Transcript

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

March 5, 2024, 10:00 – 11:30 AM ET

VIRTUAL

MEMBERS IN ATTENDANCE

Sarah DeSilvey, Gravity Project, Co-Chair
Steven (Ike) Eichner, Texas Department of State Health Services, Co-Chair
Pooja Babbrah, Point-of-Care Partners
Ricky Bloomfield, Apple
Hans Buitendijk, Oracle Health
Keith Campbell, Food and Drug Administration
Christina Caraballo, HIMSS
Grace Cordovano, Enlightening Results
Derek De Young, Epic
Lee Fleisher, University of Pennsylvania Perelman School of Medicine
Hannah Galvin, Cambridge Health Alliance
Rajesh Godavarthi, MCG Health, part of the Hearst Health network
Jim Jirjis, Centers for Disease Control and Prevention
Steven Lane, Health Gorilla
Hung Luu, Children's Health
Anna McCollister, Individual
Katrina Miller Parrish, Humana Health Insurance
Alex Mugge , Centers for Medicare & Medicaid Services (CMS)
Kikelomo Oshunkentan, Pegasystems
Rochelle Prosser, Orchid Healthcare Solutions
Mark Savage, Savage & Savage LLC
Fillipe Southerland, Yardi Systems, Inc.
Shelly Spiro, Pharmacy Health Information Technology Collaborative
Zeynep Sumer-King, NewYork-Presbyterian
Naresh Sundar Rajan, CyncHealth

MEMBERS NOT IN ATTENDANCE

Medell Briggs-Malonson, UCLA Health
Raj Dash, College of American Pathologists
Aaron Neinstein, Notable

ONC STAFF

Seth Pazinski, Director, Strategic Planning & Coordination Division, ONC
Al Taylor, Office of Technology, ONC

PRESENTERS

Jenna Norton, National Institutes of Health (NIH) National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
Arlene Bierman, Agency for Healthcare Research and Quality (AHRQ)
Liz Palena-Hall, CMS
Evelyn Gallego, EMI Advisors

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

Seth Pazinski
Good morning, everyone. Welcome to the Interoperability Standards Workgroup Meeting of the Health IT Advisory Committee. I am Seth Pazinski from ONC, and I want to thank you for joining today. I will be serving as the designated federal officer for today's call on behalf of Wendy Noboa, and as a reminder, all workgroup meetings are open to the public, and we encourage the public to participate throughout, so members of the public can type their comments into the Zoom chat feature throughout the meeting, and they also have the opportunity to make verbal comments during the public comment period, which is scheduled towards the end of the agenda today. So, I am going to start with roll call for members, and when I call your name, please indicate that you are present. I will start with the co-chairs. Sarah DeSilvey?

Sarah DeSilvey
Good morning. Present.

Seth Pazinski
Good morning. Steve Eichner?

Steven Eichner
Good morning.

Seth Pazinski
Good morning. Pooja Babbrah?

Pooja Babbrah
Good morning.

Seth Pazinski
Good morning. Ricky Bloomfield?

Ricky Bloomfield
Good morning. I am here.

Seth Pazinski
Good morning. We did get a note from Medell Briggs-Malonson, who will not be able to join us today. Hans Buitendijk? Keith Campbell?

Keith Campbell
Good morning.

Seth Pazinski
Good morning. Christina Caraballo?

Christina Caraballo
Present.

Seth Pazinski
Good morning. Grace Cordovano? We also got a message from Raj Dash that he is not going to be able to make today's call as well. Derek De Young? Lee Fleisher?

Lee Fleisher
Good morning.

Seth Pazinski
Hi, Lee. Hannah Galvin?

Hannah Galvin
Good morning.

Seth Pazinski
Good morning. Raj Godavarthi?

Rajesh Godavarthi
Good morning.

Seth Pazinski
Good morning. Jim Jirjis?

Jim Jirjis
Good morning. Present.

Seth Pazinski
Good morning. Steven Lane?

Steven Lane
Good morning. I am here.

Seth Pazinski
Good morning. Hung Luu?

Hung S. Luu
Good morning.

Seth Pazinski
Good morning. Anna McCollister? Katrina Miller Parrish?

Katrina Miller Parrish
Good morning.

Seth Pazinski

I see that Hans Buitendijk just joined. Welcome, Hans. Aaron Neinstein? Kikelomo Oshunkentan?

Kikelomo Oshunkentan
Good morning.

Seth Pazinski
Good morning. Rochelle Prosser?

Rochelle Prosser
Good morning.

Seth Pazinski
Good morning. Mark Savage?

Mark Savage
Good morning.

Seth Pazinski
Good morning. Alex Mugge?

Alex Mugge
Good morning.

Seth Pazinski
Good morning. Fil Southerland?

Fillipe Southerland
Good morning.

Seth Pazinski
Good morning. Shelly Spiro?

Shelly Spiro
Good morning.

Seth Pazinski
Good morning. Zeynep Sumer-King?

Zeynep Sumer-King
Good morning.

Seth Pazinski
Good morning. Naresh Sundar Rajan?

Naresh Sundar Rajan

Good morning.

Seth Pazinski
Good morning. All right, that completes our roll call for this morning. I want to say thank you again, and please join me in welcoming Sarah and Ike for their opening remarks.

Opening Remarks (00:03:30)

Sarah DeSilvey
We have very brief opening remarks. Thank you all for being here. I do want to just express my gratitude both early and afterwards to the SMEs for coming in to discuss the care plan data elements. We are in that moment where we hope to listen to our SMEs, reflect on them, and keep on driving through to hear and review some of the last USCDI v.5 proposed elements and get to Level 2 elements today. So, we have a packed agenda. Thank you to you all for coming again. We are not going to be convening during HIMSS, so we really need to lean into the asynchronous work in order to get ready for that transmittal letter in early April. Ike, anything else?

Steven Eichner
I echo what you said, and again, I express my gratitude and appreciation to our subject matter experts and speakers and the whole workgroup for the work we are doing. We are doing some good stuff, I think.

Sarah DeSilvey
Thank you so much. So, you can see the agenda for today. We are going to be centering the subject matter experts, as we have in past sessions, and then, at 10:40 AM ET, we are going to be switching to trying to review and go through a couple last USCDI v.5 elements and get to those Level 2 elements that we have yet to address in our sessions. All along, we are trying to make sure that we finish or at least get a good draft of the final recommendations so that we can move forward with drafting that transmittal letter. We will move to public comment at 11:25 AM ET, and then adjourn. Next slide, please.

Again, this is the charge. We review it every time, though it is well known to you all. It is reviewing and providing recommendations on Draft USCDI v.5, including new data classes from Draft USCDI v.5 and any Level 2 data classes not included in Draft USCDI v.5 that should be considered for the final USCDI v.5 release. Thank you for all of your work so far. We definitely are in the home stretch when it comes to our recommendations to HITAC. Next slide. I am now going to set the stage for our subject matter expert presentation on the care plan data elements. We have the honor of having many experts come to join us today: Jenna Norton from NIH/NIDDK, Arlene Bierman from AHRQ, Liz Palena-Hall from CMS, who is well known to this group, as most of these people are, and my friend Evelyn Gallego from EMI Advisors. It is so lovely to have you here. We are going to first ground in the data element as it is on Draft USCDI v.5, and then transition to your presentations. Next slide.

Just so everyone in IS WG knows the driver and impetus for this presentation, the draft element, which is a Level 2 element, is care plan, which is the conclusions and working assumptions that will guide treatment of the patient and recommendations for future treatment. It has been elevated for consideration by IS WG a few times over the last few years. So, this is the data element as present and represented on the IS WG data element Google sheet that we work off of, and now we are going to center the wisdom of our subject

matter experts and have some time to understand other thoughts that are laid to bear on our analysis of the readiness of these elements. Friends, I turn to you.

SME Discussion – Care Plan (00:06:50)

Jenna Norton
I will start by just saying thank you so much for having us. We are really excited to be here today to provide some recommendations and our thinking about how we can potentially move this data element and data class forward. Next slide. So, this was our intended agenda, but we recognize you have a very packed agenda today aside from us, so we are going to try to breeze through some of this background and really focus most of our time on the recommendations that Liz will give. Next slide.

Just to ground us in some shared understanding of some of the language that we will be using today, we wanted to take a minute to differentiate care planning from the care plan. So, care planning is a process. Many of the inputs that are involved in the care planning process are already reflected into USCDI, but what is potentially lacking is the output of the care planning process, the actual care plan data element, which then feeds into the all-important now quintuple aim, which focuses on improving our overall healthcare from many different aspects. Next slide.

We also wanted to differentiate some terms that float around in the space that sound very similar, but have some distinct meanings, so we wanted to differentiate care plan, which we are talking about today, from treatment plan, which is a very narrow, domain-specific plan, managed typically by a single discipline, focusing on a specific treatment or intervention, a plan of care, which is usually a clinician-driven plan that focuses on a specific health concern or closely related concerns, and then really focus on what we mean, at least, when we say “care plan,” which is a shared, dynamic, longitudinal plan representing all care team members, including the patient and caregiver, their prioritized concerns, goals, and interventions, as well as evaluation and outcomes, across all health and social service settings. Next slide.

So, they say a picture is worth a thousand words, so this is just a picture to cement the definition that I just shared in the prior slide. So, you can see we want to shift from the status quo, where patient-important health data is scattered across the health system, to a model where patient-important data is available in a centralized space to the entire care team. Next slide. We want to briefly acknowledge one important use case, just to really emphasize the importance of a shared comprehensive care plan, and that is the use case of multiple chronic conditions, but this is not the only use case that is important for a comprehensive shared care plan, it is just one that we can speak to well and among our group, but the same considerations also apply to other use cases, like pediatric transitions of care, among many others.

With regard to multiple chronic conditions, this patient population is a very complex population. Multiple chronic conditions are highly prevalent, and they lead to a huge amount of burden to the healthcare team, partially due to the fact that people with multiple chronic conditions tend to get their care from many different places across the health system, resulting in data that is scattered and care that is not coordinated, and that is why we believe a shared comprehensive care plan is so critical, because it enables us to bring together key data for this very complicated population, as well as many other potentially complicated populations. Next slide.

Just briefly looking at our previous care plan recommendation for Level 2 and comparing that to what is in the current draft of USCDI, we wanted to emphasize the point that what is currently in USCDI, getting back to those different words, is really more a treatment plan or a plan of care, rather than a care plan. We currently do not have all of the standards available that we need to align with what goes on in terms of clinical workflow for care planning, hence we wanted to put forward a revised care plan recommendation that would include care plan information, assessment, health concerns, goals, interventions, outcomes and evaluation, as well as the care team, to better match with the care planning process that we started out the call acknowledging. Next slide.

So, I just want to emphasize the potential benefits of e-care planning for clinical care: Enabling improved communication and care coordination across the care team, which improves caregiver and patient experience, access to patient-and-caregiver-reported and patient-and-caregiver-centered data that really drives care towards the patient's goals, preferences, and priorities, and acknowledges the social determinants of health from which they live their lives. It also potentially improves patient safety and reduces medical errors, and ultimately may reduce cost through redundancy and duplication of orders. Next slide.

Finally, I just want to touch on the care planning component. So, the care plan contains care plan information, assessments in order to identify what the priority health and social concerns are for the patient, goals, which include both patient-centered and clinician goals, interventions, the actions taken to treat and manage health concerns and reach the goals of the patient, and finally, outcomes and evaluation, which is really just a reassessment looking at how your intervention has changed those initial assessments, and all of this is undergirded by care coordination. I think I pass this off to Evelyn at this point. Next slide.

Evelyn Gallego
Thank you, Jenna. I know in the interest of time, I want to acknowledge first that in USCDI, we are speaking about the care planning, and thank you for the opportunity to speak today, we are agnostic to the content and the transport standards used to expose individual data elements. Here, I just want to acknowledge that as we looked at the MCC e-care plan work, we developed a FHIR implication guide, but what is important here is that it is designed to support the collection and sharing of these critical five components that Jenna just walked us through, and it also incorporates them through coded value sets for chronic conditions, so, five, and of course, the SDOH data classes. Next slide.

So, first, we want to acknowledge what already exists in USCDI. Much of what we have been talking through and all pieces of these components that make up the care plan, so we are thinking of the output. So, we have talked about, again, regardless of the IG, but the overall structure, whether it is C-CDA or FHIR, has these five basic components: Care plan information, health concerns, goals, interventions, and outcomes. As we look at what already exists in USCDI, much of it is already there, but it is just named differently. Here, we are just thinking through how care plan information already exists as we have defined it in our work on care planning and the multiple chronic conditions. The data class, patient demographics, care team members, and health insurance information are available.

Health concerns are represented: Health status assessments, problems, and goals align very well with goals and preferences. Interventions are seen both in procedures and medications. The one that is not specifically called out is outcomes and evaluation, but Liz will explain more about our thinking of where that could be highlighted. Next slide, and I will hand it over to Liz.

Liz Palena-Hall

Thank you, Evelyn. Just to underscore again, care plans are a really essential component of care delivery for people with complex care needs, and increasingly, care plans are required by CMS in its programs as comprehensive, patient-centered, longitudinal plans that identify a person's goals and health needs and the services and supports required to meet them. However, as we heard, care plans today are still largely paper-based, and when they are electronic, they are often designed for a specific care setting or condition, and in fact, people with complex care needs are more likely to have multiple care plans, which, rather than improving care coordination and integration, often leads to competing plans and increased fragmentation of care. And so, with that context, our recommendation today is in support of, again, that shared, dynamic, longitudinal plan.

So, what we are recommending is the addition, as you can see here, of a care plan data class and related care plan data elements for inclusion in USCDI v.5. We believe that this structure is needed because the assessment and plan of treatment does not contain the requisite components of a care plan that would be needed for that shared, dynamic, longitudinal plan. And so, we are proposing that the Level 2 care plan be elevated, again, to USCDI v.5, Most of the data elements, as we have mentioned, are already part of USCDI, but we have highlighted here the two that are not currently part of USCDI, but have some of the what the key parts of them are. So, as was mentioned, the care plan information data element has information about a person or a care team, and that is already part of USCDI, and the outcomes and evaluation data element is really about observations about progress towards a goal, and is often, in fact, a reassessment of a person's goals, and so, part of that, again, is already part of the existing USCDI framework. Next slide.

And so, what we want to just illustrate here is that a lot of the care plan components, again, are already existing in USCDI, such as health concerns, goals, problems, procedures, assessments such as functional status and cognitive status, and others. Next slide. Here, we are just highlighting, again, that there are existing code systems and value sets in LOINC, SNOMED, ICD-10, as well as CPT and HCPCS that, again, represent these concepts in care plan. Next slide. Again, I want to highlight that there are existing and available FHIR implementation guides for care plan to include the multiple chronic condition e-care plan, the pharmacist care plan, the ELTSS implementation guide, which is focused on the service plan, and the advance directive interoperability implementation guide. Next slide.

Just to specifically walk through how our recommendation relates to prior recommendations, what we are proposing specifically is the repurposing of the existing patient summary and plan data class to be a new care plan data class, so this would be similar in structure to how medications are currently available today in USCDI, and would include the care plan data elements as listed here, as we have described. The rationale for this is that today, patient summary is already included in clinical notes. In addition, the US CORE care plan implementation guide already requires the inclusion of the narrative summary. In addition, as mentioned, the assessment and plan of treatment does not contain the structure of components that would be needed for care plan as we envision for coordination with the care team, including the patient and caregivers, so we are recommending replacing the assessment and plan of treatment data element with the proposed list of data elements. Next slide, please.

Here, we are proposing, again, a definition for care plan, so, as Jenna had mentioned previously, the definition that we are proposing is this notion of a shared, dynamic, longitudinal care plan that represents all care team members, prioritizing concerns, goals, and interventions, as well as the evaluation of the outcomes across all health and social service settings. This would enable a person to have access to health data as well as putting a person's goals at the center of the decision making. It would include information such as clinical and social supports information, it would be longitudinal, so it would persist across acute episodes of care as well as periods of health maintenance, and importantly, it would facilitate care team coordination so that care team members could receive information that would be relevant to their role, as well as have information available to them about other interventions, for example, that would be going on across the interdisciplinary team. In terms of usage notes, again, we have identified the need for goals, the assessments, health concerns, interventions, outcomes, and evaluations, and a few examples would include that multiple chronic condition care plan, as well as the service plan. Next slide, please.

Finally, we are proposing a revision to the health status assessments definition, and this would be to incorporate that concept of outcomes in evaluation, so what we are proposing is this addition of the clause at the end to include progress towards goals, and this is because we believe that evaluating progress towards goals is a key step in the care planning process, and to determine if a goal has been fulfilled. Again, this is often through reassessment. Finally, we just want to note that we believe these care plan data elements and components are the bare minimum to represent the concept of a care plan, but we believe that care planning will evolve over time to include additional value sets and domains. With that, I am going to turn it back over to the workgroup for discussion.

Sarah DeSilvey
Thank you so much. I have a host of questions and comments in the chat. We have until 10:40, so, hopefully, we can have folks who have said things in the chat and voice raise their hand, starting with Hannah.

Hannah Galvin
Great, thanks. Thanks for this excellent work. I think this is really vital work to push us forward to have more comprehensive and collaborative discussions as a care team. I put some of my thoughts in the chat. As I think you know, we are not there operationally and as an industry yet, and I think part of these discussions focuses around data elements, interoperability, and how we share data, but a lot of the discussion does focus as well around how we bring the team's management to a paradigm shift of how we speak around care plans in a clinical setting and move from these siloed care plans, such as a reimbursing care plan, a pharmacy care plan, and a behavioral health plan, to a more collaborative care plan, and I guess I wonder a little bit more about how those other conversations are happening across the ecosystem in order to support this comprehensive care plan model in addition to what we are doing on the technical side with USCDI to also support that framework because I think both need to happen in order for this to move forward and to look at that future state.

Sarah DeSilvey
Thank you so much. There are probably ways that the IS WG team could respond to that, but I do want to make sure we are rolling through some of the questions. Katrina?

Katrina Miller Parrish

All right. So, I am going to echo Hannah, first to say thank you for this comprehensive work and explanation. I have two quick questions. First, on the idea of converting the patient summary and plan data class to care plan, I want to make sure I understand this correctly. So, the idea is that the one data element within that class, assessment and plan of treatment, would now be sort of subsumed under the note class, and then, care plan would sort of become that data class place in the sense that we exchange one for one. So, I want to make sure I am understanding that correctly, and then, also echoing Hannah, what I fear operationally is how this care plan would be curated.

I love this idea. As a family physician who has worked with multidisciplinary care plans, they balloon very quickly, so I am wondering if there is any operational guidance as to how, again, these could be curated, who is allowed to close out any items, if that is possible, who would be deduplicating items that look very similar, but are not exactly the same, and anything in that direction. If there is guidance, I am not sure I am aware of it. Thank you.

Sarah DeSilvey
I hear a couple different questions there who are echoing Hannah's operational statements, and of course, as a nurse to inpatient care plans for many, many years, I have questions about that as well, but I want to make sure we answer the primary question, which is on the envisioned direction for the renaming of the class, because it is important that we understand that before we have further conversation. I switched quickly to comments and I forgot to publicly thank the amazing SMEs again, but can one of them help us understand, again, the vision for the class and what would happen to the existing elements under the assessment and patient summary plan class?

Evelyn Gallego
I can start, and then maybe others can jump in. So, we envision, again, the repurposing of that existing data class to the care plan, and we would be replacing the assessment and plan of treatment with these care plan data elements, and that would be because the current structure today is not sufficient to support that broader vision of that interdisciplinary, dynamic, shared care plan. I will open it up to others on the team to elaborate as well.

Arlene Bierman
Evelyn, I just want to say quickly that this is happening in parallel with a lot of work to move in the direction of person-centered care and person-centered care planning, and AHRQ has a number of related initiatives working with health systems, practices, and clinicians to try to make this possible in practice, but currently, the IT standards are actually a barrier because the information is so scattered and it is such a burden to try to put it all together.

Evelyn Gallego
I know we are learning a lot, so you have the specification of how you structure this data for collecting it, but what I am hearing is that it has to go hand in hand. What is the workflow for this, right? Part of it is how we can create a baseline or structure, just some sort of container to support that workflow, but knowing that, as Arlene mentioned, there is so much work going on at AHRQ to define how we can use technology to advance person-centered care and support whole-person care, but how we can also start, as we have information, technology, and policy that supports structured formats for representing this data. We need to start there first and then figure out how we can streamline the workflow and how we can support individuals.

One thing we did not emphasize, but which I think is really important to know, is that, thinking of multiple chronic conditions, the standards as defined right now are meant not only to support those that have chronic conditions, but those that are at risk for chronic conditions. This is really important, and that is why the dynamic, longitudinal, shared aspect is critical, because we are having populations that, more and more, are at risk for these conditions, and of course, we want to be able to also incorporate their social risk and social needs. I will stop talking, but I wanted to highlight that piece.

Sarah DeSilvey
I am going to go to Hans, and then Shelly, and then I have a question of my own. I am going to raise my hand. Hans?

Hans Buitendijk
Thank you, Sarah, and thank you for the presentation. It was very helpful, and overall, I definitely support the need to get more clarity around care plans and different types of plans that are there. Therefore, the question from me is not as much about the importance of it, but how we represent it best in USCDI because the USCDI has a couple of goals, among others, likely, but there are two that stand out from our perspective. How does it set us up to better understand what kind of interoperability standards we need to support that and how can we scope that out for Step 1, 2, and 3? Those steps are typically along the lines of how we move from an unstructured narrative to one that is more structured and get the capabilities in there. Looking at that, I would support very much that in the care plan, we can get that clarity, and using a plan at that point in time as a data element always gets a little bit uncomfortable because that seems very small, and we have so much more to express.

So, with the balancing act of changing a current class to be more specific around care plan come other elements that are now ready to be structured components of the care plan, in this case, that we can reference and still leave where they are because they still have relevance on their own. Orders have relevance on their own, goals have relevance on their own, etc. I think part of the suggestion should be that as we do that, we also recognize that it is good to reference data from multiple places. So, I can have an order on its own in USCDI, but certain orders are relevant in the context of a plan. You would have facility information that is relevant in a number of places. Reference where it is relevant.

So, I would encourage having clarity in the discussion around that, and I am curious how you are looking at that. Care plan as a data class and data element then starts to sound contradictory through that. We already have it in a couple places. We have orders and we have orders, we have procedures and we have procedures, etc., and it does not really make it clear what the intent is. So, from that perspective with the terminology, how can we make that more clear so we do not get these redundant notions that it is a care plan as a class and as a data element. I do not know what that means. I then have a hard time translating it. I am looking at the care plan work done in FHIR, C-CDA, etc., and I find a lot more clarity there as to what it means, what the references are, and what is intended. I have a hard time seeing how we make it clear in USCDI so we do not have scope confusion and ambiguity of what we mean.

Sarah DeSilvey
Thank you. As a facilitator, I want to find commonality between this conversation and the one that we just had last week with advance directives. We had a very similar conversation on the possible need for a

grouping data class, a similar conversation and a differentiation between what would be those modular components of that data class that can be referenced across other data classes and a conversation regarding the need for a specific document type that can be shared that would possibly be structured in time. I am just echoing the fact that very similar things were raised in the last meeting. Again, this is my facilitator comment. My raised-hand comment is going to happen after Shelly's, but I want to make sure all IS WG folks are hearing that because this is the second time we have heard very similar things on the need to create a structure for a class within USCDI that could help implementers. Shelly?

Shelly Spiro
Thank you, and I want to thank Arlene, Evelyn, Liz, and Jenna. Great presentation, really very clarifying, especially for this group. As many of you know, we have a pharmacist electronic care plan, which has been around for quite a long time and is highly adopted in the independent community pharmacy setting, and I was very excited to be part of the MCC e-care plan, especially as part of the technical expert panel as we went through these processes. I have to agree with Hans in the sense that it is very difficult for us to look at USCDI because, for example, for care planning and what we saw with the pharmacist care plan, you have many different components that are data elements in other classes within USCDI. We run into the same problem with medications. There are probably more components of medications, such as allergy and tolerance, although that is its own class.

So, having multiple data elements in different classes makes a lot of sense to me if they are referenced because looking at it, especially as a programmer, it would make a lot more sense if we could identify those data elements under the data class of that concept, and it fits nicely into how we actually structured it within FHIR. So, I am 100% on adding this as a data class, and the whole team has done a great job of explaining what data elements should go under the care plan data class. We see this with social determinants of health, we see this with other aspects where these data elements are components of other data classes, and it becomes very confusing if you set it off to itself. So, I am all about restructuring the way we are doing USCDI to reference other data elements within a data class.

Sarah DeSilvey
We only have a few more minutes before we go to public comments. I am now just going to raise the question that I had as a member of IS WG. I just wanted to lean into what Hannah and Katrina were mentioning regarding operational readiness. I am just trying to understand more deeply whether we are talking about longitudinal care plans specifically or episodic care plans because their purposes are quite different, and just from my experience as a family practice nurse practitioner who also worked in pediatrics for a long period of time, the longitudinal care plan that I shared with an outpatient care team and specialty on my high-risk pediatric patients was very different than the inpatient care plan I had to drive my patient successfully to discharge in a patient-centered way, and I just want to understand a little bit more how the SMEs were conceptualizing that difference because I, Sarah DeSilvey, had a very different understanding and very different components across those two care plans for the very same patient because one was longitudinal and one was episodic with an intent to DC.

Arlene Bierman
Sarah, if you want an answer, I can answer that. That is a perfect question. I think it is a both/and. As someone who has practiced both in the acute and primary care settings, the idea is that the data elements that you need are still the same. It is how you organize them, frame them, and prioritize them, and I think it

will help in both settings. Right now, if your goal is to improve diabetes control, you want to track the hemoglobin A1C and make sure you are getting to that goal and tracking the social factors that interfere with that, so it is a way of putting everything in the same place, and it is the same thing when you are in the hospital, but it is just shorter-term. I think the way we have it structured can do both, and there is actually a group at the Brigham who is using our care plan in acute care settings to identify people at high risk and to improve the transition back to the community. So, I do not see them as mutually exclusive, even though they are very different.

Liz Palena-Hall
I agree, and from a patient-centered perspective, I think it is a little bit of a false dichotomy because even though, as clinicians, you might think about those as separate things, as the patient, they are thinking about what happened to them in the hospital as part of their overall care, and that continues. That is still relevant, to a degree, as they transition back to ambulatory care. The way I like to think of care plan is a data set where you can pull up the pieces of information that are relevant to the viewpoint of the person looking at the care plan and/or the context of the situation that is going on, so you might not pull up the exact same pieces of data in those two different settings, but those pieces of data still should be there and available for when they are relevant and needed, if that makes sense.

Arlene Bierman
I know we are short on time, so I will talk fast, but we are actually piloting the e-care plan right now as a SMART on FHIR app at OHSU, and it gets at that exactly. The nephrologist and the cardiologist might have specific goals, and they can see what they want to see, but then the primary care person has it all, and they can see if the cardiologist and the nephrologist are saying different things and why the patient is confused. So, just having the capacity to have the structured data is really key.

Sarah DeSilvey
That makes a lot of sense. We are at time, and we have to keep on going with our agenda, but Anna, I would love for you to bring in the patient perspective here, as you do.

Anna McCollister
Thanks, Sarah. What I am trying to get my head around, again, just using my own personal experience going through Type 1 diabetes, all the microvascular complications, eye disease, nerve disease, and kidney disease, I just had a super-mild case of COVID, but I have been fighting off early symptoms of long COVID, so I have been going to the doctor a lot, and I have two doctor's appointments this afternoon, and when I go to the doctor, I do not understand which part of all of that the doctor does not need to see. Does the nephrologist need to see that I recently had COVID? I kind of think he does, because it is resulting in what looks like systemic inflammation. So, why would that be irrelevant?

It seems to me like all of this data needs to be available to all of the physicians if they are actually going to think about my care and my needs comprehensively because if there was an infection, albeit a remarkably mild one that may be resulting in some sort of sustained systemic inflammation that is causing a cluster of weird events, that is relevant to all of my physicians. I am sufficiently aware enough to know the people who named long COVID long COVID, I know the person who is doing a lot of the clinical trials, so I can bring this to the table for my clinicians. Not everybody could, so why does that need to be grouped in some way other than all of it being available to all of the clinicians all of the time?

Jenna Norton
Anna, I think that is exactly what this standard is trying to accomplish. All of the data are there, and available, and accessible to the clinicians. I think the challenge is getting the data that is most relevant because if you literally had all of your data there, it would be 56 pages, and it would become useless because no person can process that much, and so, I think what the care plan standard enables us to do is bring up the information that is most relevant for that particular context and time. Yes, it is incredibly important. I am NIDDK, so I do kidney a lot. It is important for your nephrologist to know that you have had a recent COVID infection, but it might not be important for him to know that you broke your ankle six years ago, right? And so, there does need to be some surfacing and prioritizing of data.

Anna McCollister
I guess my concern is who decides what is appropriate. Maybe if I were seeing a gastroenterologist and I had been taking proton pump inhibitors, it might be relevant that I broke my ankle six years ago because it causes bone issues. Whoever is deciding the data class may or may not be aware of that connection, and there may be subsequent discoveries where there could be a connection. So, that is my concern, that we, or members of HITAC, or ONC, or whomever, are deciding in advance what are the potential variables that could be relevant to a particular physician based off of their specialty.

Jenna Norton
None of that is built into the standard, none of that is predetermined, so I think the answer is that you and your clinicians, as part of a care team, are able to surface data as needed through a shared decision-making process where you are at the table, but if we do not have the data standardized in any way, then it is almost impossible to even do that because you cannot find the data. You cannot get the data. It is all scattered. And so, I think this actually makes it easier to do what you want, rather than harder.

Jim Jirjis
We have a couple hands up to comment on this, if that is okay.

Sarah DeSilvey
Yes.

Jim Jirjis
Hi, it is Jim Jirjis. Having been CMIO and CHO for quite a while, the difference between the data, how we are capturing it comprehensively, and our terminology's content so we can use it is different than what I think you are talking about, Anna, and that is how we display it in the workflow. And so, yes, we cannot predict what any particular doctor is going to find relevant, so they need access to go digging through the chart with ease to find those needles in haystacks, if you will. However, the balance between signal and noise is a UI thing. As long as the data itself lends itself to us being able to classify the terminology and content, then that is really a UI problem. How can I show the cardiologist what they are likely to want to see 80% or 90% of the time in a nice screen, but then easily have them go hunt and click for other things throughout the entire record? My point is that is more of a display problem and a UI problem.

Anna McCollister
So then, who decides that? The vendor? Because that is kind of an important thing.

Jim Jirjis
It is already happening. By the way, it will never be done perfectly, so it should be decided by the specialties themselves with some ability to customize, but the challenge has always been the more we try to make it specialty-specific, the more we might miss something in the display that the doctor did not know to go look at, but the more we include, the more useless the EHR is, and the complaint is that it is like finding a needle in a haystack. So, I think there are lots of different efforts to be inclusive of specialties, to try to fine-tune the specialty-specific views, and that is an ongoing thing that will never be perfect, but what we are trying to balance is the unusability of every dermatologist seeing every heart cath configuration versus every dermatologist only seeing derm stuff when it turns out it would have been useful if they knew the patient had kidney disease. That is always going to be an ongoing, iterative thing.

Sarah DeSilvey
I am sorry to be the timekeeper, but just for the sake of time, I am wondering if, given that we do have a fairly robust agenda, usually, what it takes for IS WG to come for a final recommendation is a SME presentation, reflection, initial statements, and then moving forward. First of all, I again want to thank our subject matter experts for coming to present. You feel robust support for your work and for the critical nature of representing care plans and data elements significantly, and even consideration for data class. This echoes what IS WG has said in past years, so, hopefully, we are elevating this and moving it forward. We do need to shift to make sure we are addressing and revisiting some of the concepts we have addressed in prior IS WG meetings, and we are not in session next week for HIMSS, so if we can thank our subject matter experts and keep on talking about the elements, that would be great.

Again, just to summarize, I hear robust support for trying to include care plan so far, and then there is the conversation of whether we are considering it as a data element as suggested in USCDI v.5 or the renaming of the data class. Again, that is a longer discussion akin to the conversation we had last week on advance directive, so maybe if we go to the shared drive, we can keep on having the conversation as an IS WG. Does that sound good, friends? Thank you so much for coming, Arlene, Jenna, Liz, and Evelyn. Thank you so much.

Mark Savage
Thank you.

Other Draft USCDI v5 Data Elements Recommendations & Level 2 Data Elements Recommendations (00:48:51)

Sarah DeSilvey
All right. Now, let's go to the next slide, where we can have a level-set on where we are. We really do need to move our draft recommendations to some kind of final status that we can submit in our transmittal letter. We are hoping to have some of the conversation and the workgroup discussion that has happened in the workgroup discussion column move to a draft final recommendation in the final recommendation column on the spreadsheet. We will see that in a second. So, for anyone who has volunteered to do that, let us know. I do see some ongoing conversation on the emergency department note and the operative note, so I really want to make sure we go back into those elements and see what we need to do to get to a final recommendation that satisfies all parties on that.

Thanks to all of you who have leaned into creating those final recommendation statements. Again, we are a month away from submitting our final transmittal letter, so we really need to make sure we are on those, and we are very grateful to all of you for taking leadership on this. We have some conversation to have before we move to a final recommendation on some of those, specifically on the data class versus data element area. Next slide.

We do hope to get to Draft USCDI v.5 author and author role, which we have not addressed yet today, so that is partly why I felt we needed to keep on time. Everything else is in process, and as soon as we get a sufficient final recommendation that we are comfortable with, we can turn that item green. Again, I know there is a lot of work to do, but we are hoping we can get to those final recommendation drafts shortly. Next slide. Al, if you could take us to the Google spreadsheet so that we can start moving through and reflecting on the prior elements, that would be wonderful.

All right, we are going to start right here. Al, thank you. That was probably by design. There are two parts of our charge of reviewing Draft USCDI v.5 elements and suggesting new Level 2 elements. These are the final Draft USCDI v.5 elements that we needed to address, and so, I am hoping we can walk through these two before so that we can make sure we at least have a good plan on how to address them. So, this is the author and author role, and there is a fair bit of conversation on justification and workgroup discussion, but if we could lean into these right now, that would be appreciated, just to make sure we are doing our due diligence. Mark?

Mark Savage
I just wanted to add that I did put in basic recommendations to try to help facilitate for the workgroup to move forward. There was a question from ONC there for both of the data elements, and in order to try to answer that, I did have a phone call late yesterday, which I have not had a chance to put in yet, but the answer is that there is considerable implementation across the ecosystem, and I will put that detail in. I just did not get a chance to put it in yet, so I will do that later today.

Sarah DeSilvey
Thank you so much. I do want to note that the author element comes up frequently in all of our discussion on other data elements, and I am grateful to you for leading this and many of the elements we have been working on so far. Are there any other comments or thoughts on author and author role from the workgroup? Joel?

Joel Andress
Hello, how are all of you today? Thanks. I just wanted to say that in addition to voicing our support at CMS for the inclusion of these data elements in Version 5, we wanted to put forward a recommendation that we include specific LOINC codes as examples of the standards that exist for author and author role. These include 27602-2, the occupational therapy treatment plan author of treatment plan set, and the 27665-9, which is the physical therapy treatment plan author of treatment plan set. We also are suggesting LOINC codes for pulmonary therapy treatment plan, speech therapy treatment plan, and medical social services therapy treatment plan to provide these as examples for the standards that would be associated with the new data elements.

Sarah DeSilvey
Thank you, Joel. Any thoughts on the addition from CMS on the representative example LOINC standards for this data element?

Hans Buitendijk
This is Hans. I have a reaction and question about that. Are those codes meant to be the actual roles, the types of author that they are? The way that I am thinking with how some of those have been represented, I do not believe LOINC codes are generally used in provenance, so I am trying to figure out the relationship between LOINC and that, if you can help out a little bit with that.

Joel Andress
The purpose of the recommendation is to provide examples for what kinds of codes can go into the structured field to identify what the authorship is and what the authorship is being associated with. As we talked about before, you have a number of data elements where we are interested in understanding who the author is for the purpose of being able to support care coordination and transitioning. The purpose of recommending the LOINC codes is for us to be able to tie the author to particular pieces of information within the EHR so that when the information is surfaced by the viewing entity, they are going to be able to tie a particular portion of, in these examples of treatment plans, the providers or other authors who were the source of the information, and therefore better facilitate the coordination. So, as an example between the set, if you have different people offering treatment plans for speech therapy or for medical social services therapy, then we want to be sure you are able to contact the right author in order to engage in that coordination rather than having to search out the information independently.

Hans Buitendijk
I completely agree with the intent. I am concerned that we are getting too tight on specifying LOINC. With the way that the interoperability standards are currently expressing that, we need to figure out how both of those align. So, having come to consider the appropriateness and the use of LOINC to achieve the same objective, on which I have no disagreement, but how that fits in. At this point in time, LOINC does not seem to be used yet in that area particularly.

Joel Andress
From our perspective, we would certainly be willing to entertain alternatives. As long as the goal is achieved, then whether it is accomplished specifically with LOINC or another set of standards, we are not terribly married to the…

Hans Buitendijk
I completely understand and agree with the intent. Sarah, I had one other comment, if I may.

Sarah DeSilvey
Yes.

Hans Buitendijk
When we talk about author and author roles, in a lot of the conversations, I think we always need to be careful what that means when used in USCDI. What does that imply, given that, at this point in time, most of it where USCDI is used is for accessing data and the standards that are being used for querying and

accessing data, not necessarily the documentation of the data? In a couple of other places where we have indicated, even though the author may be a patient, as an example, that does not immediately imply that the patient, by way of this, is in scope of being able to use the standards that support USCDI to contribute data directly to the EHR and how that fits in. So, I think we always have to be a little bit cautious in the way that is going to be phrased so that the scope does not go into an area that we did not intend. At this point in time, there are areas where that is already appropriate to do. We do not want to preclude it, but at the same point in time, we want to be careful that it does not imply that the patient's authored data goes directly into the EHR itself, given the current state of the ability to do that using FHIR or the like standards.

Sarah DeSilvey
That seems like a good statement to include in a robust recommendation. I asked about where we are standing with these two elements we have here, author and author role. Katrina has a good question as well, and Mark has a statement. I just want to make sure of what I am sensing. Often with IS WG, we have general approval, but we have refinement, just as CMS did with possible LOINC data elements. Can we have further discussion on the inclusion of these two elements in Draft USCDI v.5? Mark, do you have thoughts?

Mark Savage
I do. I also have to click on the unmute button. Just picking up on Hans's last point, I wanted to throw out more of a question. The definition of author is fairly broad. It says, "The actor that participated in the creation or revision of data," so it seems like that… I am wondering if we need to have more granularity in that. When we look at author role, "Category of the actor that participated in the creation or revision of data, examples include but are not limited to provider, patient, family member, and device," those have struck me so far as being general and useful for shaping a data element that is useful in a variety of different situations. I am wondering if people continue to think that it is good to stay broad or whether we need to be getting more detailed.

Sarah DeSilvey
Any other thoughts from the IS WG building on this? Keith?

Keith Campbell
Well, I wanted to also build on Hans's comment, but I want to brief because I think it is off the specific goal of whether we add something here. I think there needs to be a broader discussion about how we choose which coding systems are appropriate. There seem to be a few go-tos that are not necessarily the best choices, and I think maybe as a group, we can try to develop criteria on how we would decide about new data elements, and there are issues of whether they have funding to do this, is it a proprietary license, is it going to enhance interoperability or actually create new barriers to interoperability because you are going to proprietary codes, and similar things. I just wanted to register that and put it as a possible activity later in the year.

Sarah DeSilvey
Keith, that is a good statement. I saw your comment on different standards to represent the elements in question. That is a big-picture question. Katrina?

Katrina Miller Parrish

Just to clarify, I think it is very important for this element to be very clear that there is a way that this actor is confirmed in the sense that I hope it is not the kind of field where somebody could enter in somebody else's name, and if it is, then to me, it is a very different consideration of what it is, how it is used, and how we title it, so I would not want that to be titled "author," but something different, so I just want to make it clear that I think it is important to know whether, again, it is a login/password/credential-confirmed actor as opposed to somebody being able to enter in someone else's name, possibly incorrectly. There are a lot of issues there.

Sarah DeSilvey
Katrina, I do see Al responding a little bit to that statement in the chat. Steven?

Steven Lane
I just want to remind everybody that we have been asking for this for years, and there is so much nuance, subtlety, and potential implementation guidance, but if we do not move it forward, none of that will matter. In response to Mark's earlier question, I think going with the way ONC proposed to define this, "including but not limited to," makes perfect sense. These things can be updated over time, so I hope that we do not get stuck in analysis paralysis and let the perfect be the enemy of moving this forward.

Sarah DeSilvey
Any objections to Steven's recommendation that we accept the statement, with Mark's context that he got late last night, that we accept and validate the Draft v.5 recommendation for these two elements?

Mark Savage
Second.

Sarah DeSilvey
Understanding nuance can be in the recommendation. I am hearing the capacity to represent nuance in the recommendation. Are there any other concerns with moving forward as written, as Steven recommended?

Steven Eichner
We can certainly make a recommendation that ONC consider things in the future, but we should not necessarily say we are not moving this forward without this option being integrated now.

Sarah DeSilvey
I hear us saying that as well, and if that is the case, and I am not hearing any objections, I am going to ask someone to take charge on writing the final recommendation.

Mark Savage
Sarah, there is one there already.

Sarah DeSilvey
Mark, I know. Thanks for all the recommendations you are writing.

Mark Savage

But it is along the lines of what we are talking about right now, to do it as ONC defined it, and the one thing I have not added in another column is the factual detail implementation.

Steven Eichner
I have one clarification. It looked like it said "include provenance in USCDI v.4." Do we mean v.5?

Sarah DeSilvey
Oh. We can go back.

Al Taylor
Sorry, Ike. Are you referring to a column in the spreadsheet? I did not catch which one.

Steven Eichner
Go to the right one column, I believe. Sorry, you jumped too far.

Mark Savage
That was merely repeating. I just put in there what we had proposed last year because it contained some detail that showed how important this is, to Steven's point.

Steven Eichner
I just saw it in passing and wanted to make sure that, as we were looking at implementing the recommendation, we were saying the right version. That is all.

Sarah DeSilvey
Eagle-eyed. Thank you, Ike. So, building off the recommendation we have said in the past, IS WG is grateful for the fact that this is included in Draft USCDI v.5. Mark, thank you for taking the lead on drafting and adding additional context. I am going to try to revisit a few v.5 elements before we go to Level 2 today. We do not have a ton of time before we go to public comment. I want to just note that we are very close in agreement, with not a ton of refinement, on a lot of the Draft USCDI v.5 elements. The areas I see that need to be worked on a little bit are, again, the emergency room notes and the operative notes, and I want to make sure that we understand the path to addressing advance directive as a suggested data element and orders as a suggested data element in light of the conversation we had last week with our subject matter experts, so I am, again, trying to get us to the point where we can get our draft recommendations.

Do we need any off-IS WG conversation or separate conversation in order to get to the point of a final recommendation on the two clinical note elements at the top there, the emergency department note and the operative note? It looks like there was an initial draft recommendation by Ricky, and then some conversation back and forth. I just want to make sure that we are getting close to the final recommendation there. Ricky, Hans, and Katrina, are we okay to get to a draft recommendation, or do we need further conversation on that?

Ricky Bloomfield
This I Ricky. I think we are pretty close there. I just had one last question that perhaps Hans and I should discuss offline regarding the LOINC code, but I think we are pretty close. Maybe we can close that out this

week, or at least have a formal recommendation this week. Hans, I do not know what your thoughts are about that.

Hans Buitendijk
I think it is probably just a question of if it is an example or a recommendation. As an example, I think there is more flexibility to address some of the concerns.

Ricky Bloomfield
Yes, I think it is fine as an example. So, why don't I take a pass at updating that, and then I will run it by Hans? We can do that offline.

Sarah DeSilvey
Fantastic. Thank you so much. I am just going to run down the list. Shelly, on lot number, I believe you were drafting an initial recommendation that we have in the workgroup discussion. Are we ready to move that to the final recommendation?

Shelly Spiro
Yes.

Sarah DeSilvey
All right. So, we will try to transfer that over again. Now that we have had time for asynchronous discussion, the hope is to move those final recommendation drafts into that final recommendation column so they can be separate and outside of the back-and-forth. Now that we have a little bit of time, I really want to center on a way to dispose of our disposition for advance directives and orders. They were combined in the presentation that we had last week, and Al, I am sorry, I am having you run all over because I am trying to focus on things of highest need to try to get to our final recommendation.

So, we had advance directives observation as suggested in Draft USCDI v.5, orders as suggested in Draft USCDI v.5, and then we had the very visionary presentation from Maria last week on talking about the addition of a possible coalescing data class, again, not dissimilar to what we were just hearing from the care plan subject matter experts. What are our thoughts on advance directive observation and orders data elements and how to integrate the thoughts that Maria had on the separate data class? We do need to move forward with some final recommendations on these two elements in order to complete our charge. How are we feeling on these? Again, we heard general agreement of trying to figure out whether we were ready to suggest new data classes or wanting to recommend them as they stood. We also heard about the renaming of the orders element. Hans?

Hans Buitendijk
Scroll to the right just a little bit more. Mark, Shelly, Ricky, and I were working on something. It is a little bit further to the right because we wanted to still keep it in draft mode. Keep on going. Yes, that one. We put something together, and we discussed this further yesterday. We are very close. Based on the discussion, we believe one part that is going to come up with orders is around do not resuscitate and other orders that would relate to pulse that we are not totally clear on yet, so I am looking at Mark, Ricky, and Shelly on whether we are ready for this, we are very close, or we want to hold on for just a moment with the orders discussion.

Ricky Bloomfield
Hans, I think we might be ready on the orders discussion, to your particular question.

Shelly Spiro
I agree.

Sarah DeSilvey
Again, help me understand what "ready on the orders discussion" means. I might have missed that part. Steven Lane, do you have any thoughts?

Steven Lane
I am still a little confused, and I admit I have not been involved in the small group process, so thank you to all of you who are doing that, but are we talking about orders generally and making that a data element that will be potentially included in USCDI v.5 or orders specific to advance directive? Because we really have not had a general discussion of portable orders, pending orders, standing orders, etc., and as I have said before, while I fully support adding those to USCDI, I do not think that they should come in simply as a component of advance directives.

Hans Buitendijk
I believe that is where we were discussing as well, that until we have that clearer, there was an element of discussion on whether that should or should not be part of ADI or whether it should be related to it because they might point back to ADI. That is what we were filling in during the small discussion. That aspect is not totally clear, so we are not sure whether we can make any recommendations in the context of ADI around that. That is why, in that cell where you are looking, which is not displaying everything right now, but is a little bit further toward the bottom, it says "draft." That is the part that we are not clear about. The rest is close to being finally baked.

Sarah DeSilvey
So, it sounds like we need to back up a little bit on a few counts and maybe discuss orders more comprehensively. They were presented together, but it makes sense what you are saying, Steven, and I also hear the progress that the small group is making. Joel, I think you want to make a comment from CMS on the elements themselves.

Joel Andress
Yes, just quickly. Aside from our general support for Maria's vision about the advance directives, one of the things that we encountered during internal discussions about orders was that there was still some confusion among our subject matter experts about whether or not the orders as currently defined simply requires a list of orders that exists within the record or if they also include the details of each order. Of course, our preference is that the order is provided and also that the details of those orders are a part of the record that is captured under the data element, and that has bene our understanding of it to date, and is certainly our preference. Given that there is some confusion with regard to how different SMEs are reading this, I think there is a risk that if we do not clarify it, then we are going to potentially have confusion about the implementation of this post-publication as well, so I think that is something to take into account when we publish the final recommendations.

Sarah DeSilvey
Thank you, Joel. Again, I am hearing some consensus that we need to revisit orders outside the specific advance directive application and consider some of the nuances there. Steven?

Steven Lane
I just want to say that I would not hold up orders related to advance directives for the sake of clarifying everything that needs to be clarified about portable orders as a separate data class. Also, just in response to the CMS question, in my mind as a primary care physician, the point of having portable orders is that they are portable, that people can shop around and take their order wherever they want to have it completed. So, in that view, it would certainly include all the details. If I were sending it to the lab downstairs, across the street, or across the country, it should include all the detail necessary for completion.

Steven Eichner
Just to interject out of turn, I would support Steven in that position. Maybe we want to include something in our recommendation something along those lines, not necessarily specifying what format, but just the general comment that there is an expectation that the order does include sufficient detail for implementation that might be attached in something like a blob or something else, but without specifying a particular format or a particular subset of elements.

Sarah DeSilvey
Any other thoughts on where we stand, again, on advance directives and orders? If the people who are working on the draft information can give us a sense of where they stand or if we need to revisit the orders data class as authored by ONC in the Draft USCDI v.5, we can do that as well.

Shelly Spiro
I just want to say that on the PMO, which is used mainly for transitions of care as we are moving from one place to the other, these portable medical orders are important, but the components of the portable medical orders fit with advance directives, and this is where I go back and say it probably would fit well into orders, but we are probably going to lose those portable medical orders that are a component of an advance directive like a living will, DNR, or some of those others that the patient has inputted their information in that leads to an order that a clinician would act upon. That is where I struggle with it, because I still believe that portable medical orders belong under advance directives, but they also belong under orders, and that is where we get back to referencing these different data elements within a data class.

Sarah DeSilvey
Hans?

Hans Buitendijk
I have two notes on that. I can see that we let that progress on its own, and then, within orders, as we define the specific category of pulse DNR, they have a characteristic, seemingly from the discussion, that they would or may need to reference the ADI that caused that pulse or DNR order to be put in place, so I think there is clearly a relationship based on the way I understand the discussion, but it remains an order. It is seemingly not the ADI in itself. That can still be addressed as we move forward with that on how we more specifically identify pulse DNR orders. If that is the case, if we want to put that on a subsequent discussion,

looking again at Mark, Micky, and Shelly, I believe that the rest of the draft that we have would then be ready for the workgroup to review whether that can be adopted with some tweaking as a final recommendation.

Sarah DeSilvey
And just for reference, under the advance directive data element, you have drafted a draft recommendation in Column U.

Hans Buitendijk
In Column U that we can move over. We can move it over, except for the notes that we have on pulse, because they would then be addressed separately with whatever we come up with.

Sarah DeSilvey
Any other thoughts? Do we need to level-set on what the original Draft USCDI v.5 recommendation for orders was, if we can go there, or are we good to make a brief touchdown into Level 2 elements? Again, this was the inclusive orders recommendation. I just wanted to make sure we are aware of this, which was, again, broadly inclusive, and Steven Lane has mentioned this, and Joel was talking about this as well. And then, there was a refinement and specification on this that was presented in Maria Moen's presentation last week in line with advance directives and specific document and order types, correct? Any other concerns on orders as represented in this data element request before we move on?

Steven Lane
Just to restate what I have said before, which is that this is pretty darn good, and moving this forward would be very valuable for the industry, and we can work out and refine the details in the future versions as needed.

Sarah DeSilvey
I hear that statement. So, this is a broad request for orders in general. I want to make sure we are just touching base on this again from the completeness of our charge in Draft USCDI v.5. Are there any concerns with moving this one forward as written, even as the workgroup that is in charge of advance directives goes deep into some of the specifics of the PMO, as suggested by Maria and her subject matter expertise?

Mark Savage
Sarah, is somebody going to write up something in Column M so that we have clarity? I agree that we should keep on moving forward, but you are asking a specific question about whether we need anything further, and it helps me to know what we have now.

Sarah DeSilvey
Yes. I am trying to make sure I remember specific columns. I was over on Column U.

Mark Savage
Well, we were on orders, so there was nothing in Column U on orders. That is an advance directive.

Sarah DeSilvey

That is true. So, what you are asking for is whether or not we have someone to take charge with something to respond to in… We do not even have anything really clear in Column L, as far as I can tell right now, specifically for the element I suggested. So, is someone willing to take a lead in putting something in as a draft final recommendation for the element as suggested originally by ONC for us to respond to?

Mark Savage
I will drop that in there. There are people wiser than I am.

Sarah DeSilvey
It will give them something to respond to, though.

Mark Savage
I agree with getting this going forward, and I will take care of that.

Sarah DeSilvey
That sounds great, thank you. Again, this represents one of the largest areas we needed to lean back into, and we can circle back around on care plan again. My ask for us all, which should have been at the end of the meeting, would be to ensure that we review everything carefully during our week off so that we can make sure that any concerns we might have are addressed in our final weeks before we complete our transmittal letter. We are just short of public comment, and if we have time, I would like to touch upon one Level 2 element, if we can. Can we go to health literacy? I am going to quickly touch base on a pearl there, and then we can move to public comment on time at 11:25.

I am going to start to talk as the IS WG cochair, but also as the Gravity Project director of terminology. As Mark so wisely stated in the workgroup discussion, health literacy is a domain that Gravity has addressed, and there are associated value sets as defined by subject matter experts for this domain. And so, one of the opportunities we see in order to support implementers in understanding the domains we have addressed within Gravity are for Gravity to submit a comment yearly to ONC in the USCDI process to update the domains that are included in our SDOH assessments, problems, goals, and interventions recommendations and align USCDI data element descriptions with all the domains we have covered.

Again, we can talk more about this when we return, but this would allow implementers to see the domains that are included in those SDOH activities value sets, and each of the elements then transition also into ISA guidance, so when we come back in a little bit, we can lean into health literacy as our first Level 2 data element, but I did want to offer that as an opportunity for clarity on domains that Gravity has addressed, a yearly submission to USCDI v.5 that includes the social risk domains that we have addressed to date to make sure they are up to date for implementer reference. We can talk more about that when we come back, but I will be drafting that recommendation from the Gravity perspective and submitting it shortly. I believe it is time to go to public comment. Thank you for an incredibly robust conversation, and we do have work to do when we have our week off. Seth?

Public Comment (01:26:08)

Seth Pazinski
All right, thanks, Sarah. We are going to move into our public comment period of the meeting, so if you are on Zoom and you would like to make a comment, please use the raise hand function, which is located in

the Zoom toolbar at the bottom of your screen. If you are participating by phone only today, you can press *9 to raise your hand, and once called upon, please press *6 to mute and unmute your line. So, we will give folks a minute to queue up. Okay, seeing no hands raised in the chat and no one on the line, I will turn it back to Sarah and Ike to close us out.

Sarah DeSilvey
Ike, any final thoughts? I think we can go to our next slide. I just want to make sure everyone sees the timeline.

Steven Eichner
We will not be meeting next week because of HIMSS. I think we have made a lot of good progress today, and we will hopefully get this stuff worked all the way through and get some good comments together for our transmittal letter. For those of you that are not going to HIMSS, or even those that are, when you can, do spend some time on the worksheet trying to refine final comments, and we will begin to work on getting those comments transferred from the worksheet into a transmittal letter format.

Sarah DeSilvey
Thank you. Again, I do want to note that having that week off, we do need to make sure we are moving through things. Do not be surprised if I call out final recs when I see you on the floor at HIMSS. We hope to return when we come back and lean into some of those Level 2 elements. Again, all gratefulness to those completing those final recommendations so we can complete our charge on time. Thank you so much, and I believe we are ready to adjourn.

Adjourn (01:28:21)

QUESTIONS AND COMMENTS RECEIVED DURING PUBLIC COMMENT
No comments were received during public comment.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT
Jim Jirjis: Jim JIrjis joined late

Jim Jirjis: there is at least a latin terminology standard that exists for flowers

Anna McCollister: Just letting you know that I am online. Sorry to miss the beginning of the meeting! - Anna

Hans Buitendijk: If Care Plan (and possibly the other two plan types as well), are data elements, how can we evolve more clearly the plan components of interest to move over time from unstructured to structured.

Hannah K. Galvin: In practice, there are nursing-specific care plans, behavioral health care plans, case management care plans. These disciplines have very specific frameworks for their care plans. Are they all incorporated into this comprehensive care plan structure?

Rochelle Prosser: Hanna +1

Maria Moen: It seems as though a construct at a named point in time provides a structured view of Problem, Goal, Planned Interventions, and lastly Completed Interventions. Whether driven by assessment results or

orders, there is an origination of the issue to be addressed by the provider, from which are born the answers to "what are you going to do about it?" and "how will you achieve that goal?". Sorry if this is overly simple.

Evelyn Gallego: Yes we are speaking to a common structure with five critical components to support any type of care plan

Steven Lane: It seems that Care Plan is potentially more a Data Class than Data Element. Perhaps like SDOH, it could be considered a crosscutting class whose component element (also) exist within other Data Classes for purposes of organization.

Shelly Spiro: @Hannah there is also a Pharmacist Care Plan (PeCP) that is highly adopted in the independent community setting and is incorporated into this comprehensive care plan structure.

Grace Cordovano: Agree Steven, with intent to be exchanged bundled.

Hans Buitendijk: Agreed with Steven in principle, but how does it then relate with Patient Summary and Plan? How do we then clarify the components of a plan while recognizing the differences between the three types of plans recognized in the presentation?

Maria Moen: Your language resonates Dr. Lane, "cross-cutting" indeed where the various components are gathered into a sensical plan that is actionable and measurable.

Jenna Norton: @Hannah - yes, the shared care plan is envisioned to incorporate all these care plans. The idea here is that (while these different view points may want to surface different pieces of data) to effectively manage care, all care team members need to be aware of what others on the care team are doing.

Evelyn Gallego: Care Plan as a data class AND data element.

Hannah K. Galvin: I think I wonder more about the paradigm shift and transition from current practice to this comprehensive care plan. I support this because there is a lot of confusion currently as to what we mean by a "care plan" - but wondering how far we are along this operational/industry transition.

Jenna Norton: +1 Evelyn - Care plan as data class and element, akin to the approach for medications.

Maria Moen: I'm interested to learn how a group of data elements is a data element by itself. Not sure I see the vision yet but I'm sure it will be made clear through this discussion.

Grace Cordovano: Great framing Albert!

Hans Buitendijk: @Evelyn - Having a clear "Care Plan" data class is very helpful, but the we should also be able to reference the various components that are part of a plan that are also present in other data classes in USCDI as they have meaning and more detail on their own, yet are also as appropriate included in/referenced by a care plan.

Lorraine Wickiser: +2 Evelyn-Care Plan as data element and data class

Hans Buitendijk: If it is a data element, how would the evolution of the care plan information be documented? Sub-data elements?

Evelyn Gallego: @Hans yes agree. we need to be able to have these data elements connect with each other.

Hans Buitendijk: So we would reference care team, goals, orders, etc. as appropriate as we identify the need and readiness to include those as structured data rather than as part of narrative text. That would be very helpful.

Evelyn Gallego: @Hans this could be designed similar to how we designed the SDOH data classes to evolve as more SDOH domains were available via the Gravity Project. Care Plan can reference various care plan content standards and use cases.

Rochelle Prosser: Evelyn +1

Hans Buitendijk: @Evelyn - Agreed it is clear how it is done and related in FHIR. Trying to figure out how to represent that best in USCDI to increase clarity and reduce ambiguity.

Grace Cordovano: Thank you for that excellent presentation!

Sarah DeSilvey: Yes thank you!!

Rochelle Prosser: This will address the Long Term Care planning that evolve over time and involve all parties of the Care Continuum. Very wonderful presentation.

Mark Savage: Thanks so much, Jenna, Evelyn, and Liz, for putting all of this critical work and recommendations together.

Jenna Norton: @Lee - for the MCC eCare plan IG, we have a model in FHIR to distinguish who expressed a goal - patient, family member/caregiver, clinician, etc

Arlene Bierman: @ Lee Yes that is possible. Our MCC ecareplan can display clinician and patient/caregiver goals on the same screen to foster shared decision making and care planning

Katrina Miller Parrish: Do we have to do away with that class and element? Could this be in addition?

Sarah DeSilvey: Katrina, this is as the USCDIv5 draft suggests it.

Sarah DeSilvey: Al, unless I am wrong!

Katrina Miller Parrish: @Sarah - thanks!

Christina Caraballo: I'm not following the data class AND data element for care plan. What am I missing? I support having a data class for care plan.

Evelyn Gallego: 100% agree @Hans

Ricky Bloomfield: Also agree with the concept of allowing different data elements to populate multiple data classes. We've been discussing that offline related to ADI.

Maria Moen: Is the intent for Care Plan to be an over-arching view of all the pieces and parts, with the pieces and parts also provided for when a need to de-construct the over-arching care plan arises?

Albert Taylor: @Katrina, @Sarah, I'm not following the question.

Arlene Bierman: @Maria, That is what we envision.

Rochelle Prosser: Goals and care plans are not static and need to be represented and expressed across all areas for interoperability is we are to include Patients and their needs within the development and scope of this data sharing objectives. If I were to understand the over arching objective with is to share information using tech... Am I correct on this assumption?

Jenna Norton: I see the care plan CLASS as a way to pull together all the needed info (much of which already is in USCDI) where the care plan ELEMENT is how we get to the "meta data" about the care plan… who is it for (i.e., the patient), what does it cover, who is on the team, when was it last updated, etc, etc)

Katrina Miller Parrish: @Al - confirming that we could ADD Care Plan as a class and we don't have to replace Pt Summary and Plan.

Christina Caraballo: I recommend a "bonus recommendation" for how we represent the evolving data classes that Sarah just mentioned (e.g., SDOH, AD, Care Plans). I am happy to volunteer to lead a subgroup on this is others agree.

Albert Taylor: @Katrina, yes, the recommendation could be either replace or add data classes or data elements.

Katrina Miller Parrish: Great point Sarah!

Shelly Spiro: @Arelene YES!

Maria Moen: Agree Shelley. There seems to be an appetite for "grouping" data elements into Data Classes so that technology partners can see elements by area, but there also seems to be an appetite for an "index" that enables the same data elements to be grouped by topic or type of topic being addressed.

Maria Moen: Jenna - nicely phrased! "Data set" is a good term to use.

Nancy Lush: @Jenna - exactly - and different users will have different needs.

Steven Lane: Not unlike the Problem List, where there is an inpatient view and a longitudinal comprehensive view.

Sarah DeSilvey: Correct, Steven!

Howard Capon: I agree with the model that includes the overarching concept data element (care plan) for exchange and the component data elements for when it needs to be deconstructed for other uses.

Hans Buitendijk: @Maria - USCDI+ appears to be starting to organize data that way, which is very helpful to ensure data elements that have applicability in multiple contexts are defined once, and referenced multiple times.

Shelly Spiro: @Arlene, Evelyn, Jenna and Liz nice job on bringing care plan forward!

Rochelle Prosser: @Anna I 100% agree. That was my point in my earlier assumption question.

Terrence O'Malley: Full support for a Care Plan data class. In addition to the benefits listed by the speakers, there are additional advantages from the proposed consolidation. As Arlene alluded to in her comment, the care plan is the framework for similar elements required in a transition of care, a critical component of the care process. The concepts and content in care plans significantly overlap because at their core, transitions are how care plans are passed across the spectrum of care. Both care plans and transitions should be grounded on the person's goals, preferences, and priorities. Terry O'Malley

Katrina Miller Parrish: Agree Anna - all care team should have access to all of it to have the full picture.

Sarah DeSilvey: We need to transition to our next topic

Evelyn Gallego: Thank you all for your time today and interest in the Care Plan standards.

Sarah DeSilvey: Thank you all for coming and offering your expertise!

Joel Andress: It is difficult to imagine, in the framing of interoperable access of healthcare data to patients, payers, and providers, a more core element of information than the longitudinal care plan of a patient across their various healthcare needs. I support a data class for a care plan that allows care providers to access standardized (and therefore usable) care plan data.

Mark Savage: Repeating the need for structured care plan data.

Hans Buitendijk: Agreed with Jenna that the focus is on having the structure and vocabulary standardized, where the content and scope will be determined for the the specific provider and patient creating the plan.

Katrina Miller Parrish: UI and Policy

Jenna Norton: We did not focus on it here, but we are building a set of apps (for patient, caregiver, clinician) that help surface these things

Arlene Bierman: @Joel We have developed the use case with user input that makes it easy for patients to see their aggregated data.

Jenna Norton: We have tested /are testing with patients, clinicians to try to address these UI issues

Steven Eichner: It shouldn't be a hunt- it should be a facilitated search/find.

David Hill: UI is a differentiating competitive feature. We should be careful about getting into that area.

Arlene Bierman: @Jim the MCC ecare plan is a tep in that direction.

Evelyn Gallego: There is opportunity for user-centered design and co-designing technical solutions to support shared care planning. The standards inform the functional and technical requirements for these technologies.

Steven Eichner: Are we speaking to a single dimension care plan or a series of care plans that are focused on particular domains?

Jenna Norton: @Anna, your concerns are exactly what we are trying to address with MCC eCare. If allowable, happy to chat further offline if helpful

Arlene Bierman: We are happy to answer questions as you move forward. We have struggled with many of these questions.

Mark Savage: Thank you, thank you!

Maria Moen: I would assume that the Care Plan data set will, in the future, be made available based on individual consent - is that right? I wouldn't want my endocrinologist to necessarily be made aware of a behavioral health problem I'm dealing with at another specialty. Just an example for context, not based on real life.

Hannah K. Galvin: Thank you, SME's!

Evelyn Gallego: Yes @Maria.

Albert Taylor: @Ike, the data classes aren't what makes the search for needed data available (interoperable). It is the design of the query or the document type with content that could be scattered across data classes.

Jenna Norton: @Maria, agreed. We discussed this issue at length in our TEPs.

Maria Moen: To support the recommendation that an Advance Directive and Portable Medical Order data element be added to v5, I was able to identify that our national registry receives anywhere from 120,000 to 300,000 queries every 24 hours. This is an area where demand is mature, and support to release those documents from clinical record systems and the people themselves is very, very high.

Grace Cordovano: Thanks for sharing that @Maria, so helpful!

Albert Taylor: Thanks @Mark. This additional information is very valuable and should be included in the discussion component of the final recommendation.

Shelly Spiro: @MariaMoen these are important statistics for our ADI subgroup discussion @Hans @Ricky @Mark

Mark Savage: @Al, yes, will add that info today. Sorry could not manage after my call late yesterday. Let me know if you have any questions once I get it added.

Thompson Boyd: Broken ankle: osteoporosis. Risk of falls and further fractures. Important to entire care team.'

Maria Moen: Thank you Shelly, we can't ONLY accommodate the Observation since that is mid-workstream. We need to make the documents available, then allow clinicians to query/retrieve them, review them, and create an observation that activates the setting-specific workflow.

Rochelle Prosser: Maria +1

Katrina Miller Parrish: Did we confirm that "Author" is the credential confirmed actor? If it is a scribe on behalf of the physician that would represented differently?

Howard Capon: Agree with Maria. The advance directive observation is created secondary to obtaining the advance directive document or Portable Medical Order. The Directive or PMO is needed for clinician action in many settings.

Albert Taylor: @Katrina it is not intended to represent only credentialed provider (physician, nurse, pharmacist) but to include other authors like patient and device

Steven Eichner: And do we mean "human" as an actor type vs. "entity" as an actor type

Katrina Miller Parrish: Thanks @Al I met Login/ password confirmed.

Katrina Miller Parrish: *meant

Maria Moen: Al, it is so important that you called out "patient" as being an author. Not just something a clinician typed that a patient told them, but actually the patient themselves. We need to open our systems to specific use cases that enable patient voice ingestion into clinical record systems.

Hans Buitendijk: @Mark: I can we stay generally more broad, but in the context of applying USCDI to interoperability standards, the expectations on whether one must be able to support data authored by certain roles directly into certified HIT is clearly maintained. Verbally that is done, but just reading USCDI and its supporting documentation that is not clear.

Albert Taylor: ONC didn't intend to define the workflow required to implement these elements. It could be implemented to capture some like a scribe or the "on behalf of" person.

Steven Eichner: +1 Maria- and separate out where a provier is acting as a scribe vs. more direct entry.

Pooja Babbrah: +1 steven

Rochelle Prosser: +1 Steven

Hans Buitendijk: @Al: That helps, but in those cases the data would be represented as informant, expressed by, on behalf of, but not "author". It is a challenge of the same term used in different contexts.

Joel Andress: +1 Steven

Maria Moen: Steven - not direct entry as much as person-created documents (Advance Directives or Advance Care Plans) as an example of a specific use case that is needed and provides a good proving ground. I wouldn't allow anybody to just key into my EMR willy-nilly, but for specific use cases we simply must accommodate what the individual says exactly and not require a scribe.

Katrina Miller Parrish: Agree with Data Class

Joel Andress: Are we speaking about Orders as well here, or just Advance Directives at the moment?

Maria Moen: Did you see the volume of queries our national AD/ACP/PMO registry is receiving each and every day? Providers are actively looking for these documents but USCDI is how we ensure they are available if indeed they exist.

Sarah DeSilvey: Joel they were coupled. So both

Joel Andress: Thank you

Maria Moen: That's a good point Joel. The odd thing with Portable Medical Orders is that they are NOT encounter-centric, where the majority of physician orders is very pursuant to a specific encounter.

Maria Moen: Excellent point Dr. Lane. Open the floodgates to existing orders and continue the discussion around POLST/DNR documents if need be.

Shelly Spiro: @Steven PMO are also an important component for transitions of care not just for shopping around

Hans Buitendijk: And then we would address the relationship between POLST/DNR orders as documented by a clinician to ADI as "supporting information" that yielded the POLST/DNR?

Nancy Lush: My understanding of the original ADI is that it was represented as a bundle because the Patient certifies this group of preferences - If taken out of context we need to ensure that a component alone has the same meaning as the whole.

David Hill: Shelly +1

Maria Moen: Agree 100% Shelly. It seems important to enable document access, then enable the care team (once validated) to inform care based on what the individual requests. There are document types that the standard supports Hans, to clarify what is a Living Will, POLST, DNR/DNAR/AND, etc.

Maria Moen: OOOhhh, someone clean up that description. Very narrow.

Tina Wilkins: +1 Shelly

Howard Capon: EMS providers are unable to act on portable medical orders or advance directives without seeing the actual document / order. That access is critical

Steven Lane: Once provider authored orders are a part of USCDI it seems that EMS could modernize their rules.

Maria Moen: Happy to help Hans, the world of advance healthcare directive documents includes those written by people for their own care, caregivers for a loved one's care, practitioners for a patient's care, and lawyers for a client's care.

Katrina Miller Parrish: POLST used to be Physician Orders for Life Sustaining Treatment

Howard Capon: @Steven: completely agree. Being able to follow those orders can be an EMS standing order - but the documents and PMOs must be available in that workflow

Maria Moen: Incredibly grateful for the public presence on these calls, you are all wonderfully inclusive leaders!

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

No comments were received via email.

RESOURCES

IS WG Webpage
IS WG - March 5, 2024, Meeting Webpage

Transcript approved by Wendy Noboa, HITAC DFO, on 3/12/2024.