Transcript

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

February 15, 2023 10:30 AM – 12 PM ET

VIRTUAL

Speakers

Name	Organization	Role
Sarah DeSilvey	**Gravity Project** **Larner College of Medicine 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
Seth Pazinski	Office of the National Coordinator for Health Information Technology	Acting 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)

Seth Pazinski
Hello, everyone. This is Seth Pazinski with the Office of the National Coordinator for Health IT. I wanted to say good morning to everyone, and welcome to the Health IT Advisory Committee's Interoperability Standards Workgroup. I am happy that everyone could join us today. As a reminder, all these workgroup meetings are open to the public, and your feedback is welcome. You can type it in the Zoom chat feature throughout the meeting or you can make verbal comments at the end of the meeting during the public comment period, which is scheduled at the last five minutes of today's call. I will begin rollcall for the workgroup members, so when I call your name, indicate that you are present, and I will start with our cochairs. Sarah DeSilvey?

Sarah DeSilvey
Present.

Seth Pazinski
Naresh Sundar Rajan?

Naresh Sundar Rajan
Here.

Seth Pazinski
Pooja Babbrah?

Pooja Babbrah
Good morning, I am here.

Seth Pazinski
Shila Blend?

Shila Blend
Present.

Seth Pazinski
Ricky Bloomfield?

Ricky Bloomfield
Good morning.

Seth Pazinski
Good morning. Hans Buitendijk?

Hans Buitendijk
Good morning.

Seth Pazinski
Good morning. Christina Caraballo?

Christina Caraballo
Good morning.

Seth Pazinski
Grace Cordovano?

Grace Cordovano
Good morning.

Seth Pazinski
Good morning. Raj Dash? Steve Eichner?

Steven Eichner
Good morning.

Seth Pazinski
Was that Raj?

Raj Dash
Yes.

Seth Pazinski
Thank you. Nedra Garrett?

Nedra Garrett
Good morning.

Seth Pazinski
Good morning. Raj Godavarthi? Bryant Thomas Karras?

Bryant Thomas Karras
Present.

Seth Pazinski
Steven Lane?

Steven Lane
Hello!

Seth Pazinski
Hello. Hung Luu?

Hung Luu
Good morning.

Seth Pazinski
Good morning. Meg Marshall?

Meg Marshall
Hi, good morning.

Seth Pazinski
Good morning. Anna McCollister? Clem McDonald?

Anna McCollister
I am here. This is Anna, sorry.

Seth Pazinski
Hi, Anna. Deven McGraw? Aaron Miri? Aaron Neinstein?

Aaron Neinstein
Other Aaron is here.

Seth Pazinski
All right. Kikelomo Oshunkentan?

Kikelomo Oshunkentan
Hi, good morning, everyone.

Seth Pazinski
Good morning. Mark Savage?

Mark Savage
Good morning.

Seth Pazinski
Good morning. Michelle Schreiber?

Michelle Schreiber
Good morning.

Seth Pazinski
Good morning. Shelly Spiro?

Shelly Spiro
I am here, good morning.

Seth Pazinski
Ram Sriram?

Ram Sriram
Good morning, I am here.

Seth Pazinski
Good morning. All right, thank you, everybody, and I will turn it over to Sarah and Naresh for opening remarks and to get into today's meeting.

IS WG Charge (00:02:57)

Sarah DeSilvey
Hello, everybody. Welcome to another one of our gatherings addressing our charge. We will go through the slides, and as we did last time, we will spend most of our day working together on the Google doc, trying to complete elements of our charge. I really want to thank everybody for the asynchronous work that happened between our last meeting and today. Naresh? You might be muted. Naresh, are you muted, or do you want to say anything?

Naresh Sundar Rajan
No, Sarah. Let's continue.

Comments and Recommendations – New Draft USCDI v4 data elements (00:03:35)

Sarah DeSilvey

Okay, sounds good. Our agenda is as follows: Again, reviewing the charge, going into the USCDI elements, reviewing the work plan, public comment, and then adjourning. Next slide, please. This should now be deeply encoded. Our charge for this episode of work for the ISWG is to evaluate new data class and elements from draft USCDI V.4 and analyze any Level 2 data classes and elements not included in draft USCDI V.4. I really want to thank everybody for doing their homework on that second element of the charge, Level 2. There are a lot of new Level 2 additions that we will review once we get through our USCDI V.4 review, so thank you for that, and again, our mission is to complete and provide a report back to HITAC by April 12th. Next slide, please.

So, there was a very sweet highlighting, so we have gone through some of the elements collectively in our last meeting. We do have initial recommendations, although there are some thoughts and commentary in the workgroup discussion on substance use, alcohol use, etc., and the substance nonmedication. There are particularly some comments on the best terminology approach in the alcohol use and substance use elements. We are now going to dive in, and as you will see, we will have a brief discussion on physical activity. We are going to be skipping facility information right now because we did agree at our last meeting to try to make sure that we had critical stakeholders at that conversation, and so, we are aiming on addressing that really at the beginning of March.

And so, please, ASAP, get to us any recommendations for stakeholders that we need to include beside the ones that we already know about. You can put any critical stakeholders in the comment in the Google doc on the share drive. So, this means we are diving into a brief conversation on physical activity, just based on some of the comments that I saw on the share drive at this time. Next slide, please. Al, are you ready to share, or should I?

Al Taylor
I am ready.

Sarah DeSilvey
Sounds good.

Al Taylor
You should be seeing my screen.

Sarah DeSilvey
Any moment now.

Al Taylor
I have a little bit of a lag on my connection, so you should be seeing it.

Sarah DeSilvey
We can see it now, Al. Thank you so much. I want to note that we are reviewing and noting the commentary that is happening in the workgroup discussion. We gave preliminary recommendations for some of the elements. Again, we will revisit them in just a short bit, but for the sake of making sure everyone is on the same page, we are going to keep on moving through. I would like to take us to physical activity right now because that is the next element. We talked about postponing that in order to get the feedback from the FHIR implementation guide work in physical activity that is happening over at HL7, but I wanted to actually elevate a conversation that Steven Lane brought to bear, which is a process element. So, as much as we were talking about holding until the physical activity IG could come and present to the ISWG, Steven raises a process element that, in the past, we have actually held on inclusion until the balloting of that IG was completed over at HL7. So, Steven, is it okay to just have you discuss more of that? Because if that is indeed precedent and we really want to hold to precedent, we would wait to include it at this time.

Steven Lane

I am happy to chime in. Again, I want to be clear that Hans, Al, or others who are more involved in the process over at HL7 can comment, but I think the point is that we want to serve no wine until it is time, and it is just important that whatever we include in USCDI really is ready for nationwide interoperability, and while the criteria to get into Level 2 have to do with technical readiness, with experience in the industry, etc., to actually make it into USCDI is really a different thing because, at least to date, we have said that you need to have a functional approved implementation guide, not by the time that we approve it, but by the time that it actually makes it into a published version of USCDI. Again, others can comment, but we have actually changed the timing of this process and the HL7 process so that they are coordinated so that we can bring forward a certain number, a certain volume of new elements that require substantial work on the part of HL7 so long as they agree that they can get it done before publication so that we are dancing together on the two sides of this, and it is just important to coordinate that.

Sarah DeSilvey
Hans, any comments? Oh, sorry.

Al Taylor
I do have a comment. I wanted to clarify something that you said, Steven. A new data element in USCDI does not have to already have a published US CORE representation as long as the path towards representing it in FHIR and later in US CORE is a reasonable expectation. We recognize that US CORE design oftentimes follows the inclusion of a new data element in USCDI, and we expect that to continue.

Sarah DeSilvey
Thank you, Al. Hans, do you have a comment?

Hans Buitendijk
Yeah, a couple things to put in perspective there. I agree, in a way, with both Steven and Al in that FHIR US CORE in this particular case, and actually C-CDA as well, need not have it at the time initially. That was intended to be the case, but after Version 1, 2, and 3, it was looked at as okay, if there is a reasonable path, agreed with Al. The question is what is considered a reasonable path? If you look at the inclusion of data elements before that were not yet in FHIR US CORE, you could already start to see that in a couple ways. One, for example, if you look at some of the SDOH data, was already described in Gravity, and some people had started to adopt it, not necessarily widely, but it was already there, so a fair amount of work had already been done, but it still had to be "copied" into FHIR US CORE. So, it was not in FHIR US CORE, but it was something else out there that would be indicative of how hard or how easy it would be to include.

So, when you take that into consideration with physical activity, it is not in such a state at this point in time. The guide that is being developed has not been balloted yet, and is still going through the process. It is certainly not published, so there is still a fair amount of work to be done there looking at the question of if there is a reasonable path to be there or we are making recommendations before we even can look at what is out there and how it has been adoption is far more challenging in the physical activity space than it would have been for other ones. So, I think that is important to understand. What is the path that it takes? How long would that take? Is it reasonable to assume, or is it more reasonable to say that yes, it is important, we understand that, but in light of where the work is to make it actually happen, USCDI Version 5 is a better place to revisit that? So, from that perspective, I would certainly recommend to consider that and let that work, percolate, and improve so that in the next round, it would have a better sense that the time to go from USCDI version whatever to published and getting it into FHIR US CORE or otherwise would be appropriate.

Sarah DeSilvey
I think what I am hearing, actually, and maybe not as formally as this, is a motion to actually pause, given that we know the surety of the HL7 process is happening out there with the physical activity IG, and the status of that, and the capacity to revisit this element after the completion of balloting with consideration for USCDI V.5. Is that what I am hearing?

Hans Buitendijk

That would be my suggestion, but I open it to the group.

Sarah DeSilvey
I hear that. So, I have Rajesh agreeing. Nedra?

Nedra Garrett
Yes, hi. I am Nedra Garrett from CDC, and I just wanted to provide CDC support for the inclusion of physical activity. We are very supportive of it. There are three LOINC codes that are associated with it, and there is a fourth one where we are looking to have a cap-weighted value that would multiply the first and the second one to get at the actual minutes per week, but I did want to at least provide our support for the inclusion in Version 4, but I do understand that in terms of the pathway with the IG not being ready, we would definitely continue to support it for future versions, but we did want to advocate for it for Version 4.

Sarah DeSilvey
Thank you, Nedra. Anna?

Anna McCollister
Hi. I just have a more baseline question. I am inclined to agree with pausing this, but just for my edification, I would love to know the process by which something like these measures are chosen, and more broadly speaking, when I dug a bit into this measure, it did not really make sense to me that that would be a… It did not feel cooked enough to be standardized, and I apologize, I have not spent that much time, really, looking into this measure, but it makes sense to me that we would… Exercise and physical activity is an essential thing that should be captured somewhere, but is this measure something that makes sense as a data element that could be structured and shared? I did not really get that sense.

It is not something as straightforward as home-collected blood pressure. That is a pretty simple thing that makes sense, but is very clinically recognizable, where, to me, I did not get a sense that this measure was particularly standardized in a way that would be relevant. I do not know. If this is an offline discussion, I am happy to have that with somebody. I do not want to derail us, but I did not feel super confident with the way the measure was laid out, and maybe that is just my ignorance and lack of background.

Sarah DeSilvey
Anna, I do not know if I am the best person to respond to this, but I actually feel like what you are saying is actually very similar to what other people have said regarding this in that there is a group at HL7 that is actually working to standardize this right now. There are suggestions about possible data elements that could complete this for inclusion in USCDI V.4 right now, but there is also a whole other group that is working to figure this all out in a very direct and invested way at HL7, so I think you actually sensed the temperature of some of those conversations that are happening in ecosystems. I would not actually call that ignorance, I would call it insight, and so, that is partly why Hans and Steven, acknowledging the work that is happening at HL7, are wondering whether we should push the pause button and then consider revisiting next year.

Anna McCollister
But when I look at the page that I think Ricky linked to, and thank you, Ricky, or whomever linked to the HL7 thing, it felt to me like… Do we have a standard measure that has been accepted by the American Physical Society Association? Maybe I just made that group up, but something along…AAFP, or American Diabetes Association, or some consortium thereof that says this is the best way to capture in a structured way a composite assessment of physical activity. Has that work been done? Because it would seem to me that the HL7 stuff would be a bit more downstream to some sort of standardized measure. I am not aware, again… Maybe that is just because I have not played in that space, but there are tons of different data things that I track personally that are structured and machine readable. It is a lot of data, and whether or not that is appropriate to upload into the EHR is a different question, but somebody somewhere must have thought about this.

Al Taylor
Can I jump in?

Sarah DeSilvey
Yes.

Al Taylor
Thanks for the question, Anna. There are two parts to this. One is the data element physical activity, in ONC's feeling, is an area of health status assessments that is important to be able to capture in an EHR or other health IT, and that is why it was proposed to be added, not necessarily because there is one single, standardized way of capturing physical activity, but it is an important enough specific kind of assessment that warrants inclusion.

We also recognize that there are several existing standardized assessment instruments, including exercise vital signs and the one that was recently proposed by the American Heart Association through the ONDEC system, which is exercise vital signs plus a muscle strengthening component, so we feel at least those two alone have sufficient standardization in the ability to represent the assessment of physical activity, not the entire scope of the physical activity IG as it is under development, but the assessment itself, but it does not necessarily mean that that is the only way that health IT will have to capture it. There is existing standardized acceptance of validated instruments already, and it is that recognition that led to our thinking that it was mature enough and that the development burden would be low enough to warrant inclusion.

Anna McCollister
Okay, thank you. Again, my apologies. There are lots of things that I am getting up to speed on, but anyway, thanks, Steve.

Sarah DeSilvey
It looks like we have Shelly next. I just want to note that if we are actually feeling like we want to keep on having a conversation, it might be wise to follow the original recommendation and pull some of the folks from the FHIR IG back into ISWG to help further discuss, so I think we were going to pause the physical activity conversation for that purpose to have them come and talk to us, and then, because of Steven and Hans's comments, there was a consideration for postponing it to USCDI V.5, so I just want to note that that is the fulcrum where we are, so it might be wise to postpone some of this conversation, if we feel like it needs to be had regarding physical activity, to when we can invite the members of the IG with us to discuss. Shelly?

Shelly Spiro
Yes. I am not sure that it warrants waiting for the FHIR 5 IG. I think that especially in the long-term post-acute care setting, physical activity is an important component of what we do in documentation, and what we are doing, especially on the pharmacy side with the Pharmacist Electronic Care Plan, is we are doing assessment for frailty, and frailty is another piece that physical activity goes into. There are codes that we use today to capture physical activity within the care plan, and those are FHIR Release 4.

So, when we are talking about the actual data points of which terminology should be used, and the standardization of that terminology is extremely important, we build it within value sets. Now, the Pharmacist Electronic Care Plan's value sets are in the National Library of Medicine's VSAC, the Value Set Authority Center, and we currently use those value sets today in multiple settings. So, I think we are getting confused that we need an implementation guide that is specific to physical activity when we are assessing and documenting that physical activity using standardized terminology. The idea behind having it in USCDI helps our system vendors follow a standardized terminology for data collection as we use it, but physical activity is an important point, especially when we are measuring frailty.

Sarah DeSilvey
Thank you for that important note, Shelly. Christina?

Christina Caraballo
Hi, thank you. I just added another comment in the document as well. I wanted to point out that the American Heart Association, in conjunction with the Physical Activity Alliance, has been doing a lot of work in this space. Over the course of the last year, I have been speaking with them on their submission into USCDI, and I do recommend that we speak with them because they have been accelerating this quite rapidly to get a better sense of the timeline for when their implementation guides will be ready. So, in conjunction with reaching out to those working in FHIR, specifically reaching out to Lori Whistle, who submitted this into USCDI as well.

Sarah DeSilvey
Thank you. I am beginning to feel some movement to continue the conversation with other critical stakeholders in the room. Ricky?

Ricky Bloomfield
I am just piling on, and we have had a lot of folks already say this, but the group with the AAJ doing the HL7 physical activity IG as part of the It's Time to Move Program are actually the ones who submitted this, and so, I think we should absolutely hear from them. I think we have had some other votes for that. I think we should hear from them before we make a final decision on this, and it sounds like there might be growing consensus for that.

The other point that I would make is that as part of our Argonaut steering committee meeting last week, we reviewed the votes from the group around the projects that may be taken on for this upcoming year, and while no final decisions have been made, in the top three of the projects that received votes was the FHIR Right Project for Vital Signs in particular, which, of course, would include these physical activity measures and physical activity data types, and so, I think that is just a sign to me that there is broader interest in the community that would be testing and implementing this type of thing, and so, this may move faster than we think, and we just need to hear from some of the folks that are actually doing this to make sure that is the case.

Sarah DeSilvey
Thank you so much. Ike?

Steven Eichner
Good morning. I have two points. One, I think the data elements really do make a difference in looking at how we are coding information in terms of what the physical activity actually means in the context of data collection and the purpose behind it. I have a rare condition, so physical activity in my community is a bit different than most others. The second component is without an implementation guide about how to operationalize data exchange, it really limits implementers' ability to utilize that data in the context of information exchange, so, without the IG that supports how the data might be accessible, it limits the utility of just collecting the data.

Sarah DeSilvey
Thank you so much. Back to Nedra.

Nedra Garrett
Yes. I think the importance has been established because these are part of the physical activity guidelines for Americans, and we have existing LOINC codes that can support those measures. We were asking for an additional one to calculate the minutes per week. However, with those codes being available to capture that, do we know what the considerations are for the IG? These are standards that can be used. Are we saying, then, that perhaps the IG might be using different ones? If they are establishing the values to be LOINC codes, then why would this not be able to go forth in V.4? I think we may need more discussions, but we are supportive of it being included in V.4 if there are these codes that can be used, and those are

codes that we are supportive of, so we are looking to hear more about how we can align with that, whether the IG is published or not. If those are standard codes, could those be allowed to go forward?

Sarah DeSilvey
Nedra, thank you so much, and it looks like there has been an answer that they are using the same LOINC codes in the IG. I feel like there is some consensus now that we just need to revisit this conversation, as we were intending to, with a few critical stakeholders, including the AHA and representatives from the IG, and luckily, Nedra, you will carry the torch for the CDC. Thank you so much. Hans, any final thoughts before we create a plan for revisiting at a future meeting?

Hans Buitendijk
Yeah, just one additional thought there. It is very reasonable to have that conversation in light of the discussion, and I particularly would like to ask a couple of clarifications that then can come up, so, not for today, but that would be discussed as part of that. During the conversation today, there was an indication that we are actually looking at one, two, or three data elements, not the full implementation guide that is needed, so we are trying to figure out since the submission is specifically talking about proposing what is in the implementation guide, how that changes the scope if we only look at a couple of attributes like alcohol and substance abuse.

So, that would be one part, and the other part to clarify as part of that conversation coming up is whether the intent is that it is patient-collected information or patient-provided information. That is a subtle difference that I might make, but is it to be entered, managed, and documented by a clinician, or is it to be collected by a patient and then integrated within the system? Those are two different things. I think Ricky is pointing at abilities in Argonaut, where, generally, the flow of how we can start to get towards rights of data that is not done by the clinician in the main HIT systems that we use, how it can come from patients and otherwise, and where this fits in. The interpretation so far has been that it is clinician-documented data that they have obtained from the patient in some fashion, not a contribution directly by the patient, and it would be helpful to clarify in that conversation.

Sarah DeSilvey
Hans, thank you so much. I think those are wise thoughts, and I think we should bring them into our conversation when we revisit because if we are focusing specifically on the elements themselves, it might be easier to go forward with V.4. So, after entertaining some conversation on whether to pause, given this date of the ballot of the IG, we actually are leaning into addressing this in a future meeting and ensuring we have critical stakeholders. I think I heard the critical stakeholders, definitely members from the IG, which also includes the AHA, and we will make sure that we have folks, and again, we are looking to have some of those public conversations, including facilities and advance directives, in March in time to give the community awareness of when they need to attend those meetings. Does that sound like a good action item for right now? I hear no **[inaudible – crosstalk] [00:30:03]**.

Bryant Thomas Karras
I am trying to find the thumbs up button.

Sarah DeSilvey
All right. I will have quiet represent “carry on” in this instance. So, now we are moving. We are going to go over facilities because we have already agreed that we are going to address facility and facility considerations with stakeholder presence, so that means if we look at our spreadsheet, and feel free, please, to, again, write any of the thoughts you have mentioned, very critical conversations regarding physical activity, in the workgroup discussion for posterity’s sake, so whatever our final recommendation is, we can capture your voice. I see Christina has added that element there, but if you had a critical thought in our preceding discussion regarding physical activity, please go in and note it there. Again, Nedra, I think the voice of the CDC in that element would be helpful, and then, anybody else who wants to make sure that their voice is heard, not just on the call, but in the text that eventually will be wrapped into our

recommendations, that will be great. So, we are skipping over facilities. I think that takes us down to Entry No. 9 in Row 10, if I remember correctly.

Naresh Sundar Rajan
That is correct, Sarah.

Sarah DeSilvey
All right. So, we are moving on to average blood pressure in vital signs. It looks like, if we go over to workgroup discussion on this one, there is a lot of consensus to include. Hans has some challenge regarding calculations, but are we ready to discuss this at this time, remembering that the work to bring us here is almost an assumption of recommendation, and then we discuss whatever breaks and implementation concerns we might have? So, thoughts on average blood pressure? Hans?

Hans Buitendijk
Sorry, I had to find the unmute button. **[inaudible] [00:32:12]** that are being raised are around clarity. What is the average blood pressure, how is it calculated, how do you indicate the period of time, the intervals between, etc.? Do they include patient-provided or clinician-provided? So, there are a number of questions that, in the submission, as we were trying to look through it, that we are not sure what it means, and then, including an attribute like that, what is then the value that it has from an ability to compare and otherwise. So, it sounds like it is more than an individual element that gets us into if we need to include the contributing data points that were part of that, and that starts to create some other questions of how that then gets expressed beyond a "simple" individual observation. So, depending on what the answers are to what is really intended to be the average representation of blood pressure, it is going to then raise the question on what kind of guidance is needed to be able to represent that fully and correctly.

Sarah DeSilvey
Thank you so much, Hans. Grace?

Grace Cordovano
I was also curious: Is this manual calculation? Is this using a digital tool that is calculating? Is there any background on this? Because I struggled with this one myself. Are we talking remote patient monitoring or patient-reported outcome?

Al Taylor
If I may…

Sarah DeSilvey
Yes, thank you, Al.

Al Taylor
The intent of this data is that a health IT module would be able to represent an average blood pressure, not a reading, as it is not really, technically a reading. It is a calculation, but it is calculated by whatever method is used to generate. In some cases, we have been told home monitors of blood pressure may sometimes only provide average for forwarding that on to a provider for inclusion in the record, or at least considering including it in the record. Sometimes, the system itself, the vital signs machine or the monitor, can calculate it and report it out from its ongoing average. There are a lot of different ways of getting to the average blood pressure, but this data element is simply being able to represent a value as an average blood pressure by whatever calculation and determination means is used. That is all it is. And so, this can be used for all of the examples that we talked about. This can be used to represent an average blood pressure by all of the different use cases we talked about, and some others.

Sarah DeSilvey
Thank you, Al. It looks like there was a presentation to the workgroup last year on this matter. Steven, I am calling on you. You can reiterate the comment you made in the chat.

Steven Lane
Thanks, exactly. We have had this discussion. We went through this last year, we scheduled a meeting, we brought the people from AMA who submitted it, and that is what informed Al's comments. Really, the idea was that there are certain devices that only output an average blood pressure, they do not give you each of the individual readings, and the thought was that that was really important, to be able to identify a BP that was calculated as an average as separate from one that was an individual reading. When they presented, they convinced me. I supported it last year; I support it this year. I do not think it is a huge deal, but clearly, there are bunch of people who are involved in blood pressure monitoring and cardiovascular disease prevention that see this as really important. It has bubbled up all the way through the AMA, and again, the details about it have been clarified in the submission.

Sarah DeSilvey
Thank you so much, Steven. Shelly?

Shelly Spiro
I am going to agree with what Steven had said. Especially on the pharmacists and within the care plan, when we are trying to exchange the information, providers do not want a whole list of all the blood pressure over a period of time. So, because of wearables and the technology that is in place for managing hypertension, most of the clinicians within the care team want an average of the blood pressure without having each of the individuals. Those feed into dashboards, and then into other information. If we do not standardize which terminology we are using and there is a proprietary terminology or some other type of terminology that is standardized terminology that is being used, then it becomes a problem. And so, I think that this is an important aspect, it is being used today, and I think it is our job as part of this panel to go ahead and recommend that we have a way to standardize the terminology that we are using for average blood pressure.

Sarah DeSilvey
Thank you, Shelly. Nedra?

Nedra Garrett
Yes. I just wanted to express the importance, obviously, from CDC, from our Division of Heart Disease and Stroke Prevention and the Million Hearts Initiative, that we use this data for monitoring and evaluation. The goal of that project, obviously, is to prevent one million heart attacks and strokes in five years, and so, we do plan to leverage that data for surveillance and epidemiology studies, and we would like to lend our support for inclusion in Version 4. It is really important for us. We know that the research has shown that an ideal protocol for patients is to capture those two readings in the morning and two in the evenings for seven days, and we strongly advocate for the inclusion of this in Version 4. The only thing that we are asking for a very simple change in the descriptor is rather than indicating it as a mean value, that it is consistent with the name of the data element to also say "average." Thank you.

Sarah DeSilvey
Nedra, thank you, and it seems like a very important change in definition as well. Thank you so much. Anna?

Anna McCollister
I would just like to get more detail on the specifics of this measure. It is not clear to me where I can get that. Where would I be able to find that? I think this is absolutely critical. I am skeptical of average blood pressure, but I am certainly empathetic and understand why that would be preferred from an EHR perspective over a whole bunch of static measurements, but I would just love to have a source document by which I can get my head around the specifics of it. So, is there a repository, like a presentation that AMA made or whomever submitted this as a measure, that I would be able to check out and read?

Sarah DeSilvey

It seems like we can find that, Anna, from past meetings and get that. What I hear us saying is, similar to the alcohol use and substance use measures, it is like a conditional approve for this moment, with a need to gather further information, understanding that some of the action items from our side can be to ensure that everybody in this year's ISWG has access to last year's presentation for clarity and has time to review the submission and ensure that they understand the elements, and I just want to note the definitional changes that Nedra is talking about and Hans has specified. So, does it seem fair to make sure that everyone has the recording from last year and give a conditional approval? It sounds like that is the consensus from this group, with a need to just clarify as we did above. Hans, any thoughts on that?

Hans Buitendijk
I think as part of it, it would be helpful to have a little bit more clarity on what the additional data is that is being discussed that needs to accompany the average value. As I think Ricky brought up, perhaps there is some indication of time period that would be helpful to clarify to better understand what the scope is.

Sarah DeSilvey
Wonderful. So, if folks can place their very important comments on definition, changes, and specificity in the discussions, we can record that for posterity. That would be really helpful. And then, I hear us saying conditional approval, no final recommendation yet, as we did above. Does that seem fair?

Anna McCollister
I would like to get more clarification just for my own knowledge about what has literally been proposed before I suggest conditional approval. We have to be able to capture blood pressure, but I am not completely sure what it is we are talking about capturing here. Is it in-clinic, is it outpatient, is it home-based measurement? So, I would like to get more clarification.

Al Taylor
Anna, and not just for Anna, but for everyone else, I just want to direct everybody's attention to the submission itself from the AMA. So, there is the submission, which is, to some extent, what is included in this data element that we have added to the draft, but ONC has sometimes, and may in this case, expanded a submission to a broader scope, and not just the scope outlined by particular submission, but the submission does provide quite a bit of detailed information about why it is being proposed, and CDC actually added to the information being provided. The CDC submitted a separate use case, and Nedra talked about that just a minute ago. What is included in the submission, which is embedded within the data element in draft V.4 itself, may answer your questions, though it may not answer all of them, but that is the first place to go to figure out as much information about it as we have.

Sarah DeSilvey
We will just give everyone time to review the materials discussed and then return next week, as we always do, to see if we can get to approval at that time. Steven, any other final thoughts?

Steven Lane
Just a process point. I did not quite know how to put this in the chat. It is important for us on the workgroup to think about the relationship between the submission and the entry that ends up on USCDI. They are not the same. When we put an element into USCDI, it does not come with all of the details in the original submission necessarily, and yet, that is always there as a reference. I remain a little confused about that, but it is really once we add it to the USCDI and we specify a technical standard, that is what makes it official, but at this point, as we are thinking them through, really going back and looking at those submissions is so critical because that is what has informed the ONC in making their recommendations for the draft. And again, I will add, and Al and Nedra, you confirm or deny, but it seems like the submission has been changed since a year ago. I think the addition of the CDC use case is really nice and strong, and makes it even clearer, to those who want to review it, where this is coming from.

Al Taylor

That is right, Steven. We did make a modification. We added that information to it, and we sometimes do that. We add to the submissions displayed on the website. Sometimes it is because the original submitter provided more information, and sometimes it is because someone else came along, like CDC in this case, with what I call a distinct use case that points to this being more broadly applicable to the entire enterprise. So, there is that. You are right, there is more information than what was in there when it was originally submitted.

Sarah DeSilvey
Thank you so much, Al. I believe our plan is to just revisit this as we do, and then see if we can come to consensus after we have had a chance to think about the factors, but again, please note any critical elements in the workgroup discussion so we can carry them forward. We now are going to dive into a fairly extensive conversation on results, and so, if we can go down to Row 11, Entry No. 10, I believe.

There are a set of elements regarding laboratory elements that are all together, and I just want to note specifically before we dive into the conversation that there is some conversation about the relationship between the particular item here, which maybe is actually Row 11, Entry No. 10, about the relationship between this element and a Level 2 element that is captured on No. 26, and I believe that one was added by Steven Lane. So, entering into our discussion on result interpretation, result reference range, etc., and there are a few more in this lab set, with a consideration for how this relates to a Level 2 element that I believe Steven entered on No. 26. Thoughts on result interpretation at this time? Is it an “aye, aye”? Does silence mean “go forward” in this instance?

Hans Buitendijk
I gather that it is widely supported out there. I think it is another example that maybe not every… Depending on which system you are talking about, it is the one that maintains it or creates it, and sometimes it is not needed, although less so with this one, but it is out there being communicated all over the place.

Sarah DeSilvey
Agreed. Hung?

Hung Luu
I was just going to speak in support. This is required by legislation, and so, it is already being used, and we just want to make sure this is a functionality that exists throughout the healthcare ecosystem.

Sarah DeSilvey
Lovely. Any other thoughts on this? Any need to discuss its relationship to test interpretation/abnormal flag on Entry No. 26 that Steven identified, and I think is otherwise discussed? Maybe we want to hold on that and just go forward with… There is a set, basically, which are here, so it is Entries No. 11 and 12. Eleven is result reference range. Actually, Entry 10 is result interpretation, Entry 11 is result reference range, Entry 12 is result unit of measure, Entry 13 is specimen source site. We have two more. Entry 14 is specimen identifier, and Entry 15 is specimen condition and disposition. These all carry very similar recommendations in workgroup discussion and similar requirements for regulation. Pooja?

Pooja Babbrah
Just a procedural question. So, as we were reviewing Version 2, I guess I did not realize it was to bring data elements forward. Is that how we are doing that to add it into the spreadsheet as a discussion point?

Sarah DeSilvey
Yes. So, if there is a Level 2 element you feel is critical and we want to elevate it into USCDI V.4, we add it to the bottom of the list, where there is really good precedent to follow. I think Grace and Mark were the first to do that, and now we have further additions there. Once we get through this push to try to make sure we review all the elements in USCDI V.4, we will be doing a dive into those Level 2 elements to see which ones need to be elevated.

Pooja Babbrah
Perfect, thank you.

Sarah DeSilvey
Steven? Sorry, Al, do you have a comment there?

Al Taylor
I just have a quick statement addressing Steven's question about Line No. 26, which is called abnormal flags. The abnormal flag data element was the one that became the draft V.4 data element. We changed the name to simplify it. The definition should be aligned. We may have adjusted the definition as well for clarity, but the abnormal flag in the test interpretation tends to be the same data element. As we have done across, I think, every other data element that was in Level 2 that became a data element in draft V.4 where there was a new name, we have adjusted the name for various reasons. We made a note that said, "This data element in Level 2 became another data element in draft V.4, and here is the link to that." I think it was a mistake that we did not add it to the one that Steven was pointing to.

Sarah DeSilvey
Thank you so much, that is helpful.

Al Taylor
…which we will resolve momentarily.

Sarah DeSilvey
Thank you, Al! Steven?

Steven Lane
Thank you so much, Al, for that clarification. It is always a pleasure to find the opportunities to make things even better. I do want to point out to the workgroup that we had extensive testimony on these lab data elements last year. Hung and others organized a set of subject matter experts to come and speak to us. I think here, again, it would be helpful for the ONC to go figure out which of our meetings that was in, find the recording, and put a bookmark on that part of the presentation for those who would like to review it. As per my written comment, I strongly support the inclusion of these. These are going to be critical for us to really be able to support semantic interoperability of lab results data, and I am thrilled to see that even though ONC did not include them last time when we suggested it, that they are here now, and it is a good reminder that sometimes good things do come to those who wait, and thank you for that.

Sarah DeSilvey
Thank you, Steven. Hans?

Hans Buitendijk
I would like to comment on the specimen condition and disposition specifically, but as for the rest, no disagreement with what Steven just mentioned. There are data attributes there that have been widely communicated, already done, even some of them already in certification, so there is no reason they should not be in USCDI. On specimen condition and disposition particularly, it is certainly an impression that two different concepts are being put together, and we may want to split them.

This is some feedback that I heard specifically more in some of the HL7 workgroup discussions around this, where there is the condition of the specimen, and then there is the reason that it is rejected and acceptable, which is in the context of a specific test for which that condition of that specimen is not suitable. That might therefore be muddled in two different places. One is on the specimen, the other is on the test that has not been done and the reason why it has not been done, so there is a little bit more going on there that, typically in current transmissions, is not necessarily addressed in this particular way. The suggestion here is to split them up so they can be recognized as two things that need to be addressed and that there is clarity in how to express that in C-CDA and FHIR US CORE.

Sarah DeSilvey
Thank you, Hans. Hung?

Hung Luu
I would agree with that. The intent of this particular submission is that there are a set of criteria on whether a specimen is acceptable or not acceptable for a given test. And so, this has to do with interfering substances or has to do with the viability of the sample within a period of time. And so, the intent of this submission item is if, for example, ammonia should never be performed on a specimen that has hemolyzed because of the fact that that is an interfering substance, that will actually give you a possibly spurious result.

However, there are times when, because of the acuteness of the patient or just the criticalness of the result, a clinician might ask the laboratory to perform the testing despite the fact that the specimen falls outside the acceptability criteria. In that case, what we do is we still perform the testing, but we include documentation that the specimen fell outside the acceptability criteria, and the result needs to be interpreted with caution because of the fact that it was hemolyzed and will cause interference or it was performed despite the fact that the specimen was collected outside of the four-hour timeframe that is acceptable for stability. And so, the intent of this particular item is for tests that are actually run despite not meeting the acceptability criteria, not to document rejection reason for tests that are not run on canceled orders.

Sarah DeSilvey
Thank you for that clarification. Steven?

Steven Lane
So, just speaking as an ordering provider, it is important to realize that sometimes, I will order a test and I will get a callback from the lab, and they will tell me there is this issue with the collection, the specimen time, or what have you, and they will say to me, “Do you still want us to run it?”, knowing that you will only be able to interpret it in a certain way, and then it is up to the clinician to say yes or no, and the clinician knows that, but I think as Hung is pointing out, it is critical that that kind of information is able to live and travel with that result over time because it is very important to its interpretation.

Hans Buitendijk
It would be very helpful that as part of the submission that did not jump out that it is particularly focused on the documentation of when a test is still performed while the condition was otherwise not necessarily sufficient. If that is the focus specifically, I think that would be helpful. Otherwise, the conclusion on how it is going to be interpreted on providing the guidance and how to put it into FHIR US CORE and C-CDA will change, so it will be helpful to clarify which one it is, or both.

Sarah DeSilvey
So, I hear us wanting to make sure that Hung’s clarifications on the intent of this data element are clarified in our recommendation.

Hans Buitendijk
Correct.

Sarah DeSilvey
Great. And then, I otherwise hear no concerns and general consensus on the critical inclusion of these elements in USCDI V.4 from ISWG, this set of laboratory elements which have regulatory requirements in CLIA and otherwise. All right, sounds great. So, akin to encounter information above, we have another one moving to rec. Again, it sounds like this is built on the precedent of the work that was done in last year’s ISWG and the extensive investment of the committee at that time, so I am just grateful for, as Steven says, the patience and deliberation that got us here. Moving on, I think we are now down to time of procedure, which is Entry No. 16. I believe there is some consideration about whether actually procedure needs to be the only place for the time and date, but I open the conversation up for comment. Hans?

Hans Buitendijk
That comment came from me because when looking at USCDI, there is an area for lab tests, and then there is separately for procedure. Some of the comments were made about the need for a variety of times on the lab tests. Then, looking at the lab tests, unless I missed it, there was no date and time on it. So, I think we are actually looking at two data classes in our comments here, one on what needs to be added to procedures, date, time, and when it was performed, and then, there is one on lab, and there is a discussion on what kind of dates are needed because there is the specimen collection date, which already is available in FHIR US CORE, and there is the date of the analysis, which is a different date and time, perhaps, which is not necessarily on FHIR US CORE, so I think we need to look a little bit about both, lab tests and date and time of performance that are relevant and the procedure data class. I think the comments were more about lab, less about procedure, but we do still need the lab. I do not disagree with that. That is just how USCDI is organized.

Sarah DeSilvey
Wonderful. Hung?

Hung Luu
I would agree with this comment. The intent of this is to recognize that there is not a single time around lab tests. There has to be the collection time, but also the time that the report is actually resulted, which is obviously not the same because there are some tests that can take days to be able to perform. And so, we want to make sure that there is a recognition that it cannot all be lumped into a single procedure time, and there are different points in time, and they mean very different things. The technology has to be able to accommodate all of those.

Sarah DeSilvey
Hans is raising that these would be in different areas because procedure date and time would be in procedure and the clarity on data collection and data resulting would be in labs, but the intent and rationale would be the same across both. Is that what I hear us saying?

Hung Luu
Yes.

Hans Buitendijk
Yes, and I think that adding to lab further effectively… The six that were just discussed are dates that are commonly already communicated, and it does not round out fully, but there are still probably a few left, but it makes the lab data elements more complete as to what is actually already happening, and procedure having a date/time there on what is performed outside of lab setting would make that more complete as well.

Sarah DeSilvey
Absolutely. Any comments on that recommendation? Again, it is such a critical element of documentation, and one that is already happening. It is not an added development, it is a verification of the requirements of what is already occurring in the ecosystem at this time. So, again, repeating the recommendation as I hear it, the date and time of procedure was presented in the procedure area, and we are recommending that it be duplicated in lab with the specification of differences between time of collection and time of result, as that is the industry standard. Any other thoughts on that? It seems like we are again in agreement that this is critical. Mark?

Mark Savage
I just want to check. Are those the only two relevant times? I saw comments from somebody that the time of actually processing might be a third time that is collected. I myself do not know, but I am just making sure that if we are capturing times, maybe there are more than just those two that you just mentioned, Sarah. I look to others to know the answer.

Sarah DeSilvey
There are so many times. There is the time of order, time of acquiring, time of sending, time of processing, time of resulting, time of… The lifecycle of a requisition… Yes, Mark, you are right to say that there are many. Again, in my ignorance, I think we are leaning to the two that rise to the top. Steven?

Steven Lane
I will just put voice to my comments in the spreadsheet. I think we need to be able to not only capture multiple times, but have a label that explains what each of those times indeed represents, and I think over time, it would be nice to develop a set of appropriate responses to the lab workflow, to the procedural workflows, etc., but at least having multiple times and multiple labels and a label to specify what each one means would be a good place to start.

Sarah DeSilvey
Al?

Al Taylor
My question for the workgroup… I am not clear about what the exact recommendation is. Is it a recommendation to add supplemental information, like we were talking about for average blood pressure, or is the workgroup recommending that multiple different kinds of timing elements be added to USCDI Version 4, or is it something else?

Sarah DeSilvey
I have an idea. Hans, do you want to take a stab, or Ike?

Hans Buitendijk
Sure, and responding in that way to Steven's comments as well on the multiple times and labeling them, I think where the recommendation is heading is to add a date and time procedure was performed to the USCDI procedure class, and to that laboratory data class, add at least one data element, maybe two or three, where the comment to Steven is going to come up, to have at least a collection date/time, date and time of when it was analyzed, and then how many dates and times within lab are relevant to do that. My comment was going to be back on that to be as specific as possible. Right now, there are two dates, actually three dates, that are in play that are already there. It is a collection date and time.

There is a reporting on the overall reports date and time, there is a little bit of a question mark where the actual analysis date and time in FHIR or in C-CDA would be, but that should not be too hard. It is commonly part of Version 2 messages to sort out, but is it those two or three, or are there other dates and times? Then, the more dates and times you are going to put in, you might go out into when it was ordered. That is not on the tests anymore, and now we need to go back to the order to have that date and time. So, it would be helpful to understand what that set is. It is not all going to sit on the tests performed. There are going to be different places in the record where the right date lives, and USCDI representing those respective dates and times is good, but at the same point in time, we do not want to give the impression that it all has to live on the test.

Sarah DeSilvey
Thank you, Hans.

Al Taylor
I just wanted to follow up on that. This is something that ONC has said in various settings over the last couple of years, that data elements that belong to a certain data class do not only need to be used in the workflow associated with that data class. So, something like care team provider could be used to modify procedure, could be used to modify an encounter, and "encounter provider" has actually been proposed and recommended as a separate data element from "care team member provider" or "care team member role," for example.

hat was one where the data element could be used against multiple different data classes, and the intent of this single data element in draft V.4 is to do just that with timing, and that is a question that we ask. Now, I do not presume to know what the response to the question is going to be, but the question that we ask particularly in the standards bulletin is this reusable timing element. It could be used for specimen collection time, test performance time, result reporting time, or anything else that has an inherent similar shape or timing element. Is that the right approach for ONC to take rather than having, as we look through USCDI and look through the Level 2 data elements, multiple timing elements that are related to specific submissions, specific data elements, in all kinds of data classes? That is really the question that ONC has by putting these single data elements in drafted form.

Steven Eichner
Thank you so much for that, Al, and just to build on that idea, there are things beyond laboratory-related procedures that might very well have times associated with them, looking at something like an assessment, which I am not sure if you would want to call a procedure or not, as well as looking at start and end times, again, not to make it more complex than necessary, but for some activities, start and end times are really, really relevant. If you are only using a single time value for a particular activity, is that start time or end time? In other words, looking at a laboratory analysis, is it the time that I start the analysis, or is it the time the analysis is complete that is relevant? Obviously, some analyses can take much longer than others. So, my recommendation in this space would be to at least look at the data element and perhaps relabel it.

Al Taylor
Timing of assessment was one of the areas because assessments are relatively new to USCDI. The time of assessment was one of the areas that we thought would be a candidate for use for this generic timing element because yes, an assessment is, in a way, a procedure. It is a structured process with sort of a defined goal to provide specific information. And so, especially when assessments are done serially, which assessment are you talking about, the one that was done a month ago, before you came into the hospital, or the one that was done today, when you are leaving, for example? That could be the same assessment, but it is done twice. That is one of the areas where we thought timing would be relevant without adding a separate “time of assessment performed.”

Steven Eichner
Absolutely. I wholeheartedly appreciate, understand, and agree. That is what was making me think that attaching the label “time of procedure” may be a little limited going in and confounding to people down the line if you started to use that data element label for other things. It could get really confusing.

Al Taylor
Understood.

Sarah DeSilvey
I think we lost Ike’s last comment here. One of the things I am hearing is a need for clarity on definitions prior to complete approval, even though we generally recognize the need for this, and I am just holding space for that fact because that is what many of us are mentioning as being critical in order to understand and interpret the data going forward, and to meet multiple use cases. Bryant?

Bryant Thomas Karras
Thanks. I will be quick because I think this has already been stated, and I put it in the chat, but I wanted to make sure that if what Hans is saying and I think Steve echoed, that this time of procedure or time of specimen collection and time of processing are reused across multiple activities. This one is on procedure, not on laboratory testing, but are we reusing those same FHIR data elements consistently? It has been inconsistently collected across the country. It would be great if we had this as a mechanism to consistently get what times the laboratory was collected and processed as the two data points. When it is reported to public health, we have, because that hits our system and we can timestamp that, but we do not know those other two unless they are reported and included in the data stream. Thank you.

Steven Eichner
And just clarifying, again, the process timestamp as to whether it is the start of the process or the end of the process, because those analyses that take more…

Sarah DeSilvey
"Processed" and "resulted" being subtly different. I do have a note in the chat wondering if, given the collective wisdom in this group regarding definitions, maybe we can spec out some clarity on what definitions we require, and then bring it back to the meeting next week, but I am assuming Hung will have wise thoughts on this as well.

Hung Luu
I just wanted some clarification from Al in terms of if this is a recommendation that we use the format of time of procedure for all the different times that are associated with lab or if we are saying we use one time across all these and relabel them. Our concern is that the times are different because of the fact that there are analyses that need to occur. For example, with some certain companion diagnostics, such as testing that predicts the prognosis for breast cancer, the time in formalin is very important, so there is consideration of some regulation around how long a specimen can stay in formalin or the time in formalin that needs to be reported out in order to know how valid the immunohistochemical testing is on those prognostic tests.

And so, the time that is collected, the time it is received in lab, and then the time it is put in formalin are three different potential timepoints, and they cannot be subsumed under one, so there needs to be a way for us to differentiate between those times and perform calculations. If not, we are going to have a very hard time meeting the upcoming regulatory requirements. That is my clarification. Is this recommendation just that we are using the format of the time, or are we saying that we want to use the same time elements for all these points, which can muddy analysis? I am fine with using the same time format as long as we can guarantee that the individual times are recognizable and we are able to differentiate and perform analyses based on the different timepoints.

Al Taylor
I think that the time format is… No, I do not think anybody wants the data element that provides the time that a test was resulted to be called "time of procedure." That is not what we are saying. It is the time format that can be used across anything that is done. It is not a technical term, but when was it performed? Carmela had mentioned the use of the FHIR term "perform time." It is very generic, so anything that is performed, whether it is a collection process, a testing process, or an assessment process, that perform time seems to me to be the right model. Even though it is listed under procedures, the perform time data element could be relevant to a lot of different uses.

Hans Buitendijk
If that is the case, then we should be more clear in USCDI that "procedure" is a generic term of which labs are a specific iteration of that, so whatever is listed under "procedure" would be applicable to laboratory and like other ones, but "procedure day/time" would not necessarily be applicable to an encounter. I think we have to be very careful in the way that we do that so that the interpretation of these kind of more generic constructs are properly interpreted in the context of where they actually apply because some dates relevant to lab are not going to be relevant to physical therapy or to assessment and otherwise, and it is important that we understand which ones are of interest to be shared. I just made a comment along those lines. There are actually many more dates and times that are being captured to manage all this, but for USCDI, for EHI, there is a subset of those that are relevant and critical, and if we do not name them but have a rather generic construct, it makes it very hard to understand where to focus.

Al Taylor
That is a good point, Hans, that I think should inform a specific recommendation. The current definition for this data element is time and/or date of procedure or other action as performed. That may or may not be

acceptable, that may or may not cover all these concerns that have been brought up here, and if it does not, then a specific recommendation is what we are looking for to change.

Hans Buitendijk
That is not to say that dates and times are not important, it is just in the context of USCDI that **[inaudible – crosstalk] [01:20:19]**.

Steven Eichner
Hans, some of that would be addressed in an implementation guide as applicable in terms of looking at what data would be exchanged between two entities as far as the date is concerned, so if you have the IG available before the vendor implemented the technology, they would be able to associate the right set of fields with the right exchange, or be able to record it as part of the right element if you are using FHIR, for example, but I agree there is some complexity, and there are a wealth of date and time stamps, many of which may not necessarily be needed to exchange on a regular basis. With start and end time of a surgery, for example, I cannot imagine that that moment-by-moment start or end date is necessarily relevant, or at least the start time. Perhaps the end time might be more relevant because of subsequent procedures based on that time.

Sarah DeSilvey
Thank you, Ike. I am going to have Hung speak. We are just about brushing up on our public comment, but I want to note that I put a comment in the chat. I am hoping that members of the workgroup can try to figure out some of the definitional concepts we are talking about, either propose it in workgroup discussion or meet separately, and come back to the group next week because there has been a lot of wisdom in critical sub-definitions of how to specify to meet the needs of the ecosystem, both the public health and clinical practice, etc., and it seems that we could just capture that and come back to the group, but Hung, any other final thoughts before public comment?

Hung Luu
That was exactly what I was going to volunteer, if I could work with some of my colleagues to perhaps come up with a slate of what we consider cardinal points in time that are specific times that are required by regulation or by CLIA that we have to have. I think those need to definitely be differentiated from the other points in time that are relevant for perhaps operational issues, but these are the ones that are critical that I think need to be defined by themselves. Would that be acceptable? And then, where would we put the points in time, in the discussion or suggest them as new elements down at the bottom?

Sarah DeSilvey
Let's put them in discussion for now, and then, if anybody wants to volunteer to come and help you, that sounds great, but I would put that work in the discussion because that relates to the conversation we have had now, and I am very, very grateful for that because it seems like the necessary next step. It looks like you have volunteers. I think we should pull the public comment slide right now. If there is anyone who wants to volunteer to work with Hung on those definitions, please put your names in the chat. Switching to public comment.

Public Comment (01:23:23)

Seth Pazinski
All right. We would like to open the meeting for public comment. If you are on Zoom and would like to make a comment, please use the raise hand function, which is located on the Zoom toolbar at the bottom of your screen. If you are by phone only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. We will give folks a few seconds to tee up for public comments. I am not seeing any hands raised. Excel, do we have anyone on the line for public comments?

Sarah DeSilvey

We did have a comment from Charles Gabrial earlier regarding facilities. I do not know if he wishes to make that comment at this time.

Seth Pazinski
Yes, Charles, you have your hand raised. Please go ahead.

Charles Gabrial
Good morning. Thank you, Sylvia. I want to ask about the rationale behind the facility ID. I have some assumption for collecting this data, but I would like to hear or get pointed to the material if it is available on the USCDI website. I would appreciate it if you can just elaborate on the rationale.

Al Taylor
I can take this one. Charles, originally, it was submitted for situational awareness related to the pandemic, things like availability of resources or services, things like ventilators, bed space, and the like, but facility information is also relevant and important to patients who want to know where the facility was. So, if I had 10 appointments with consultants, and one of them was here, and one of them was across town, and one of them was somewhere else, it has that relevance there as well, so it can be used for not just how many beds are available at a particular facility, but for other purposes as well.

Charles Gabrial
That was my assumption. The pandemic would be one justification or one rationale in terms of counting resources?

Al Taylor
Yes. That was the original submission, but given other use cases that are relevant, the intent of that was to expand it to be used for other purposes.

Charles Gabrial
I have a follow-up question, if you do not mind, Al. Do you know if the MTF is part of the list in terms of facility ID? If not, we will definitely recommend that, but I just want to double-check. I am assuming there is a universal list for the facility ID. Is MTF part of this universal list?

Al Taylor
Whether there is a unique facility identifier or not, where that is, and who stewards that list, I am not aware, but certainly, "facility" would include an MTF, which is "military treatment facility," for those who do not have a military background, or "medical treatment facility," if you will. Those would be included. That certainly is a facility that would be where something happens or where something might be available.

Charles Gabrial
Okay, I appreciate it. Thank you, that helps.

Seth Pazinski
Thank you. I am not seeing any other hands up. Do we have anyone waiting on the line?

Unknown Speaker
No other comments.

Seth Pazinski
All right, that will wrap up public comment, so I will turn it back to Sarah.

IS WG Workplan and Timeline (01:27:37)

Sarah DeSilvey

Thank you, everybody. We are now looking forward again, so we are just reminding everybody that we are aiming to have our final review done by the latter part of March, even the middle part of March, so we can get our report drafted back to HITAC in time for the April 12th deadline. Next slide, please. This is what we have reviewed in the past. We are going to be adding green lines to it. We had a bunch of approvals today, especially in the laboratory category. We do have a few pieces of information that were asking if we are going to bring physical activity back. We were talking about some definitions in order to get you further clarity on some of the different elements.

Excellent work today, all, and I am very grateful for your participation. Look for homework coming after the meeting, and we are going to be trying to facilitate that conversation regarding the date-and-time huddle in order to gather clarity on those definitions before we reconvene. Again, as always, if there are any guest speakers that we need to invite in order to address thoroughly the data elements of reference, please put them in the workgroup discussion. Next slide. I think we are complete. Thank you, and we look forward to seeing you next week, and we look forward to all the work to happen in the interim.

Al Taylor
Thank you.

Adjourn (01:29:02)