well, but given

the predominant use of SNOMED for this FHIR resource, it might be useful to make sure that we are being comprehensive here.

**Sarah DeSilvey**
That seems important. Luckily, Shelly has her hand up. Shelly, do you?

**Shelly Spiro**
Yes. This is what we are finding. In terms of drugs, which has already been identified, it really should be RxNorm. What the compendiums do within their clinical decision support algorithms is use the drug class, and what we are finding is the drug class is not granular enough to identify the clinical manifestations that can occur from drug or even the individual ingredients that are part of a combined drug, such as a filler or a dye that would be used. And so, as I said, again, this is work that we are working on to identify more. What we are finding is SNOMED would be applicable to the nonmedication products, such as eggs or latex, but for the medications themselves, it would be RxNorm.

**Sarah DeSilvey**
Thank you, Shelly. Albert?

**Al Taylor**
So, to the previous comment, and I am sorry I did not catch who said it, but when you are talking about applicable vocabulary standards in USCDI, the intent of designating an applicable vocabulary standard is to say what health IT should be able to represent at least, not necessarily every possible encoding of a nonmedication allergen, but at least representing, so that could be the majority of or best single fit when it seems like one standard covers a lot of ground, but maybe not all of it. So, there are other examples in USCDI. Sometimes, there are multiple standards that should be used to represent something, like problem is represented in SNOMED and ICD-10, different use cases for the different vocabulary that are used. In the case of SNOMED, it is possible that it covers enough ground where it is sufficient to be the minimum standard required to represent it, even if it does not require everything, because we have to set a guideline in certification about what a system has to be able to do in order to meet that particular data element.

**Sarah DeSilvey**
Thank you, Al. I believe it was Ricky who was talking about the substance hierarchy within SNOMED CT. It looks like there are no further questions, so for the sake of moving forward, we clarify the definition, the grounding of this being a nonpharmaceutical substance that is relevant for clinical care according to the submission. The submission also references leaning on the SNOMED CT substance hierarchy there. So, I think Ricky was raising this, and I do recognize that there is a need to ensure that there are not missing data classes. Al mentioned the caveats there. I definitely want to reference, again, the consideration for LOINC, but is it okay to consider an initial recommendation, not final, for inclusion in USCDI V.4 with all of the intelligence of all the comments noted in discussion? And we can try to ensure that we capture that in our discussion so that it can be included in the final report, even though it is an ongoing topic. Does that seem fair?

**Ricky Bloomfield**
Yes, that sounds reasonable. This is Ricky.

**Sarah DeSilvey**
Thank you. Deven, any further thoughts on that matter?

**Deven McGraw**
Well, this is related matter. I do not know if it is related to the question that Ricky just addressed. I was starting to have a conversation in the chat, and Dr. Lane responded to me, and it occurred to me that it might be worth just raising with the group really quickly. So, does pharmacogenetic results fit into the allergy and intolerance category? If someone has a genetic test that shows that a medication would not be effective for them or it is not exactly an allergy or intolerance, but it certainly is a quality-of-care issue, and one where there is a growing body of evidence around the cost savings that can accrue with respect to certain pharmacogenetic results in addition to, of course, alleviating suffering if people are getting the wrong drug, even if they are not necessarily manifesting an intolerance. Steven says he thinks it is applicable for potential ADE, but not an allergy or an intolerance. At any rate, while we are on the topic of drugs, I just thought I would bring it up.

**Ricky Bloomfield**
This is Ricky. I have not seen that allergy intolerance has been modeled to include pharmacogenomics yet, but it is certainly a great comment and point, and something that will likely be used more in the future, so, maybe something that could be considered in the appropriate HL7 workgroup.

**Sarah DeSilvey**
Thank you.

**Al Taylor**
This is Al. I will add that there is a set of codes that include the concept “propensity toward intolerance,” so it is possible that pharmacogenetics could indicate a propensity towards intolerance, and things like general anesthesia are something where there is a genetic test for that, and that genetic test could result in a propensity toward intolerance of general anesthesia, and so might fit into that category, and that might be what you had in mind, Deven. I think it could, but the scope of this particular data element may not be sufficient to cover that ground as well, along with the example that I gave about an intolerance to a procedure.

**Sarah DeSilvey**
Shelly?

**Shelly Spiro**
Yes, you are on the right track, and what we are seeing in USCDI right now is for observation. You have observed; you are recording it in your system to assure that something is not going to happen in the future. What we are looking at for potential versions of future USCDI would be a category of potential adverse drug events, where you would use LOINC for the actual pharmacogenomic testing, and then you would use SNOMED for the interventions that are actually occurring, and of course, RxNorm for identifying the drug or medication that would actually cause that potential error. All of that is still work that is being done, so it is not appropriate to put it into USCDI now, but it is something, especially on the pharmacy side, that we are looking at for future use.

**Sarah DeSilvey**
Shelly, that all makes a lot of sense, so, thank you. All right, so, this is future, to-be-determined, additional information. What I hear us saying is an initial recommendation for inclusion. The justification is I see the elements we've have been raising are in line with submission, which are missing. We have pharmacology covered well in allergies and intolerances, but not nonpharmacological substances. I hear us referencing the SNOMED substance set, but we need to consider LOINC, and I tried to put that in the workgroup discussion. Grace, you are with us right now, but just as you were mentioning, I am trying to note alignments with prioritization criteria. That seems like Prioritization Criteria No. 5, which is a critical missing element, given that it is the missing facet that builds upon the pharmacology sets that are already in USCDI. Hans?

**Hans Buitendijk**
Just a general procedural question. As we go through, we have comments and discussions specifically about data class and data element, and capturing that here. Where do we capture candidates along the way for general recommendations and comments or considerations that do not apply necessarily to any particular one, or that apply to a number of them? Where would we like to keep track of those?

**Sarah DeSilvey**
I am going to lean on those who came before me for precedent, but it seems like those kinds of things should be captured in the conversation section of our final recommendations, things that have been recommended and discussed from the wisdom of the collective, but do not necessarily specifically align with USCDI V.4 or in Level 2 submission. Is that the precedent that came before us? So, to not lose that wisdom in our conversation.

**Hans Buitendijk**
Yeah, and I think we did it in the past, either in line with this spreadsheet or on a different tab that we could track of those as they came about. That is one of the comments that I think we wanted to keep track of as well that came up in this conversation.

**Sarah DeSilvey**
For now, given that it arose during this discussion of this data element, maybe we can put it in the workgroup discussion there so it at least can be captured. I tried my best to do shorthand conversation regarding SNOMED and LOINC, but it seems like whoever is willing to include those elements, and we do get a printout of the chat, of course, to try to abstract it, but if someone would not mind leaning into the work of discussion and documenting the key findings from that in there, that would be helpful.

**Steven Eichner**
Sarah, that is consistent with how we have done this in years past, keeping it in the discussion, and then pulling from that when we put together the final recommendation.

**Sarah DeSilvey**
Oh good. Thank you, Steven. My instincts are not off.

**Hans Buitendijk**
So, you would like to then do it in the chat discussion, not in Column J?

**Sarah DeSilvey**
No, sorry. I might have misspoke. I actually hope we can include it in Column J, and we will just take it out if it was information that was covered in conversation of this element, but is not directly related to the element. It will be here for posterity and able to be abstracted into our final recommendations.

**Hans Buitendijk**
Got it. I will add the comment in there.

**Al Taylor**
This is Al again. Real quick, SNOMED is the current applicable vocabulary standard for this data element in draft V.4, and I would suggest that where changes to those applicable vocabulary standards are recommended, that even a shorthand specific justification for why an alternative is being recommended, so, with LOINC, the example of pharmacogenetics, which is better presented with LOINC rather than SNOMED, so, adding a justification where changes are recommended.

**Sarah DeSilvey**
Thank you, Al. That is very helpful. So, I am looking for friends and colleagues to ensure that we capture the really critical wisdom and document the workgroup discussion. I did do a shorthand note regarding SNOMED and LOINC. I will look to colleagues and myself to lean into that so we can make sure it is included in our final recommendations. I am hoping to move on to the next element, again, just to keep our work going forward. I believe encounter information and encounter identifier were the next elements of review. Again, I do not see any comments on this at all. Hans, you have added elements on the first one. So, again, understanding the precedent that comes, the public comment, and the elevation from ONC, any concerns with approving or recommending a counter-identifier? We can go to the submission if need be. Any conversation regarding this?

**Ricky Bloomfield**
This one seems like a relatively straightforward technical change that is already a required part of US CORE, so it seems relatively uncontroversial.

**Hans Buitendijk**
Yup.

**Sarah DeSilvey**
I agree.

**Bryant Thomas Karras**
Hear, hear.

**Sarah DeSilvey**
That is a nice one. All right, going once, going twice? It sounds like initial approval. Moving on to a set of different elements that are newly grouped within the health status assessments area, there are three: Alcohol use, substance use, and physical activity. I am hoping to lean into alcohol use first. I want to note that Steven and myself will comment that the submission of reference for USCDI V.4 is LOINC in referencing standardized instruments, but there is a different Level 2 submission with SNOMED. Both are

applicable and aligned with data standards, so we would merge the USCDI V.4 submission and existing Level 2 submission, which I think was submitted by our friends at NACA, Julia Skapik. So, I just want to center us in that conversation, both the LOINC element in the submission in USCDI V.4 and the SNOMED CT reference in Level 2, alcohol use area, and now open for conversation. Bryant?

**Bryant Thomas Karras**
I wanted to open the conversation with a joke. I am glad we waited until February, not dry January, to have these discussions.

**Sarah DeSilvey**
Thank you. Steven?

**Steven Lane**
Well, I cannot point directly to it. My recollection is that we have precedent for data elements that could be satisfied using one of two data standards, so I do not think it would be out of the question to allow both SNOMED and LOINC in this situation.

**Sarah DeSilvey**
I agree. I also, again, tried to put in the prioritization criteria that this, again, aligns with behavioral health, the first prioritization criteria being USCDI V.4. Any further thoughts on alcohol use as an addition under the health status assessments area?

**Steven Lane**
I am curious about the ONC response, maybe from Al or others. This has come up before, and it will come up again, in fact, when we get to advance directives. There are closely related submissions, and it seems like ONC has sort of picked one of a set of submissions to suggest for advancement, and I am just curious what the thinking was behind that, as opposed to making the effort to harmonize or bring forward multiple overlapping suggestions.

**Al Taylor**
So, we acknowledge that there are sometimes, like in this case, data elements that are very similar, if not identical, and we work to resolve them. We have not resolved all of them, clearly, as evidenced by this. The submissions may have been done over time. I think in this case, one was a social history and one was a substance use history submission, and we worked to reconcile those two and come up with what we think is the best related data element to meet the goals, which is, in this example, to advance behavioral health data for interoperability.

So, we look at what is submitted, and we sometimes make changes too, including things like the vocabulary standards or the definitions, to fit sometimes a broader use case or a somewhat different use case, and in with the example of alcohol use, we felt like, obviously, the topic of alcohol use is important, it is a very important assessment of health that, in various care settings, needs to be done or should be done, so we may have modified a particular submission to meet the use case that we felt like was most appropriate, and that is one of the reasons why it went from either the social history data class in the submission or the substance use data class to the health status assessments data class rather than alcohol or other

substance use disorders, which categorizes a problem or a diagnosis. In that case, it might be more appropriate in a problems data class, but it was reclassified into this for that reason.

**Sarah DeSilvey**
Thank you, Al. I believe in the SNOMED CT relevant submission, Dr. Skapik was referencing the use of SNOMED CT and social history documentation, so that aligns with your statements, and of course, it aligns with the mapping to FHIR, C-CDA, and use of those elements in social history as well, so that is good to know. Ricky?

**Ricky Bloomfield**
I just wanted to make a comment. I agree with everything that Al said here. The precedent that exists for US CORE right now for smoking status is that specific guidance was given around use of a single LOINC code. If I remember correctly, the reason that a completely separate profile was created for smoking status was because of some of the unique aspects here, but also because there was interest in ensuring interoperability because there are multiple codes, potentially, and to try to align on as narrow a definition as possible to ensure this could be interpreted easily across systems.

So, I think there is some thinking that could happen here as to whether we need something similar for alcohol status, for other substances, and smoking status is an observation with a category code of social history. That was how it was defined, and then you had the single code for the smoking status. So, I think that might just be part of the conversation in terms of subsequent standards development, if this general motion is approved, but I just wanted to raise that in case this group has any thoughts or opinions about how we might recommend any of those details out of this committee.

**Sarah DeSilvey**
Thank you, Ricky. That is really important, not just for this element, but for some of the others in this set. Any other thoughts on what Ricky has raised? Shelly?

**Shelly Spiro**
Yes. When we are talking about substance use, maybe I am not clarifying this right. We are not just talking about alcohol, we are talking about other substances such as cannabis or some psychedelics. We are seeing RxNorm beginning to code some of those, so would it be beneficial to add RxNorm? That is something I have not quite wrapped my head around, but it is emerging.

**Ricky Bloomfield**
I think that is exactly right. For substance, there is a much larger list, and a list that is ever growing, as there are all sorts of new substance that are being used or abused, like Tide Pods or all sorts of things that probably do not even have codes associated with them, so that needs to be more flexible. I think the broad question here is whether we have any thoughts about how that should be considered to ensure maximum interoperability. I think Al's point earlier that the code sets recommended as part of US CORE are recommended to be sort of a minimum baseline set to help provide some guidance here, and I think the question for alcohol and other substances, which are two separate categories here, is whether there should be similar guidance to ensure maximum interoperability.

**Sarah DeSilvey**

Ricky, thank you. Shelly, if you would not mind putting the RxNorm element in the substance use row in Column J, that would be really helpful because, again, it is one of those considerations that is really important, and Ricky, if you would not mind encapsulating that brilliant thought in one of the areas just so we can make sure it is captured from a conversation perspective… It can be in alcohol use because that is where it started, but I fully agree, and I just want to note that on the mapping to FHIR and C-CDA, the Gravity Project SDOH assessment was brought up as a precedent. Gravity Project did not address alcohol use, substance use, etc., so it would be aligned with previous work in similar assessment categories, but I just want to make a comment, putting my Gravity Project hat on, that these two elements are not currently in Gravity's scope. So, they would be aligned with the SDOH assessments category, but would not be included in that work at this time. Maybe in the future, but not right now. Bryant?

**Bryant Thomas Karras**
I will try to get some advance results from this that could inform our discussion here, but for awareness, I wanted the group to know that ASDOH, the Washington State Department of Health, and the University of Washington are currently doing an evaluation of the smoking status data elements in electronic medical records systems in health insurance…"claims" is not the right term, but rate reduction categories, the self-attestation of nonsmoking status with insurance companies, and the all-payer claims data to see how smoking status is actually used and if there are consistencies across these different data sets. So, that could potentially inform and let us know how useful smoking status is, as one of the examples listed here, in the EHR, if people are actually using it the way we think they are using it.

**Sarah DeSilvey**
Thank you so much, Bryant. Hans, any other final thoughts?

**Hans Buitendijk**
Yes. I am reacting to your comment that the elements are not yet defined in SDOH and are not on the calendar yet. If you look at the progression before, Gravity has been used recently to then inform FHIR US CORE and C-CDA, but particularly FHIR US CORE, on how to address some of the SDOH data. Do you foresee this to be an area that requires a fair amount of effort beyond adding the appropriate code set/value set that needs to be supported, or is it indeed, just from your perspective as you have seen it, a value set addition in the context of already-existing structures and guidance that is out there? That would indicate the complexity of this to get that included in the right places at the right time.

**Sarah DeSilvey**
I am going to do my best to give an off-the-cuff answer to that. So, the good thing about each of these elements, alcohol use and substance use, is the standardization of screening instrumentation, which is the primary focus of this area of work with Gravity, are far further along than the social determinants of health elements are, so I feel like there is little risk in proceeding with this as it stands right now, given the fact that even in the submission, the highly evidence-based standardized instruments that would be included from a LOINC perspective have been in the ecosystem for a long, long time. The only thing that would be problematic would be the SNOMED CT terms, but Ricky notes that we would limit that set just by focusing on some of the precedent going forward. I hope that was a good answer to your question, Hans.

**Hans Buitendijk**
It certainly clarifies it, and it is helpful.

**Sarah DeSilvey**
All right. We have had a lot of wonderful discussion, and some of it is actually carried across each of the different elements, alcohol use and substance use, which are considered independently. It adheres very similarly, actually, to our first element that we discussed, which is the nonmedication substance addition to allergies and intolerances, approved with wise commentary. So, it is not that we do not approve of the USCDI class. We approve of it, it aligns with Prioritization Category No. 1, and there are a lot of thoughts from the wisdom of this collective regarding considerations therein. Does that seem safe to say?

**Steven Eichner**
Sarah, this is Steve Eichner. I have one quick question that I honestly do not know the answer to. As marijuana becomes more in use from a medical perspective, is that being considered as substance use? How is that falling into the envelope?

**Sarah DeSilvey**
That is a brilliant question.

**Steven Lane**
I am happy to respond as a clinician, if you like. It is tricky because when people use cannabis, it can be recreational and/or therapeutic, and certainly, in my practice, I have often chosen to put it on the medication list when it is being used therapeutically, but we certainly do not do that when it is being used recreationally. It is an important point.

**Al Taylor**
This is Al. If I might, with that sort of thing in mind, we crafted the definition for substance use as the evaluation of a patient's reported use of drugs or other substances for nonmedical purposes, or in excess of valid prescription, and so, I think that addresses that problem. And so, your responses to a substance use questionnaire would be about nonmedical use.

**Steven Eichner**
That is wonderful, Al. I figured you probably had something in mind for that. My friendly amendment is that with any recommendation we make in this space, we highlight that as an important factor going forward so that there is a clear understanding and use of that field in line with the definition. That would be an easy one where if you were not paying attention or misunderstood the definition, you might misapply it.

**Al Taylor**
I recognize that the spreadsheet does not have the official published definitions and standards that we have on draft V.4. I will remedy that in the very, very near future. Anybody who wants to have a comment, they can comment referencing a definition or a standard. It is just missing.

**Steven Eichner**
That was not intended as a critique, but my suggestion is looking at including that as a recommendation going forward because quite often, definitions get lost or placed in other places, and are not front and center, and I think a lot of folks are accustomed to a certain definition. The change is a helpful change, but

reminding folks that there is a change is useful throughout. That might be something that the committee wants to highlight, going through the recommendation and clarification on the utility at the end of the day.

**Sarah DeSilvey**
Okay. Any further thoughts on alcohol use as it merges into substance use? We are kind of talking about both rows at this time.

**Hans Buitendijk**
Sarah, the only comment is the one that I just put in the chat. It sounds like there is still some potential follow-up on these, so I want to make sure we understand the meaning of "approve" here, whether that is a draft approval, which I think was the intent, or a final approval, which sounded more like encounter identifier. That seemed to be very straightforward.

**Sarah DeSilvey**
Thank you, Hans, for raising that. So, at present, Column K is final recommendation, so it seems for encounter identifier, there is absolutely no further identifier. You are correct, we can move to final recommendation. For the other elements, as far as I understand, it is a draft recommendation with further conversation to happen until it moves to that state. Does that seem fair?

**Hans Buitendijk**
Yes, that clarifies, thank you.

**Sarah DeSilvey**
All right. Again, the thoroughness of our commentary is driven by the ability to document the considerations from the collective in the workgroup discussion, so we are recording this conversation and capturing it in the chat, but if you were responsible for something that drove conversation, please do take time, if you can, after the meeting, or even now, to go into the workgroup discussion element and make sure your thoughts are documented. Oh, here we go. Al is making edits as we go. So, I just want to note that if we think about moving on to substance use, which I think was the next one after… No, we went straight to physical activity. There we go. So, in physical activity, there was a comment to…

**Al Taylor**
Substance use seems to have disappeared.

**Sarah DeSilvey**
Yes, substance use did disappear. I do not know what happened! It was there. No, that is not it. We will find it in a version and make sure that we include the comments. The good thing is much of the comments we had regarding alcohol use apply to substance use as well.

**Ricky Bloomfield**
Was it previously labeled "drug use" and renamed "substance use"?

**Al Taylor**
Yes.

**Ricky Bloomfield**
So, I wonder if it…

**Hans Buitendijk**
It is a couple down. It ended up on Row 9.

**Al Taylor**
Oh, I shuffled it. There it is. I think I got it.

**Sarah DeSilvey**
Thank you. Al is shuffling the deck on us as we go forward. The good thing is the entry numbers can ground us, right, Al?

**Al Taylor**
The entry number is manual, so it should sort. We will sort it out later.

**Sarah DeSilvey**
So, for the next element, even though the location on the spreadsheet has changed, the next element via entry number, which is the original documentation, is substance use. I believe much of the conversation we just had regarding alcohol use applies here. I do want to open up the conversation to ensure that I am not incorrect in that. Again, in the original submission, there were a few LOINC instruments that were recommended in USCDI. There is an applicable Level 2 element as well, I think, or at least there is an ISA page that has different elements open for conversation. Again, making sure we differentiate substance use from substance nonmedication, which we already covered there. Any thoughts? Are we feeling like we covered the shared concerns across alcohol and substance use? And again, highlighting the fact marijuana is used for therapeutic purposes and would have to be documented separately if that was the case, and that consideration was part of the definition. Are we okay with conditional early approval? Shelly?

**Shelly Spiro**
I am a little confused. If it is recreational for cannabis, would we still codify it in SNOMED or LOINC, or would we use RxNorm since there are RxNorm codes for cannabis, even though it is not a prescribed medication, it would still be recreational?

**Al Taylor**
Shelly, the primary use case for this data element is assessment of and not identification of, so, identification of substance use or assessment of substance use rather than naming the medication or substance. I do not know if that helps.

**Shelly Spiro**
So, it would just be yes or no, Al? Is that what you are saying?

**Al Taylor**
So, for example, using the DAST, the Drug Abuse Screening Test, that would be the primary way to document this data element.

**Shelly Spiro**
So, wouldn't that be in an assessment, not necessarily in the section?

**Al Taylor**
Well, this is the assessment section. This is the assessment data class. It is in the health status assessment data class, so, yes, it would be. That is why it is there, and not in the problem list, the problem data class, or a separate social history data class.

**Shelly Spiro**
Got it. Thanks, Al, for the clarification.

**Bryant Thomas Karras**
Sorry, Al, just to clarify, this does not remove the diagnosis code from being present in the problem list, this is supplemental.

**Al Taylor**
Yes. Going back, again, to the well-structured SDOH family of data elements, so the SDOH assessment is not the same thing as the SDOH problem/health concern. Same idea. And, for the record, that is the same way we represent basically any clinical issue, is how we assess the issue, what we do about the issue, and how we diagnose the issue.

**Bryant Thomas Karras**
So, I am wondering if we have a precedent. Can the data element name itself be modified to prevent misinterpretation of putting yes/no or diagnosis codes into this category? Perhaps "substance use assessment" is the data element.

**Al Taylor**
So, the name itself was simplified just for clarity, but within the data class of assessment and the definition of being "evaluation of." We feel like that combination of things clarifies that sufficiently, but if the recommendation is to make the name explicit that this is the assessment of instead of the diagnosis of, that is a perfectly legitimate recommendation.

**Ricky Bloomfield**
This is Ricky. I think these are all great pieces of feedback for the profile development that will need to happen after this, for example, making sure this is appropriately codified as a social history construct rather than a diagnosis, and then, also, the concept that Shelly raised around cannabis and whether this is a medication on the list or a different code than RxNorm. I think those are all things that the profile developments can go into with a bit more nuance to figure out what makes sense when this is used at scale. To the point Hans made earlier, some of this comes down to feasibility from the EHR vendors, and what codes they currently use, and what makes sense in the real world, and input from this group can be helpful in informing that, and then, they can get into more nuance around actually creating that profile. So, I can add a few comments here as well into the spreadsheet. I am not at a computer right now where I can type that, but I can highlight some of that nuance as we move our recommendations forward.

**Sarah DeSilvey**

Thank you, Ricky. That is, again, incredibly helpful. So, what I hear us saying is again, this is akin to a conditional early approval, not a final recommendation, given it shared concerns and some individual concerns with alcohol use, specifically because of the capacity for prescription of some of the elements that are within this set. I do want to note that in addition, we see that psychedelics are prescribed within psychiatric settings. There are lots of additional new, novel, and actually maybe some longstanding, but maybe more standardized uses of substances that used to be strictly utilized in community settings that are now being prescribed. That differentiation is important across multiple substances, not just marijuana, of course.

**Steven Eichner**
This is Steve Eichner. I might be jumping a little bit ahead, but thinking about substance use and nonmedication, I guess looking at who is making that determination as to whether it is nonmedication, patients saying it is self-medicated… What is the suggestion in looking at that line of differentiation? I might be jumping a little bit ahead, but I do think it is relevant here.

**Sarah DeSilvey**
You are referencing what we were talking about before, but it is actually really important, I think, considering how the conversation regarding prescribed and nonprescribed substances relates to the pharmaceutical versus nonpharmaceutical differentiation within the substances nonmedication element. So, I believe some of that was picked up in Shelly's conversation, and I see that she has her hand up. Shelly?

**Shelly Spiro**
Yes. Actually, we had this conversation in the HL7 pharmacy workgroup in relation to alcohol. We have some settings, like a long-term care facility, that actually does prescribe alcohol use for some patients, and we are also seeing that for cannabis, so there are situations, including the LTPAC setting, where it could be either categorized as substance use or could be categorized as medication use. So, there is not a clear line as to what is what, but we have to be able to accommodate both.

**Sarah DeSilvey**
And as many in the chat were commenting, it is not necessarily a limitation on the substance nonmedication element, but more a need for a separate new element in line with all the work that is happening in the pharmaceutical world that Shelly represents. It looks like we are moving to our public comment period. I will need to step away. Any final thoughts as we wrap up public conversation? Again, I want to thank everybody for their engagement. I really hope that folks put all the wisdom that you possibly can into the workgroup discussion elements so we can move things along as we go forward. Steven?

**Steven Lane**
I am just echoing your thanks to the workgroup members for the great engagement in the spreadsheet. It is incredibly helpful, and it facilitates our discussions here.

**Sarah DeSilvey**
Thank you, Steven, and thank you also just for your guidance and for helping this novice cochair and learn how to do the work. Any other final thoughts before we move to public comment? Again, we are moving a little early, but I will need to step away. So, I think we arrived at a conditional approval of substance use. Before we go into public comment, because we have a couple minutes, I just want to note that we did

discuss bringing folks from the physical activity FHIR implementation guide to future meetings to assist with that work, but it seems incredibly relevant given the depth that they have gone into in that space, and we will reach out to the team over there for that purpose. Some of the considerations might be akin to the previous data element, but it is actually a little bit different. We also have discussed the facilities elements and all the work to be done to convene individuals who are important for that work as well. Any other final comments before we move into public comment? All right, Mike. Back to you.

## Public Comment (01:19:39)

**Michael Berry**
All right. Great, thanks, Sarah. We are going to open up our meeting for public comment. If you are on Zoom and would like to make a comment, please use the hand raise function located on the Zoom toolbar at the bottom of your screen. If you are 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 from the public raises their hand. I am not seeing any hands raised, Sarah and Naresh. I know that we have one slide a couple before this about upcoming workgroup meetings if you want to cover that before we wrap.

## IS WG Workplan and Timeline (01:20:19)

**Sarah DeSilvey**
Yeah, if we can go to the next slide. This is the slide about our upcoming workgroup meetings. You can see that the number of meetings is diminishing as they occur. Again, I made this yellow callout of that because even though our recommendations are due in the middle of April, it really is important that we get consensus prior. So, again, I am hoping to get some of our stakeholders to our conversations at the end of this month and early next month to ensure that we have everything we need in order to make our final recommendations.

I do want to encourage everybody as well to, if there are Level 2 elements, which, again, is the second element of our charge, they feel like they need to elevate into USCDI V.4, there are already some examples of this. Please add them at the bottom of the spreadsheet so we can start looking at them and developing feedback for them, and in time, we will address them as well. Any other final thoughts from the collective? All right, thank you. I am going to hand it to Naresh, but thank you for this really productive meeting. It feels great to dive into the work with everybody's wisdom from each of their different stakeholders, representatives, and experience and come to task with the work we do. Naresh, any final thoughts?

**Naresh Sundar Rajan**
Great comment, great solutions, and thanks a lot.

**Sarah DeSilvey**
Mike, back to you.

**Michael Berry**
Great. I just want to remind everybody that we are back on our normal schedule for the workgroup next week. We are meeting on Wednesday at 10:30 a.m. Eastern Time. Also, a note that the full HITAC will meet tomorrow at 10:00, and I know that Sarah and Naresh are providing an update on this workgroup's

work to date, so you are welcome to tune in. You can register on the HITAC calendar. Thanks so much, and we stand adjourned until next week.

## Adjourn (01:22:38)