Transcript

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

March 8, 2023 10:30 AM – 12:00 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
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

Name	Organization	Role
Terrence O'Malley	Individual	Presenter
Holly Miller	MedAllies	Presenter
Maria Moen	ADVault	Presenter

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 join us today. We do have a few guest presenters with us today, and I would like to welcome and thank them for their participation. All 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 would like to begin rollcall of our workgroup members, so when I call your name, please indicate if you are here, and I will start with our cochairs. Sarah DeSilvey?

Sarah DeSilvey
I am here.

Michael Berry
Naresh Sundar Rajan?

Naresh Sundar Rajan
I am here, good morning.

Michael Berry
Pooja Babbrah is absent today. She will be joining us next week. Shila Blend? Ricky Bloomfield?

Ricky Bloomfield
Good morning.

Michael Berry
Hans Buitendijk? Christina Caraballo is also unable to join us today, but she will be back next week.

Hans Buitendijk
This is Hans. I was muted, sorry.

Michael Berry
Hi, Hans. Thank you. Grace Cordovano?

Grace Cordovano
Good morning.

Michael Berry
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? Bryant Thomas Karras? Steven Lane?

Steven Lane
Good morning.

Michael Berry
Hung Luu?

Hung Luu
Good morning.

Michael Berry
Meg Marshall?

Meg Marshall
Hi, good morning.

Michael Berry
Anna McCollister? Clem McDonald?

Anna McCollister
I am here, this is Anna.

Clem McDonald
Good morning, this is Clem.

Michael Berry
Thank you. Good morning, Clem. Deven McGraw?

Deven McGraw
Present, good morning.

Michael Berry
Aaron Miri? Aaron Neinstein?

Aaron Neinstein
Good morning, I am here.

Michael Berry
Kikelomo Oshunkentan?

Kikelomo Oshunkentan

Good morning, I am here.

Michael Berry
Mark Savage?

Mark Savage
Good morning.

Michael Berry
Michelle Schreiber? Shelly Spiro?

Shelly Spiro
Good morning.

Michael Berry
Ram Sriram?

Ram Sriram
Good morning.

Michael Berry
Good morning to all, and thank you. Now, please join me in welcoming Sarah and Naresh for their opening remarks.

Bryant Thomas Karras
Good morning, Mike. I am here as well.

Michael Berry
Thanks, Bryant. Sarah?

IS WG Charge (00:02:41)

Sarah DeSilvey
Welcome, everybody. It is Naresh's and my honor to welcome you all to this conversation today. We are going to be continuing our deep dive of certain data elements with subject matter experts. We are very grateful for Terrence O'Malley, Holly Miller, and Maria Moen to come and talk about treatment intervention preferences and care experience preferences. After that time, we hope to do a focus on some of those residual USCDI V.4 elements. We may be able to address physical activity, which was one of the elements we were hoping to revisit. It looks like AI solved the problem on the share drive, but we do want to make sure that we look into those Level 2 data elements as much as we can and start addressing those. A note: I will be leaving early to switch to presenting at a CMS webinar, but Naresh will be here for the entire time. Next slide, please.

This is just a grounding, again, on our charge. We are making great headway, again, and have almost fully examined the full set of draft USCDI V.4 elements and are looking forward to leaning into Level 2 data classes. Again, we are very appreciative of our subject matter experts who come into this meeting to help us understand some of the subtleties of those draft USCDI V.4 elements, and we had guests last week, we have subject matter experts again today, and look forward again next week to having some colleagues, again, talking about facilities information from the CDC/CMS. Next slide, please.

This is our status. Again, everything in green has been completed with full consensus agreement by the IS WG. It looks like we do have to revisit physical activity, I think, for a final disposition. It is green here. But we have some revisiting to do on some of these elements, such as wrapping up alcohol use and substance use, average blood pressure, etc. We do have our colleagues working on the medication instructions and

adherence. I do not believe Pooja is able to be here today, but they will be coming back to present next week. Again, we are doing a deep dive on the treatment intervention preferences and care experience preferences today, so we are well on our path to completing our primary charge in order to get that final recommendation to HITAC by early April. Next slide, please.

It is now my honor to allow our presenters for the first part of our conversation on treatment intervention preferences and care experience preferences, Terry O'Malley and Holly Miller, who are well known to this group, HITAC, and IS WG in the past, and we already know their mics work, so I am going to pass the mic to Terry and Holly.

Treatment Intervention Preference/Care Experience Preference (00:05:56)

Holly Miller

Thank you so much, Sarah, and good morning. We are honored to be invited to present to you today regarding goals, preferences, and priorities, which Terry and I will refer to going forward as GPPs. We greatly appreciate your interest in the subject, as we believe that it is a critical aspect of patient-centered care. As such, this information should be captured and regularly updated by the individual, made accessible to the care team, and always be transmitted as part of the transition-of-care document that accompanies the individual across care environments. This is a subject that is very easy to relate to, as all of us either are patients or will be eventually. I am sure we all want our own treatment, care, and quality of life preferences recorded and respected.

We strongly agree with the importance of the proposed GPPs for treatment and care. We believe these additions to USCDI are consistent with ONC's policy goals and do not impose a significant burden on providers or developers. We are, however, proposing for your consideration a third GPP data element in addition to treatment and care which is equally important to patient-centered care, that of quality of life. To give you some background, Dr. O'Malley and I have been working for some time on developing an essential long-term post-acute care transition-of-care data set. GPPs naturally fall into this work. To validate our assumptions regarding essential elements for this data set, we gave a presentation in October of 2022 at the LeadingAge Summit. During our presentation, we polled approximately 40 audience members to determine the data elements they felt were essential or not necessary for a skilled nursing facility to know in advance of an admission. We personalized it by asking them what they would want the skilled nursing facility to know if they or a loved one were to be imminently admitted. Next slide, please.

You see the results summarized on this slide. The data elements fell into three buckets: GPPs for treatment, care, and quality of life. GPPs for treatment and care have LOINC codes; however, there is no value set for the codes, as they are documented in the patient's own words. Stay tuned on this, as Terry will discuss remarkable work in progress to develop these value sets. To be clear, we are considering preferences for treatment as those interventions the individual does or does not want in general, and specifically at end of life. "Preferences for care" deals with the setting of care and who is providing the care rather than the content of the care itself, for example, preferring to have care delivered in one's home rather than in a facility or preferences to have culturally sensitive care, such as those required of a variety of religious practices. "Preferences for quality of life" defines what is important to the individual to enhance the meaning and value of their life.

As you can see on the slide, the frequency of essential responses varied from 100% for code status with treatment preferences to six percent for cultural norms with care preferences. In our small group of respondents, the vast majority felt that the proposed treatment preferences were essential, whereas with non-care preferences, only the element "understanding expectations for the SNF stay" was deemed essential by the majority of the group, with caregiver preference and culturally sensitive care deemed not necessary by the large majority. Finally, with every element of "quality of life," the majority of the group felt these elements to be essential, with naptime, very surprisingly, privacy, autonomy, socialization, and meal choices ranked highest. We found these responses fascinating, and they surprised us.

The things that are important to note are that this is an extremely limited sample, 40 participants in a conference, so the results are certainly not definitive. However, it does demonstrate that this group raised a wide range of issues even though it was a small sample. Larger population samples are needed to validate the LTPAC data set and would no doubt identify more issues. A coded location where treatment and care preferences can reside within the electronic health record with the addition of these data elements to USCDI is an excellent start, particularly, as we have discussed, how essential it is that these data are available to the care team and move with the individual across care transitions.

Importantly for your committee, the study supports the choice of preferences for treatment and care. However, it also supports additionally adding to the USCDI quality of life preferences. As previously discussed, currently, there is not a standardized value set for the LOINC codes for treatment, care, or quality of life. However, Terry is now going to continue and describe the exciting work within the Moving Forward Coalition of implementing the recommendations of the 2022 National Academy of Sciences, Engineering, and Medicine, or NASEM, Report on the Imperative to Improve Nursing Home Quality, which includes building a standardized value set for GPPs. Terry?

Terrence O'Malley
Thank you, Holly, and thank you to the committee, and my vote goes for naptime for quality of life. So, I would like to give you an example of how these data elements are going to be put to use in the Moving Forward Coalition. So, Moving Forward came together in response to the 2022 NASEM report, and our last slide has a link to that report, as well as a couple of other links that you may find useful. So, the report made seven sets of recommendations, including patient-centered care, specifically aligning care to the individual's goals and preferences. It also called for financial transparency, rational financing, quality improvement, quality measurement, staffing upgrades, and health information technology deployment.

Greg Alexander, who is a nurse and PhD professor at Columbia School of Nursing, and I cochaired Committee 7, the HIT deployment committee, and one of our workgroups is working at how we can collect GPP data efficiently in greater detail and then use this more granular data to inform care, and as a final step, we want a process that can measure whether the care provided aligns with the individual's GPP. Maria Moen, who is going to follow us, and whose work you have already seen, and who is a leader in making all of this happen, also cochairs this workgroup. Next slide, please.

So, this slide outlines the model that Moving Forward is using to measure the concordance of the care provided to the individual with the individual's GPP. It is a three-step process. Step 1, in blue, is the current process in nursing homes to create a care plan, which then determines the care provided. The individual's GPPs are fed into the care planning process. So, we are going to add two more steps to this process. Step 2, in red, involves comparing the individual's GPP with the care provided to see if they align. The alignment measure requires the individual to answer affirmatively that the care provided addressed their priorities in a way that was acceptable to them to achieve outcomes that they valued. That is our definition of concordance of care provided and goals. In the event the care is not concordant, then Step 3, in green, kicks in and leads to a reassessment of GPPs or revision of the care plan, and the cycle starts again. Our hope is to make this process easily repeatable so that care is frequently assessed and realigned with GPPs.

So, although Moving Forward is focused on nursing homes, the process of measuring concordance is applicable in every setting where care is provided. There is a huge benefit to creating a standardized set of GPP data elements and making them available wherever the individual receives care. So, our workgroup for GPP includes subject matter experts as well as nursing home residents, staff, and owners. We are starting with the task of assembling a taxonomy of GPP, which, in turn, will help us create an HIT-enabled process to collect those data efficiently. This workgroup has obtained permission, with the help of Maria, and also has gotten IRB approval to analyze 10,000 deidentified advance directive records using natural language processing. The company providing the records, AD Vault, stores over 200,000 advance directives from many companies.

This is an incredible and potentially groundbreaking work that we are undertaking. We plan to create a taxonomy based on how individuals in this sample have expressed their GPP for treatment and care. We expect that many of the answers will also address more general issues of quality of life as well, so we plan to supplement this list with other GPP profiles such as the Eden Alternative, for which there is a link on the final slide. Of note, the nursing home residents on this workgroup have already stated that the taxonomy must include quality-of-life preferences in addition to preferences for care and treatment, and as Holly noted, because transitions of care are such an important use case, we are in the process of proposing to CMS that they establish standards for transitions of care that address timeliness of data availability, data usability, and data completeness, and in our opinion, goals, preferences, and priorities for treatment care and quality of life are essential components of a complete transitions-of-care data set.

So, in summary, both the projects that Dr. Miller and I discussed have uncovered a range of goals, preferences, and priorities, and they fall into three buckets: End-of-life treatment preferences, preferences for ongoing care, and preferences for quality of life. So, we applaud your work to add goals, preferences, and priorities for treatment and care to USCDI. It is essential and long overdue. We respectfully request you consider adding goals, preferences, and priorities for quality of life as well. Thank you for your kind intervention and your kind invitation. Our remarks are done. Thank you.

Sarah DeSilvey
Thank you so much for this very important presentation, Holly and Terry, and for your longstanding engagement with this work on a national level. Usually, what we do is open up questions. Are you all able to stay through Maria's presentation? Should we group questions at the end? How long are you with us, just to respect your time?

Terrence O'Malley
I am good until after 11:30. That is fine.

Holly Miller
Sarah, I am able to stay as well.

Sarah DeSilvey
Okay, perfect. So, it does seem reasonable to move forward with Maria's presentation, and then have collective conversation after the fact. Thank you so much for being able to stay with us. Now, I am grateful to Maria for presenting on the same topic from her expert perspective. Maria? Is Maria with us? I do not see Maria. She might have dropped, so what we are going to do is, respecting the fact that we just did have a very brilliant presentation, while waiting for Maria to come back, we might be able to take questions from the IS WG. Any questions for Holly and Terry? Mark?

Mark Savage
Thanks very much, and thanks so much for the presentation. I wanted to raise a couple of points that I had noted in the workgroup discussion. One is just to confirm that while the submission for this data element was framed around advance directives. I think the presentation we just heard acknowledges that there could be many sources of information about preferences and that we are really working a data element that works with the definition, and it does not look at advance directives as being the only source of truth, the only source of information to complete the value sets. Is that correct?

Holly Miller
Yes.

Terrence O'Malley
Yes, absolutely.

Holly Miller
Good observation.

Mark Savage
The second thing I wanted to check about is how a person's response about preferences might intersect with the statements of a personal representative or someone with power of attorney for healthcare about representatives. I am going to guess that this may not be the data element to sort that out, but rather, it leads me to raise something that the workgroup has been discussing, actually, last year and this year, which is the importance of having a provenance and author data element so that we know who is providing the value, if we need to sort that out at some point. So, maybe the open-ended question should be in your minds, how does this data element work when a person has specified a value, but then a personal representative, who is coming in later and may have to make the call, might specify something different?

Terrence O'Malley
Holly, let me take that one.

Holly Miller
Please, Terry.

Terrence O'Malley
Mark, that is an incredibly important point because in nursing facilities, about half of the residents have cognitive impairments, so, to some degree, they can advance their own goals, preferences, and priorities, but they often rely on a proxy, and the more advanced the cognitive impairment is, the more important the proxy becomes. And so, I think having that provenance is going to be essential, so let me agree 100% with your proposal, and it is going to be a real challenge to get people's goals, preferences, and priorities from a secondhand source, and I guess that source, however, is the only source available, so that is probably as good as we are going to get.

Mark Savage
Thanks so much. I appreciate that.

Sarah DeSilvey
Mark, any further thoughts, or should we go on to the next person?

Mark Savage
You should go on, thank you.

Sarah DeSilvey
Thank you. Hans?

Hans Buitendijk
Thank you, and thank you for the presentation. It is very helpful to understand the intent and the scope generally. I have a couple of questions about where we are, and I believe that Maria might provide some additional insights there, but on the stage of development of implementation guidance otherwise, because it sounds like that on the one hand, we are talking about a data element, yet in the description and exploring the submission, that could actually be a couple of different data classes and relationships that span the gap between advance directive, Pulse, PMO, and the structure of how that would sit. Particularly in the FHIR space, there is still some work to be done on how to express and agree to understanding interventions, intended or not intended, desired or not desired, to be expressed.

So, I am trying to understand a little bit the progression or the need for the guidance needed for HIT that wants to be certified to these capabilities on what is already there and what still is in development, what we should expect, and therefore, what is really the scope that we are trying to achieve now in Version 4 versus what we are looking at in future stages that we need to grow into.

Terrence O'Malley

Hmm. Where is Maria?

Hans Buitendijk
Yes, but just in general, and you can discuss it later for us as well.

Terrence O'Malley
Holly, do you want to go?

Holly Miller
I think you are exactly right, Hans. I think this is the start of a path, and as we better define and understand GPPs, we will certainly be adding, I hope, to USCDI.

Terrence O'Malley
Maria has really been the leader in moving GPP into FHIR and making sure that all of the coding is semantically interoperable, and I think what we are going to find… She started off, actually, with three LOINC codes that represent the questions, "Do you have preferences?", and the anticipation was that the answers would be text. I think that is the beginning of the road, and the road ultimately ends with much more discrete value sets that people can choose out of dropdown rather than have to express with text, so I am not sure if that helps, Hans.

Hans Buitendijk
It definitely helps, because it is indeed the progression from initial documentation of what could be perhaps text in play and recognizes that where we want to go is to a place where the documentation is done in such a way, either directly in computable format or by way of NLP in a computable format, in some fashion that it can be utilized. I think in the discussions, at least, that we are still having in Las Vegas, Nevada, or actually, Henderson, Nevada, to be more process, are that there is a lot of work in that middle and latter part on how to do that, and that is where I am trying to understand it. We might address it as a question for ONC and otherwise. What is the initial step to take, and what would that scope be versus what is then, over time, the growth path? Jumping to the end goal, which I think we would all agree is where we need to be, is probably too much for USCDI Version 4, but what is a good first step? It is not clear yet what exactly that first step entails.

Sarah DeSilvey
I do want to note that Maria is here, but trying to connect to audio, so we look forward to her presentation as soon as she is able to be fully with us. There is interconnectedness between these two presentations, of course.

Maria Moen
Hello!

Sarah DeSilvey
Oh, hello! Maria is with us!

Maria Moen
I am so sorry. It is airport internet, and it is sillypants, so I apologize for that.

Sarah DeSilvey
No apologies. Shelly, Bryant, and Grace, is it okay to pivot to Maria's presentation? Great. And then, knowing that Terry and Holly are here, it seems like at half past, we can then have a collective conversation. So, Maria, thank you so much for joining us, I am glad your audio is working, and we look forward to hearing about your work. Carry it away.

Treatment Intervention Preference/Care Experience Preference (00:27:49)

Maria Moen

Thank you so much, and again, I apologize for any background noise. I definitely wanted to be here for this to weigh in, and yet, I am on my way to Tampa in a couple of hours, so, thank you. So, I want to talk a little bit about the USCDI draft V.4 advance directive interoperability considerations. If you want to go ahead and go to the next slide, that would be lovely. Thank you. So, I am and have been the use case lead for this project for about two and a half years now. When we originally created the implementation guide for STU1, we were focused on person-authored information, and like most projects, you can pick a name, and it is just not going to apply to every use case, so we picked a name that was representative of the totality of the content we are seeking to liberate through FHIR.

Now, STU1 was person-authored. Those are personal advance care plans, like Five Wishes, My Directive, Prepare for Your Care, as well as statutory jurisdictional documents that are advance directives and are available not only in every state, but even down to a micro level smaller than that. So, we have done an environmental scan, deconstructed all the data, and have created a FHIR IG.

Our use cases are to create and store, share, allow someone to query access, allow an individual to update and replace, and then verify that what was pulled back to the query access is the most current version. We are wrapping up the ballot comments and have pivoted, and are now looking at STU2, which are those creatures called portable medical orders for life-sustaining treatments. Now, these are practitioner-authored documents, and yet they fall under the same umbrella of advance healthcare decision documents. In this particular aspect of the project, we deconstructed all 84 instruments that are in use across these United States. Right now, we are a U.S. realm project, but we are getting a lot of pressure to go global. So, those are POLST, MOLST, MOST, and EMS-level DNR. Sometimes they are called DNAR. Sometimes they are called EMS comfort care. So, we have swept the totality of the jurisdictional documents, and we have learned a lot. Would you please go ahead to the next slide? Thank you so much.

So, I was on last week, and we were looking at the data class advance directives, and the recommendation under draft V.4 is to move it to the “goals” data class, and I was asking some questions, and I loved the response, which was that these are not the only sources of people’s goals, preferences, and priorities. I lead the HIT committee as part of the Moving Forward Commission, along with Terry and Greg, so I get it. That made sense. “Your Honor, I rest my case.” I am fine if it lives under the “goals” data class. But, what we want to bring to your attention that is critically important is that since the advent of COVID, people learned that when our healthcare system is strained, we are going to deliver the highest possible care in mass quantities, and sometimes, what falls to the side is personalization.

And so, we have a data element called the “care experience preference.” Just to define it, these are all of those moments, years, months, days, and hours, before and after a health crisis or an emergency. Now, how do we reflect the health crisis or emergency decisions? That comes under treatment intervention preference, so those are values, or spiritual, or cultural goals, preferences, and priorities that really should inform treatment so as to honor what the person has memorialized. So, between those two, you have “What do I need to know in the moment?”, and maybe a little bit before and after, and “What are all those things that we can do to deliver that person-centered care?”

One of the things that I wanted to speak to to raise to your consideration is that the missing component is a designation of a durable medical power of attorney. Now, that is currently at Level 1, but when you look at the work that entities like the Uniform Law Commission have undertaken, and the Uniform Law Commission is that national body of legal, care delivery, and advance care plan experts. For the first time in 30 years, the recommended national document as a standard for advance directives is being updated, and they have put so much focus on the designation of a healthcare agent or durable medical power of attorney, tomato/tomahto, they have put so much focus on that aspect of this topic that that is the only section that is left, to require what is in a notary, because it is such a serious thing, and many people who are reticent to talk about this topic will at least designate somebody to speak for them. So, I did want to

raise this to your attention. This is really the last slide. I certainly will not blab at you, as I wanted to have a two-way dialogue, but I wanted to state our point.

In the Moving Forward Coalition, under D, you will see the quality-of-life priorities, and I know Dr. O'Malley and Dr. Miller will speak eloquently to the importance of this data element when it comes to really capturing what enables goal-concordant care. So, we love A and B. It is in draft V.4. Please do not stop. Please bring this across the finish line and enable people to have their wishes available for data exchange and accessibility, and then, I am raising data element C to your notice, and then, I am bowing to my coworkers and having Dr. O'Malley and Dr. Miller speak to D. Would you mind very much moving to the last slide? Thank you so much. We do know, because, my goodness, we have met with teams of sweat-down-the-line-of-your-back clinicians who fought and are still fighting COVID in the buildings and we have met with experts in the EHR and the clinical care delivery space.

We have covered a lot of ground in two and a half years. The advance directive observation that is currently at Level 2 is a facilitator. It is the catalyst. You can have all the paper you want, you can have all the documentation you want, even digital, and it is immutable, and it is authenticated, but we have to have a catalyst to start the clinical workflow. And so, when a clinician observes, "Yes, I see the documents, yes, I validated that they are authentic, I can use them to honor what is important in care delivery," this advance directive observation is the catalyst that starts that workflow. The last item that I wanted to talk about was No. 2. Under the data class "orders," there is currently a data element for orders for end-of-life care at Level 2.

We would like to propose that that data element be renamed "portable medical orders" to make it expansive. There are certain jurisdictions where portable medical orders are appropriate for all patients, not just those who are at the end of life, like Maryland, where any medical encounter with an adult indicates that a MOLST be prepared, and so, we would like to be expansive, like some of the work that you guys have done, and ask you to consider that. And then, the last data element is "advance directives," and that is at Level 2, and in our opinion, we really do not need this anymore. There are LOINC document types that can indicate the type of document, such as a living will, a personal advance care plan, or a durable medical power of attorney, and then, for those states that bundle living will plus durable medical power of attorney, so I am not quite sure that we need that advance directive data element. So, I am done talking, I will go on mute, and I will be happy to answer any questions in case I am going too fast.

Sarah DeSilvey
Maria, thank you so much. You really are the twin to the presentation from Holly and Terry, so, thank you. We do have a set of hands raised, and I am going to start with Shelly.

Shelly Spiro
Thank you, Terry, Holly, and Maria. Great presentations. Being involved in long-term post-acute care for the last 30 years plus and an active member of the LTPAC HIT collaborative representing pharmacists and pharmacy services in this particular arena, for those who are ancillary providers to all care settings, including long-term care settings, having a transition of care is extremely important to these other types of entities, and many times, pharmacy and other types of ancillary services might not have access to the information, and transitions of care become extremely important, and having codified data being exchanged using FHIR resources is extremely important for all of these settings to make sure that we can build a comprehensive care plan for our patients. The GPP is critical, not only to pharmacy, but to other types of ancillary services, like rehab and such. It is important, and something that we have worked on on the pharmacy side for quite a while, in coming up with leveraging the transitions of care for certified health IT to encompass these types of preferences and goals.

It is really important for pharmacy. Just as an example, if you have a patient who is refusing antibiotics, we need to know that prior to receiving a prescription for an antibiotic, and being able to build into the care plan, such as the Pharmacist Electronic Care Plan, for this type of exchange. We are working on another type of transitions-of-care document for including medication-related specific data points that are important,

which would include advance directives and other goals for the patient to assure that we can work with the care team, in a way, because medications are such an important piece. As we know, so are other types of ancillary services that are out there. I am in full support of the work that Holly, Terry, and Maria are doing, and they are trying to incorporate that in the work that we are doing in medication-related issues.

I would like to also call out the comments that Michelle Dougherty made for this. They are great comments. It is not just about LTPAC, it is about post-acute care interoperability, which is part of the IMPACT Act, and we owe it to our patients, especially the aging population, to make sure that we understand their cognitive and functional status, that we are able to exchange their preferences working in a care team manner, and care planning is an important aspect of transitions of care because if we do not understand when the person is moving from one setting to another, we are not going to be able to have an appropriate care plan for that patient. So, thank you very much, and I am in full support of moving this forward and also including the quality portion for preferences. Thank you.

Sarah DeSilvey
Thank you so much, Shelly. Al?

Al Taylor
Thank you. I had a question for Maria. This is a follow-up to a comment you made about no longer needing advance directives as a data element or potentially as a USCDI data element. You pointed to one data element in USCDI in Level 1, durable medical power of attorney, and my question to you is if a data element or a concept like durable medical power of attorney, living will, personal advance care plan, or advance directive is more of a construction, a structured document, or some other sort of construct rather than a component element? What are your thoughts about those concepts as either the building blocks or the actual building? That is important because USCDI is a bunch of building blocks, and not so much the building itself. I also had a follow-up question for Terry and Holly about the durable medical power of attorney, but Maria, could you address that question?

Maria Moen
Yes, sir, I would love to. So, our project framework is provided by MITRE, and MITRE is sponsored by CMS. So, we have had a lot of discussion about these things, and we were told that we should not get bogged down and concerned about a data class. If the data elements make it through to one of the versions USCDI, it is less important how they are classified than it is to find them there within USCDI. So, if there is a data element called “advance directives,” how can that play when you have data elements for the other important components? It seems like they will bump heads, like there will be a convergence that will render a lack of clarity. If the information, regardless of class, is what makes a good care experience for me, what my treatment intervention preferences are, such as if I am a member of a particular religious sect and I cannot have blood transfusions, and the list goes on, who do I want to speak for me if I cannot answer these scary questions but I have a loved one legally designated who will speak for me?

And then, what makes a good quality of life for me, whether I am receiving care or not? I see the advance directive data element as being unnecessary if we move these other data elements through. In fact. I see it rendering a potential lack of clarity, and I fully confess it may just be my vision. I do not see everything, and I learn something new every day, but that is the best response I might have for you, and maybe you need to educate me, and I am open to that.

Al Taylor
I appreciate that. I appreciate the focus on the essential components of something that is bigger or broader than those preferences, so I appreciate that.

Maria Moen
Oh, I left something off the table, I apologize. So, here is what I learned, Al. In doing this work for the last two and a half years, I do not think I could be more intimate with the laws, the clinical standards of practice, and how risk management within a hospital sees legality as opposed to clinicians. Well written within almost

every state statute is the fact that while an advance directive can be a statutory, regulated form, it is also permissible to receive a verbal expression of a person's goals, preferences, and priorities, and that that should be documented and honored in many states as seriously as a form would be. I apologize, because you asked that question, and I neglected to answer it, so, thank you.

Al Taylor
Thank you. That is an important thing to realize, and to define it as more of a structure rather than even a verbal or a handwritten expression of them. My take on it is it could be constraining to define that, so I appreciate that additional point. Thank you for that. I also wanted to ask Holly and Terry… With USCDI, we strive to try and create or add more broadly usable data elements that can be used for more than one purpose, and we have talked about that for some of the proposed data elements within draft V.4, but with this concept of a designated agent or proxy, I wondered if you had some thoughts about whether or not "agent" or "proxy" could be considered one of the possible choices in a care team member role. The data elements that were added to USCDI Version 3 include care team members, and specifically care team member role and care team member type, and I wonder if that could already be captured as a type of care team member role.

Terrence O'Malley
That makes sense to me.

Holly Miller
I certainly think it should be. Very good point, Al.

Sarah DeSilvey
Thank you, Al, Holly, Terry, and Maria. Al, I believe that was your one-two question and we are moving on to Bryant.

Bryant Thomas Karras
I have a three-part question, but I will try to hone it in to just the critical one, because we are probably running short on time. Maria, great presentation. It reminded me of lots of our conversations in Henderson. I am really excited to see this go to a next step. One of the things that Terry and Holly's presentation concerned me with or brought up a question for me is what happens when one of the components of patient preference, especially when it is in the patient's own words and not explicitly encoded, conflicts or is at odds with something that is encoded in other components of a USCDI data element. Is there a feedback mechanism or any kind of accounting for what to do in those situations? I am specifically thinking, in addition to end-of-life care, about what happens when it is a situation of memory care, behavioral health, or mental health crisis care, where patients may change their minds on the fly and it becomes a complicated situation when you have multiple sources of truth. Any thoughts or discussion on that? But first of all, I am super supportive and excited to see this move forward.

Maria Moen
Go ahead.

Holly Miller
Go ahead, Maria, please. I can follow.

Maria Moen
Okay, great. I have been throwing some chats out there to you guys, too. I will certainly check the FHIR resources to see if we have noted any barriers or limitations within the current set of FHIR resources. I agree, I think "care team member" with a role equal to "healthcare agent" or "proxy" could work. We want to make sure that it is not lost in translation, but I will certainly create an action item for the MITRE team to look into that very carefully and diligently. When you talk about how we can be sure, you guys know better than anybody in the world that this is a heavily fragmented healthcare system, and state registries and repositories are on the rise.

Still, in all, we are building an onramp from a paper world to a digital world. Is it possible that in a particular state, which may have a registry and repository for this type of information, there are providers that are not connected to the state HIE and have their own version that we are not going to know about? Yes. Is it possible that someone is going to cross a border on vacation and come over to a state that does not have their documents and cannot access it? Yes. So, we have made provisions within our FHIR IG to require, though I will not say "PDF" because my tech team would kick me in the shin, that a human-readable copy of the document should always accompany the FHIR data bundle. Can we make sure that the most current version in Maryland is also going to be the most current version that is pulled up in California? No, not yet, but it is our role to build the infrastructure for tomorrow and then to nudge people into dropping the paper and moving to a digital, person-centered ecosystem. That is my little rose-colored glasses response.

Sarah DeSilvey
Maria, thank you so much. I believe your question created a pathway to what Hans might be asking. Hans?

Hans Buitendijk
Thank you, and thank you, Maria, for your overview, and in combination with the discussion earlier by Holly and Terry and the question that I asked earlier, it is an area that can range very much between a couple of elements and a variety of data classes and data elements that need to be pulled together across different areas to make this fully functional as intended. There is a lot of work going on where some guides in C-CDA are already ready, other ones have just passed ballot, and other ones still have to go through it. There are different aspects. As you go from looking at the goals and the interventions and some of the other preferences like the living will, they have a varied level of standards and implementation guides developed, agreed to, and adopted.

So, from that perspective, when we look at the proposal for USCDI Version 4 and read "treatment intervention preference," it could actually span a variety of those data classes and may not be suitable for just goals, but it might be a plan, intervention, or orders. The question I have is what is really the intended first step to start to move in this direction for USCDI V.4, considering that the current state of the variety of C-CDA and FHIR implementation guides that would be needed still have a ways to go, or are already there, or might not be implemented yet in a wide range? So, we have that spectrum there. What is really the first step that you see for USCDI Version 4 to be a manageable step and not get too far ahead, but also start to make some progress? That is not clear from the discussion and from the proposals, including the submission. What are we trying to do? PMO, POLST, advance directives, a couple of interventions that we still need to define in FHIR exactly how we express that? Where on the scale are we?

Maria Moen
Thank you, and I apologize… Go ahead, Terry.

Terrence O'Malley
I was going to say, Hans, at the center of all of the things you mentioned, the care plans, advance directives, and treatment preferences, are the individual's goals, preferences, and priorities. I think that is the nugget and the starting point. If you are able to clarify and make accessible an individual's goals, preferences, and priorities, then that information will feed plans, treatments, goals… It will feed everything. If you wanted a first step for USCDI 4, it would be to establish places for goals, preferences, and priorities to live within USCDI.

Maria Moen
Okay. I was just going to put this into the chat, and I will probably still hit send. The group who created the FHIR IGs spent almost six months working diligently with the same team who created the CDA IGs for personal advance care plans and the C-CDA advance directive template. We made sure we were lockstep: Same value sets, same general ways of representing content and information, same LOINC codes. Sure, you do it differently in CDA than you do in FHIR, but we made sure that we were perfectly aligned. They support care experience preference, they support treatment intervention, they support healthcare agents,

and we have tried to work very closely to make sure that it does not matter whether you are dropping a CDA or a FHIR bundle, the data are going to be consistent. Just decide what shape you want it to be. So, I hope that was a good answer to your question.

Hans Buitendijk
I appreciate that answer. I think there are still some questions open in that space, but then we dive too far into details, and it is particularly around the preference part and interventions where some open questions are. Are we ready for that, how far can we go with that, and what is the adoption rate that we currently see in this space to say yes, it is ready for USCDI Version 4? So, it is a maturity question that also comes into play.

Maria Moen
I think my only point is everybody can do a CDA these days, or everybody should be able to, so if that is what you can do, these data elements will stand the test of time. When FHIR is more mature, when people are understanding what the ONC is trying to do, it is going to be an easy step into FHIR, and some receivers will still want CDA. It is the same data sets, it is the same framework, it is the same data elements. Perhaps the right term is that we tried to meet people where they are.

Sarah DeSilvey
Thank you so much, Maria. I believe we have time for one more question before we close this period, and Ricky, I think you might build off that previous conversation, given your area of focus. Ricky?

Ricky Bloomfield
Great, thanks so much. I agree with the other comments here, that this is really meaningful work, and creating an implementation guide that harmonizes or tries to account for the variety of forms out there is not easy work, so, kudos to being able to do that. My question does kind of build off Hans's question. My understanding is that the level of implementation for structured data in this arena within EHRs today is highly variable, but most EHRs and most health systems will still scan in these paper forms when those are made available, whether it comes from EMS or whether it comes from a conversation that the care team has with the individual, and they fill it out on the piece of paper.

So, I wanted to get your thoughts about whether, as one of the potential first steps here, it would be useful or meaningful to include the advance directive LOINC code as one of the required clinical note types that should be made available, similar to the proposal to add operative notes that our team discussed earlier. For those that have the data as a scanned document in the EHR, that would be made available if present, and that is something that would likely apply to every health system while we work on the more in-depth and rigorous feature to have the structured data comes through as goals, preferences, etc.

Maria Moen
I think that is a good question. So, we have had Epic, Emma Rose from Athena, and some pretty large vendors weighing in and holding our hands since the birth of this project, and they, too, have said, "I have the free world's supply of scan documents. I am not going to have this discrete data." So, we have made sure in the CDA IG and both FHIR IGs, STU1 and STU2, which we are working on, that you can attach a CDA header with a completely unstructured document and you can wrap a FHIR document reference around a completely unstructured document. So, yes, having a clinical note that is advance directives… Golly, why wouldn't you? You are asking the question anyway.

All of you have been to the doctor. If you have any kind of ongoing chronic illness like I do, hypothyroidism, they always say, "Do you have an advance directive?" They are going to ask the question. Nobody is going to do this in an electronic world until it is in USCDI. People will meet regulatory, they will meet market demand, but they are not going to add things voluntarily until the carrot gets replaced by a stick. So, that is one of the reasons we believe that this will actually prompt more adoption, and there are platforms that do capture discrete interoperable data, but they are the exception, not the rule, if that is what you want.

Ricky Bloomfield
Great. Yes, that is really helpful, so perhaps it is a conversation that our workgroup can have. Right now, there are five required clinical note types within USCDI. Could this be another that could build off of the existing implementation work across all EHRs to support the ability to convey clinical notes? Perhaps adding that as the note type could be one step in a broader set of steps that would happen over time, but at least put a stake in the ground that this is really, really important to continue the conversation.

Maria Moen
I love it.

Ricky Bloomfield
If there are specific LOINC codes that you would recommend, that would be helpful for our group. I know there are at least a couple that I am aware of, but aligning on which ones are the right ones to make sure we capture this in a standard way would be an important part of that conversation.

Maria Moen
Yes, sir. I see them on the back of my eyelids at night when I go to sleep. I absolutely know what there are, and there are only four or five. I did just recently request a new code from Regenstrief to encompass mental health directives, which is another document type due to the rise in behavioral health concerns. So, yes, if that is the use of advance directive, then I am sorry I said I did not think we needed it. I only know what I know, so that was very helpful.

Ricky Bloomfield
Thank you.

Sarah DeSilvey
Thank you so much, Ricky and Maria. We are at time, so, Ike, if you have a brief question, we can, but I do want to respect the time of our guests, Terry and Holly, who specifically said they only had until 11:30, so I want to be careful of their time. Ike?

Steven Eichner
Yes. This is a perfectly valid parking lot kind of question because it does not really affect the interoperability aspects, but looking at what becomes a source of truth from the patient perspective about creating the information, and it is great to be able to exchange it, but what the source of truth is where a patient is providing or editing this content is a relevant issue, again, not from the interoperability standpoint, but from an implementation standpoint. Do I get to do it at home, do I have to take time away from my doctor's visit to modify my EHR there, etc.? I do not think I am looking for an answer here and now, but am just presenting a parking lot issue for future conversation.

Sarah DeSilvey
Thank you so much, Ike. Given time, and given that you allowed us to think about that as a parking lot question, in the presence of no other questions, I want to take this time to thank Holly, Terry, and Maria again for your historical engagement in this work, your current, Herculean efforts in this space, and for taking the time to come and talk to us all today to expand our knowledge on these critical areas that you are all experts in so that we can make our best recommendations regarding these data elements. Thank you so much for being here with us today.

Maria Moen
Thank you for listening.

Terrence O'Malley
Thank you all. This is great work you are doing.

Comments and Recommendations – Draft USCDI v4 and Level 2 Data Elements (01:03:36)

Sarah DeSilvey
All right. I believe we are now pivoting to the next section of our agenda, which is to do our typical work of going in, and it does not look like we have officially resolved some of the complexity on the physical activity element, or at least it is still blank to me, so what I would like to do is start the Level 2 elements. There is some actual synergy there, based on one of Grace's comments, which is, I think, the second of our Level 2 elements in there, so if we can go to the share drive, I believe we are starting with Mark's Level 2 element first, and then, what we will do is reintegrate some of those draft USCDI V.4 elements in our future conversations, again, hoping to center physical activity when we return. This is Hans's email recognizing the removal of physical activity, which we will address shortly. I believe Al is probably pulling up his version of the share drive.

Al Taylor
Hang on a second, I am sharing the wrong screen. Let me stop share and reshare. Could you please direct me?

Sarah DeSilvey
Yes, I believe this is where we are. This is entirely correct.

Al Taylor
The flying squirrel concept. Okay, good.

Mark Savage
Except, Sarah, I loaded recommendations and so forth. I see, it is there.

Sarah DeSilvey
Yes, I think it is there. Again, it seems like physical activity is the one that is missing. Mark, would you care to lead us in discussion on this Level 2 element you are recommending for inclusion?

Mark Savage
Sure. So, it is a Level 2 element, and as we have just heard from the previous presentation, so much fits into what the care plan is. This workgroup has talked about care plans in previous years, and I am just recommending that we lift it up for V.4. I took a look at the care plan FHIR resource, and I put some links into Column K. So, the first one, the care plan resource, is the one that has actually been proposed for this time, and they self-identify as capturing the basic details. It is an intermediate level of complexity, not the full range. There is other work being done by NIH and AHRQ on the multiple chronic care e-care plan, and I am actually on the advisory group for that, but this is sort of a beginning point that seems wise to me to meet some important values, not only the ones… I do not see this here. Anyway, care coordination, value-based care, and having a care plan is critical. So, with that, let me stop in the interests of time.

Sarah DeSilvey
Any comments? It looks like Shelly has a comment. I know that Hans had a comment on the share drive, too. Shelly?

Shelly Spiro
Yes. I totally agree with you, Mark, and I have also been involved on the technical expert panel for the MCC care plan, which really feeds nicely into what Maria was talking about on patient preferences because there is a patient interactive portion of the care plan also, where we can reconcile some of the areas that need to be reconciled within care plans. Care plans are extremely important to the pharmacy profession at this time of capturing encounters on medication-related issues and being able to share that with the care team, so I totally agree with all your comments, Mark. Thank you.

Clem McDonald

This is Clem. I am still not clear on what we are really ending up proposing, C-CDA, FHIR, or all of them. To me, it is a little blurry.

Hans Buitendijk
This is Hans. I effectively have the same question. "Care plan" is a large concept. We already have, under patient summary and plan, some elements of plan. For the FHIR US CORE and C-CDA document types, there are already care plan components in there, so the question would be what other data… I am not saying there is not other data, but what is the actual proposal on what is being added? Again, like some other concepts that we discussed today, "care plan" is very big and wide. Are we planning to encompass everything or a couple specific elements? What are we looking at?

Mark Savage
Hans, I took it that the submission that is available for us to consider was one that focused on the implementation guide, what has been pulled together, and excluding what has not yet been pulled together there. That is why I noted that it was sort of an intermediate approach to complexity.

Clem McDonald
So, Mark, there is an existing one that is pulled together. Is that in FHIR or CDA? What world is it in?

Mark Savage
It is in FHIR, and that is the link that is in the spreadsheet. Does that answer your question, Hans?

Hans Buitendijk
Not fully because that is the resource. So, are you looking at chronic condition e-care plan and everything in there?

Mark Savage
No.

Hans Buitendijk
Looking at the care plan resource, that has a lot of attributes and components to it. Are you suggesting that all of them should be supported, and would every HIT system have relevance to that or not, depending on what they are doing? That is where I am challenged, trying to understand what subset is really of interest, and that can then help understand if that is a reasonable next step for all the systems that are supposed to support that.

Mark Savage
I am not sure that I have a delimited answer to that at this point, Hans.

Clem McDonald
But Mark, you tend to pick the middle of the road so something will get done. Do you have a thought on that along that line for this?

Mark Savage
Well, I think the submission was presented as a middle-of-the-road approach, but it is not answering Hans's question, and perhaps your question.

Hans Buitendijk
When I go to the submission, it still leaves a wide space of variability of what should or could be included, and that makes it hard to then say that if "care plan" is added to USCDI and it is not specifying the data elements or is going to include everything without further review, what does that translate into, and is that too big of a step, given the variety of systems that would need to support that where they are at?

Mark Savage

Sarah and Naresh, can I suggest that we try the small-group approach to see if, between meetings, we can try to figure something out, whether something can be done?

Sarah DeSilvey
That sounds wise.

Mark Savage
Shelly's hand is up too, but I am just throwing that out there. What we are hearing on these calls is that care planning and a care plan is important in so many ways. Let's see what we can do.

Sarah DeSilvey
That sounds fantastic. We certainly have addressed many elements of the care plan in our conversation, even today. Shelly?

Shelly Spiro
I put most of my comments in the chat, but I do want to state that the care planning process is an extremely important process. In the independent community pharmacy setting, we have millions of care plans that are being captured and highly codified with value sets. We do have a version of both C-CDA and FHIR Release 4. I am not sure if the category belongs in care planning, but care planning is definitely the wave of the future, especially for those ancillary services such as homecare, hospice, rehab, and pharmacy. Those are all integral parts of sharing the care team information, and we have already proved that codified information can be captured within the care plan, and if we focus on some of the sections that we already have, such as health concerns and health status.

Some of these components fit into those. It is very similar to what we did with SDOH information as part of the Gravity Project. It is encompassed in the care plan, just as we are hoping that some of the concepts of PACIO, like cognitive functional status, advance directives, SPLASH, and other areas can also be incorporated into the care plan. So, I am not sure if "care plan" needs its own section, but we have to be very careful about making sure that we are capturing those components within the data classes that have been established within USCDI.

Steven Eichner
This is Steve Eichner. One of the things that I just thought about that fits into the care planning component but that we have not really addressed, and it is not necessarily in our scope, but I could see future USCDI elements tying to it, is looking at payment source for elements of the care plan, whether that be preapproval, documentation, or potential sources of funding, or whatever else, to begin to bridge that gap. So, one of the things we might want to consider as we are working through this is what growth of the USCDI looks like so that we are not setting ourselves up or setting future taskforces up where things are categorized in a way that does not allow them to grow.

Clem McDonald
This is Clem. So, historically, the care plan has been a narrative. Do we really have a good handle on how to break it into discrete coded structures?

Hans Buitendijk
Stepping into Aaron's comment in the chat, the various care plans that different systems support have varying levels of structure. For USCDI, the question is what is the common denominator across them that is a reasonable starting point that when you start to go beyond just text, what is a reasonable set of data that then are common characteristics of a care plan? And then, you have specialty care plans like the pharmacist care plan or other kinds of plan that are in play that hone in on various specific combinations of data, and if you look at, in a way, the earlier discussion of advance directives and intervention preferences, you are starting to not necessarily define a care plan in the way that we otherwise might think of it, you are starting to define the goal and what you are trying to achieve, you are starting to define what interventions you do or do not want to have done, so you start to build into that as well.

In a way, it is a specialty form as well, and in that area, what is really the common core that a care plan should have, and can we get agreement on that as the starting point, where the specialty type of care plan for different purposes and contexts can then continue to build on top of that. I think that is where the challenge is. You also will see that the further you get into some of the specialty areas, maybe not all HIT needs to be able to support that. A current characteristic of USCDI is that whatever we put in, it is something that all HIT that needs to be certified, plus other programs in whatever they need to do, but particularly as certified HIT, must support everything, and that is the other dimension that we need to keep in mind. That is why it is a balancing act of understanding not only the full concept and general idea, no concern there, that is the interest overall, but what specifically can we put in that we can ask everybody to support?

Steven Eichner
This is Steve again. From a structured future, and Clem, respecting the idea historically that a care plan may have been more narrative, but as we are looking at greater coordination of care with different actors providing different supports and care elements to it, I would think that down the line, there might be a narrative section, but there also might be more distinct elements or specific tasks, if you will, within that care plan so that there becomes a way of tracking progress or marking off activities that have been done in support of that care plan because you are going to be dealing with multiple providers, and it would be good for all parties to know who has undertaken responsibility for a portion of the care plan and what activities have actually occurred in that aspect of the care plan.

Sarah DeSilvey
Thank you so much, Ike. I want to respect Mark's question, which I think is actually a really important one. Should individuals want to gather and coalesce around a recommended path for documenting this element within the breadth of existing care plan facets that we have already, either in Level 2 or draft USCDI V.4, I think that is really important, and so, akin to how we coalesced around labs with Hung and Pooja's gathering people regarding medication, I hear Mark volunteering to gather people to talk about this Level 2 element. That seems like a good disposition at this time, given that there are similar definitional requirements. Mark, does that sound like a good plan?

Mark Savage
It does. Can people drop their names in the chat that they would like for me to reach out to them or whatever is the best way? But yes, let's try to make it happen.

Sarah DeSilvey
Okay, and we can include it in homework as well. Fantastic. I do have to proceed to my webinar for CMS, so I am going to pass the baton to my colleague Naresh, and we are going to move on to the next Level 2 element, which I believe is Grace's element. Grace's second Level 2 suggestion is regarding advance directives, but her first, I think, is actually in operative notes, and Grace is with us today. Grace, do you have a moment to discuss this? We are almost to public comment, so maybe a quick introduction, understanding we will need to return to this next meeting.

Grace Cordovano
Absolutely, thank you, Sarah. It is very self-explanatory. We discussed this previously. I tried to include all references and comments in the spreadsheet. Essentially, in a nutshell, out of all the information that a patient typically gets from the designated record set that is really available in the EHR or that could be available at point of care, surprisingly, operative notes are not part of the package. So, from a patient advocacy standpoint, the operative note is critically important for a patient to have a copy of. It may have information of samples and tissue that may have been collected, which can lead to guiding what pathology samples may be available, and it is necessary for demonstrating medical necessity and a lot of different parameters that patients need to make informed, educated decisions about their care. I hope that is enough at the moment. I am trying to be mindful of time.

Naresh Sundar Rajan

Thank you, Grace. Any other questions or comments around this? Hans?

Hans Buitendijk
Thank you. I agree that operative notes are important, and the question also in this area is what is the source of that operative note and the systems that need to be there. There is a note there to include all note types as part of the conversation as well, beyond operative notes, and I have no disagreement that they need to be covered over time, but it raises that same question of where we get the clarification that not necessarily all HIT needs to support all document notes and types that are in there. In principle, I have no concern with operative note or any other one per se. It just goes back to that general question of how we manage that and what the source of that information is. Is it the EHR or some other system where that is being created? Are we setting the right expectations? It is increasingly getting more challenging with USCDI, so I will sound like a broken record on that a number of times, but that is more of a concern than the validity of the document type. All of them are important in the end.

Naresh Sundar Rajan
Thank you, Hans, for that. We want to go to public comment, given the time on this, and before we move there, Al, I just saw you unmute. Do you have any final comments?

Al Taylor
No, sorry. I accidentally hit the space bar.

Naresh Sundar Rajan
Okay. So, we will continue this at our next gathering, and I will just move to the public comment section.

Public Comment (01:23:07)

Michael Berry
All right, we are going to pause our meeting for public comment. If you are on Zoom and would like to make a comment, please use the hand raise function, which is located on the Zoom toolbar at the bottom of your screen. If you are on the phone only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. Let's pause just for a moment to see if any member of the public would like to make a comment. I am not seeing any hands raised, Naresh, so I will turn it back to you. Thank you.

IS WG Workplan and Timeline (01:23:39)

Naresh Sundar Rajan
All right, thanks for that, Mike. There is one comment in the Zoom. I am not sure if we are addressing that right now, but "Has the medication administration data element been discussed?" This is a question that came through. All right, let's move to the next section. Can we go to the next slide, please, Mike? All right, we have the next workgroup meetings scheduled here. With respect to the timelines in here, we are marching toward the April meeting and final recommendations to be pulled together for our next upcoming meetings. This is going to be our area of focus for March 15th, personal information. Next slide, please. Here is our vision of where we are currently, and again, last slide, any other guest speakers should be invited with respect to our existing elements of interest.

Clem McDonald
This is Clem. When you showed the previous slide, I had a number of questions. It was not clear what level of specificity those variables would be specified as. For alcohol abuse, there are a number of standard survey instruments. Are we talking at that level, or are we talking about "Oh, do you drink?"

Naresh Sundar Rajan
Al, is that something you can answer?

Al Taylor
Yes, thanks, Clem. The intent of this particular data element is to capture the typically structured assessment for alcohol use or substance use.

Clem McDonald
So, it would be a particular questionnaire?

Al Taylor
Not necessarily, but something like the AUDIT, AUDIT-C, MAST, or CAGE. It is to be able to capture the assessment of, not the condition of.

Clem McDonald
Okay, good.

Naresh Sundar Rajan
Thank you, Al and Clem. Any other questions or further feedback on guest speakers? If there are none, we can move to the next slide.

Hans Buitendijk
One comment or question is that as we are getting closer to the creation of the draft final recommendations, when should we start to provide feedback or comments? There is the body of work there, but when do we target to begin the review of that?

Naresh Sundar Rajan
Good question, Hans. Al, unless you have any specific timeline in mind, we will discuss that and definitely get back to you on the timeline on when we should get to that. Before I say that, Al, do you have any other thoughts?

Al Taylor
Generally, what we do is within two weeks of the due date for the report to the HITAC, we will start drafting the recommendation letter, so that is going to take all of the recommendations, especially the individual specific recommendations, and compose the letter. So, it does not mean that we cannot make some additional changes in the last two weeks, but the end of this month, basically, is how long the workgroup has to come up with the bulk of the recommendations, whether it is a recommendation to accept draft V.4 in total and add additional data elements or specific qualities of each of those data elements, like "Use one particular standard" or "Change the definition of," things like that. Those are the things that we ought to have almost entirely done by the end of this calendar month.

Naresh Sundar Rajan
Thank you, Al. With that, we will move forward to adjourning this meeting. Mike, any final comments?

Michael Berry
I just want to mention that Naresh and Sarah will be doing an update of the workgroup's activities at tomorrow's HITAC meeting. This is a meeting of the full committee of the HITAC, so you are welcome to tune into that. You can register, if you are not already registered, by just searching for the HITAC calendar and registering. Other than that, we will see you next Wednesday. Thank you, everybody.

Naresh Sundar Rajan
Thank you. Bye.

Adjourn (01:28:52)