Health Information Technology Advisory Committee
Interoperability Standards Workgroup Virtual Meeting

Meeting Notes | March 8, 2022, 10:30 a.m. – 12:00 p.m. ET

Executive Summary
The focus of the Interoperability Standards Workgroup (IS WG) meeting was to continue to work on Charge 1, which included reviewing the new data classes and elements from draft Version 3 of the United States Core Data for Interoperability (draft USCDI v3) and considering data classes and elements in Level 2 that might be appropriate to add to USCDI v3.

There were no public comments submitted verbally, but a robust discussion was held via the chat feature in Zoom Webinar.

Agenda
10:30 a.m.	Call to Order/Roll Call
10:35 a.m.	Workgroup Work Plan
10:45 a.m.	Charge 1a – Draft USCDI v3 New Data Classes and Elements
11:00 a.m.	Charge 1b – Level 2/Other Data Classes and Elements Not Included in Draft USCDI v3
11:55 a.m.	Public Comment
12:00 p.m.	Adjourn

Call to Order
Mike Berry, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the meeting to order at 10:31 a.m. and welcomed members to the meeting of the IS WG.

Roll Call

MEMBERS IN ATTENDANCE
Steven Lane, Sutter Health, Co-Chair
Arien Malec, Change Healthcare, Co-Chair
Kelly Aldrich, Vanderbilt University School of Nursing
Hans Buitendijk, Cerner
Christina Caraballo, HIMSS
Grace Cordovano, Enlightening Results
Steven (Ike) Eichner, Texas Department of State Health Services
Rajesh Godavarthi, MCG Health, part of the Hearst Health network
Sanjeev Tandon, Centers of Disease Control and Prevention *(Attending on behalf of Adi Gundlapalli)*
David McCallie, Individual
Clem McDonald, National Library of Medicine
Mark Savage, Savage & Savage LLC
Michelle Schreiber, Centers for Medicare & Medicaid Services (CMS)
Abby Sears, OCHIN

Ram Sriram, National Institute of Standards and Technology

MEMBERS NOT IN ATTENDANCE

Thomas Cantilina, Department of Defense
Jim Jirjis, HCA Healthcare
Kensaku (Ken) Kawamoto, University of Utah Health
Leslie (Les) Lenert, Medical University of South Carolina
Hung S. Luu, Children's Health
Aaron Miri, Baptist Health

ONC STAFF

Mike Berry, Designated Federal Officer
Al Taylor, Medical Informatics Officer
Matthew Rahn, Deputy Director, Standards Division

Key Specific Points of Discussion

TOPIC: OPENING REMARKS

Steven Lane and Arien Malec, IS WG co-chairs, welcomed everyone. Steven reviewed the agenda for the meeting and invited all attendees to share comments, questions, and feedback in the public chat in Zoom and reminded members of the public that they were welcome to share verbally at 11:50 a.m. during the public comment period. Steven explained that the co-chairs and ONC team leads are working through the many suggestions and items submitted by members into the WG's working Google spreadsheet. As a result of the presentations the WG heard during previous meetings, many new items have been submitted. The list of submissions will be prioritized within the document and will be discussed first.

TOPIC: WORKGROUP WORK PLAN

Steven highlighted areas of focus, which were detailed in the March 8, 2022, IS WG presentation slides, and reviewed the charges of the IS WG, which included:

- Overarching charge: Review and provide recommendations on the Draft United States Core Data for Interoperability Version 3 (USCDI v3) and other interoperability standards
- Specific charges:
  - Due by April 13, 2022:
    1. Evaluate draft Version 3 of the USCDI and provide HITAC with recommendations for:
       - 1a - New data classes and elements from Draft USCDI v3
       - 1b - Level 2 data classes and elements not included in Draft USCDI v3
  - Due June 16, 2022:
    1. Identify opportunities to update the ONC Interoperability Standards Advisory (ISA) to address the HITAC priority uses of health IT, including related standards and implementation specifications.

TOPIC: CHARGE 1A – DRAFT USCDI V3 NEW DATA CLASSES AND ELEMENTS

Hans presented a slide depicting how proposed USCDI data classes, data elements, and supporting vocabulary (across USCDI versions) are supported by data access and document structures in HL7 FHIR (Fast Healthcare Interoperability Resources) US Core implementation guides (IGs), which is an IG that has been called out to support USCDI and will be eligible for updates in the next round of ONC's Standards Version Advancement Process (SVAP). He explained that it described the health IT perspective from implementation to certification to adoption, and that certified health IT must use defined HL7 FHIR US Core C-CDA R2.1 + Companion Guide versions to demonstrate support of USCDI. The slide was included in the IS WG presentation slide deck.
Then, Hans shared a spreadsheet containing the new data classes and elements that the WG could choose

to recommend as additions to the USCDI v3. He described the color-coding system and columns, which indicated whether the classes and elements were new or reclassified and listed applicable standards, IGs, and whether they were included in C-CDA. He explained that this document was meant to provide background for the current state and added that the WG should determine which items were ready for inclusion in the USCDI and which were not.

Steven commented that if the WG recommends to the HITAC that classes and/or elements be added for inclusions in USCDI v3, members need to be aware of the work that HL7 and others must do to support these new additions.

DISCUSSION:

- Arien asked Hans if he had done mapping on whether there is guidance (versus structural issues) in FHIR for the elements and classes.
  - Hans commented that there are not too many structural issues. However, there are data elements that are available in C-CDA 2.1 but that are identified as optional in the database guide. The companion guide provides more specifics on the binding to the vocabularies. He explained that, in FHIR, there is a good use of "must support," which indicates that there is clarity around the required use of the items. The guidance that is needed is around which option to use.
  - Arien asked if the work for HL7 included the creation of the IGs, vocabulary standards, and explaining where to put concepts. Hans agreed and added that there are no major structural issues for FHIR.
- David thanked Hans for the diagram and asked about what the health IT vendor community is targeting for future releases. Are they committed to this work, or is it years away?
  - Hans responded that some vendors already have guidance available, while others do not; all have agreed that they will support it if the IGs are agreed upon and published in a timely fashion. He explained that, while the SVAP process is voluntary, as versions of the USCDI progress, vendors are motivated to continue to participate.
  - David asked about whether vendors will use new elements or classes when there is no applicable IG or standards guide; he cautioned against creating obligations for vendors to upgrade that may accidentally create issues. Al responded that ONC's intention is to ensure that all IGs are sufficiently updated to be able to accommodate changes to the USCDI, such as is currently occurring to support USCDI Version 2. This is the reason ONC adjusted the SVAP timeline, so as to better accommodate the update process across USCDI, US Core, and C-CDA.
  - Arien commented that the SVAP is the mechanism for standards advancement, so there should be a way for the SVAP to flow down into technology associated with incentive programs. He described some of the issues there now, adding that they are due to the Administrative Procedures Act, and he described how others are working to create a glide path. The WG should focus on getting items into new versions of USCDI and thus into the SVAP process while being thoughtful about timelines and the need for work on IGs, so then these elements and classes can be more broadly adopted across the industry. He asked the WG to assume that the policy pieces are also underway to eventually support new items.
  - Hans discussed differences in which IGs must be supported for health IT certification for the various levels of the USCDI, recognizing that adjustments must be made when new certification guides are published but that there is also a progression that allows health IT vendors to spread updates out over time. The WG must ensure that all of the pieces will work, and anyone who wants to certify has all of the necessary tools and mature standards in place to do so.

CHARGE 1B – LEVEL 2/OTHER DATA CLASSES AND ELEMENTS NOT INCLUDED IN DRAFT USCDI V3

On behalf of CMS, Michelle discussed the following recommendations and justification for their inclusion in USCDI v3 (all of which were leveled by ONC at Level 2, meaning that they are eligible for inclusion in USCDI v3):

- Data element Facility Identifier in the Facility Level Data data class
- Data element Discharge Medications in the Medications data class
- Data element Dosage in the Medications data class

She explained that these potential inclusions were supported across government agencies, are well-established, and invited WG members to provide feedback. Steven asked Hans to comment on potential challenges to HL7 in relation to these recommendations.

DISCUSSION:

- Clem asked how an organization/hospital's provider identification numbers/facility-level NPI would be used.
  - Michelle responded that CMS prioritizes the exchange of the CMS Certification Number (CCN), and Clem stated that justification for the use of specific identifiers should be explained.
  - Arien commented that the last time the WG discussed this topic, they agreed that the identifier should be a combination of assigning authority (code set) and identifier to accommodate multiple types of identifiers for the facility. Clem agreed that this is how it has always been done. WG members discussed the variety of identifiers that are currently used for payers and providers and the need to allow multiple identifiers when appropriate, while prioritizing the requested CMS identifiers.
  - WG members discussed how the different numbers are used and whether they can all be supported. Hans commented that more work needs to be done on whether all providers can support all identifiers. Arien shared a question from the chat that asked if this is an organizational identifier or a sub-organizational/ "brick and mortar" location identifier. Hans explained that there is an organization identifier resource in FHIR already but commented that what this identifier is associated with must be determined (e.g., against an encounter, against the patient?). Are the identifiers mentioned in the recommendation from CMS meant to be supported by all certified health IT?
  - Steven reminded members that just because something is added to the USCDI, it does not mean that it must be collected if it is not part of the established workflow.
  - Arien asked WG members to comment on the following recommendation: CMS's recommendation should be amended to be an organizational identifier with the combination of **assigning authority** and an **identifier**, consistent with FHIR, and it should be attached to the **encounter**, as opposed to the patient. Or the WG could request that CMS address some of the questions the WG raised.
  - Michelle responded that CMS would support a more general identifier, with the CCN and PTN listed as examples. Hans asked if this would be useful and possible for all certified health IT, and Steven stated that first it would be added to the USCDI, then to the SVAP process, and then it could be included as a certification requirement. Hans emphasized that standards need to be able to support this, as they will eventually go into the SVAP process. Arien commented that this is already included in HL7 and is likely in the consolidation CDA specifications. All the health IT vendor must do is demonstrate that the information can be filled out with some value (not necessarily the specific ones shared by CMS). Ike emphasized the need to capture the assigning authority to reconcile the ID terms in the future. Clem suggested that greater clarity is needed around the identifiers.

- The WG discussed the following proposed recommendation: amend this to be an organizational identifier that is composed of an assigning authority and identifier, that there be support for a multiplicity of organizational identifiers that the coding system accommodates CCN and PTN, and that it be associated with the encounter. It would be in the category of “required if known.” Members determined that this recommendation should be added to the draft column, pending further homework from Michelle.

- Prior to collecting feedback on the CMS-backed data element Discharge Medications in the Medications data class, Arien explained that USCDI v1 and v2 say that Medications are encoded by RxNorm. However, he stated that this is a shorthand for a complex field for structural representation of medications and asked Hans to confirm that health IT vendors are already required to demonstrate the variety of medications and medication concept representations that are expressed/implied in the C-CDA and US Core FHIR to demonstrate interoperability. He suggested that the WG recommend keeping Medications at either the current more general level or that they must be defined in as detailed a manner as they are in the underlying standards and interoperability specifications.
- Hans commented that, in use, Medications data focuses on the order or request for a prescription. It does not go to an in-depth level, though EHR systems may capture individual administrations. Michelle commented that this is part of the issue and suggested that the more in-depth/ ”whole hog” approach in clinical representation would be more helpful for patients and other stakeholders. Clem commented that there is no ambiguity around medications in RxNorm but that there are differences between lists for outpatient and in-patient and challenges with the specification of whether medications are dispensed. WG members discussed complexities around Medications. Hans commented that it would require a substantial amount of effort to align everyone and requested greater clarity in the potential recommendation in order to make it supportable (by the IGs, standards, and specifications). Does it just cover a list of medication administrations? Clem asked Michelle if most are currently representable in C-CDA, but Arien stated that this is not the issue; rather, is it part of the USCDI so that structured IGs with lists of discharge medications can be created?
- Steven asked if the WG would support the proposed recommendation from CMS that the two data elements be added to the USCDI. Are these items ready to be moved, or should they be left at Level 2? Clem, Arien, and other WG members agreed that the IS WG must either specify very specifically what medication-related data elements should be included in the USCDI or leave these elements in their current, more general state until the work to determine the correct level of specificity is done. Michelle stated that by leaving these elements, there is no way to differentiate between dosages, active, ordered, or administered medications. The full lifecycle of medications must be able to be expressed in order to support informed clinical decisions or quality measures. Arien explained that these are fully expressible in the underlying specifications but agreed that the lifecycle of medications is not fully expressed through the USCDI.
- Clem and Al discussed whether medication information was properly supported in RxNorm, and Al emphasized gaps in information around the lifecycle of medications (e.g., was an injection actually performed?). This would be handled elsewhere, so he explained that Michelle is asking for this level of detail and these attributes be included in the Medications data class. Then, this level of detail would be accessible to anyone who accesses the medical record. Arien commented that if the WG makes this recommendation, they must make sure that the Medication data class in the USCDI fully represents the needed representational complexities. If the WG puts in some but not all, they would be implying that the ones that are not included are not required. They could import the implied Medication model into USCDI from FHIR and then ensure that the representational models, discharge medications, medications administered, medications ordered, medications as part of a clinical trial (Trial Status), and the home medication list are fully in USCDI. Steven reiterated that ONC has done the work to ensure that the data elements that CMS requested were leveled at Level 2, meaning they were mature enough for inclusion in the USCDI. Al described how ONC chose the most important attributes of medication for a certain data class and explained that they do not need to map the entire model to FHIR.

- WG members discussed what is included in and implied by the data element of Dosage, and Hans offered some clarifying points to the spreadsheet. He described how Medications is currently supported by a current medication list that is already being used. Arien asked Hans if the proposed recommendation should be to simplify it to Medications and Medication List and then to specify that the medication list be applied at admit, discharge, and be sufficient to represent orders and medications taken. Hans agreed that this would support what is has been administered and described how systems use medications list and support this with FHIR and US Core.
- Michelle voiced her support for Arien's amendments to the proposed recommendation, which were reflected in the text of the spreadsheet. She asked for feedback on how to handle ambulatory medication lists, and Arien stated that there is a critical distinction between Medications Ordered and Medications Taken. Hans and Arien determined that they would put together a proposal on this topic for the WG to review at a future meeting.
- Steven asked Al if other elements could be added to the Medications List if they have not explicitly been leveled as Level 2. Al responded that the concept of current medication list goes beyond the collection of vocabulary terms or collection of data elements because they would have to be formatted together. He discussed which items were in and out of scope for the USCDI and stated that ONC would have to determine what data elements or attributes are required in order to support the concept of a medication list. WG members discussed how to frame the proposed recommendation according to what is in scope and to recognize the most important data elements for the CMS use case. They discussed how to handle medications administered (applicable to inpatient as well as home care).
- Michelle commented that CMS thought that because the data elements were leveled at Level 2 the discussion would simply be about whether and where to add them as part of the USCDI. Should a separate workgroup consider this to provide further recommendations? WG members and Al discussed the potential recommendation that USCDI requirements should be added for all the data elements necessary so that health IT systems could identify and represent a Current Medication List. They discussed where the list could be utilized and how it should reflect what has been ordered versus medications taken.
- The WG asked Michelle to discuss members' comments with CMS before moving the recommendations forward, and Michelle invited members who have knowledge of granular details to help refine the potential recommendation.

- Steven reviewed the recommendations in which the WG previously suggested including all Notes data elements that have a LOINC code associated with them. He suggested that the WG discuss moving specific notes forward that are high value and have associated LOINC codes.
  - Al explained that recommendations to add additional note types and document types under the Clinical Notes data class were included in the USCDI v2 cycle. Therefore, they can be discussed during this cycle of the USCDI. WG members discussed how to phrase the recommendation so that it is more likely to be included in the USCDI this time, and Al explained that there is a limit to the practical number that can be required in any version of the USCDI. ONC's decisions are based on aggregate work required for developers and implementers/providers and their prioritization criteria. Al confirmed that Discharge Summary Note is an element that is already required in previous versions of the USCDI.
  - Following a long discussion of types of notes that are commonly used, how they are used, and whether they have specific associated LOINC codes, the WG agreed to re-submit its previous recommendation that all notes expressed through LOINC codes be added (that was not approved by ONC the previous year) and, as a separate recommendation, to specifically include the Surgical Operation Note as an addition to the current list.. Members expressed concerns that if all note types were included, it could affect the certification process for health IT systems. Hans discussed stratification strategies for health IT to avoid a monolithic approach.

Action Items and Next Steps

IS WG members were asked to capture their thoughts and recommendations between meetings in two Google documents that will inform the WG's recommendations and streamline the conversations. Members should share a Google email address with ONC's logistics contractor at onc-hitac@accelsolutionsllc.com to be set up with access to the document. Once WG members have gained access, they may input recommendations and/or comments into the appropriate documents:

- IS WG Member recommendations regarding Draft USCDI v3 and Level 2 Data Elements (members have full edit access to this document)
- Draft USCDI v3 data elements sheet for recommendations on changing or removing data elements (charge 1a) (members may add comments but may not add lines), and consider these questions:

IS WG members will be prepared to engage in conversations with presenters to better inform the WG recommendations. WG members may enter comments on this topic into the Google documents to keep track of individual thoughts.

- For homework for the March 15, 2022, meeting:
  - Given the amount of work remaining and the WG's current pace, the co-chairs are planning an extra meeting on Thursday, March 17, 2022, at the regular time of 10:30-12:00 a.m. EDT. An invite is forthcoming.
  - In order to make the review of the recommendations as efficient as possible, the WG will schedule discussion on the recommendations in the following data classes from the IS WG Draft USCDI v3 Member Recommendations (Editable) Google doc. If you are the "recommender", please be prepared to support your recommendations and answer questions.
    - Medications (Michelle Schreiber) – Lines 12, 13, 22, 23
    - Facility Data – (Michelle Schreiber) Line 17
    - Patient Demographics (Patient Address) – Lines 2 and 3 Questions related to metadata (normalization, homelessness flags)
    - Patient Demographics (Sex and Gender) – Lines 18 and 55
    - Health Status (Disability, Functional Status) – Lines 11, 27, 28, 36, 58-67
    - If the WG completes the above work, it will next consider other recommendations regarding Author and Patient Generated Health Data
    - Finally, the WG will pick up at the next available recommendation and plan to continue its deliberations at the meetings on March 17 or 22.
  - The WG will use the Draft v3 Data Elements for IS WG Review google doc as a reference to inform any recommendations that pertain to any Draft USCDI v3 data elements.
  - The current deadline for new recommendations to be submitted on the editable spreadsheet is Friday, March 18, 2022, but WG members were encouraged not to wait until the last minute share input as it is unclear how successful we will be in getting to all suggestions.
  - We will try to work through the whole spreadsheet over the next 3 meetings, reserving the March 29, 2022, meeting for recommendations that came in that week, followed by prepping the recommendations transmittal for review and finalization by the WG on April 5, 2022. The WG co-chairs must deliver the recommendations letter to the HITAC the week of April 4, 2022.
- Members are invited to consider more ideas on the WG's Task 2 work on the Interoperability Standards Advisory (ISA) Standards, which should start in early April 2022, following the completion of the WG's Task 1 recommendations to the HITAC. ISA related topics to consider
  - TEFCA standards enablement
  - FHIR roadmap, standards from FAST, patient access leveraging QHINs for national access
  - Additional exchange purposes that are contemplated in CURES but not perfectly enabled

via initial TEFCA
- Potential standards/IGs for HIE certification
- Social Determinants of Health (SDOH) / Gravity data standards
- Race/Ethnicity vocabulary subsets, e.g., CDC
- Lab Orders/Results
- SHIELD/LIVD, LIS to EHR/PH SYSTEMS
- Public Health (PH) data standards and potential PH Data Systems Certification
- eCR Standards
- Other ISA topics of interest

Public Comment

QUESTIONS AND COMMENTS RECEIVED VERBALLY

There were no public comments received verbally.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT

Michael Berry: Welcome to the Interoperability Standards Workgroup. We will be starting soon. Please remember to select "Everyone" when sending a chat if you want everyone to be able to see it. Thanks.

Mark Savage: Steven and Arien, send you an email about high priority, or write in the "priority" column on spreadsheet?

Mark Savage: Arien's questions and Hans' responses seem important to summarize for WG recs to HITAC.

Matthew Rahn: Here is the blog we released in October related to switching the SVAP timeline https://www.healthit.gov/buzz-blog/interoperability/aligning-with-standards-development-community-the-new-cycle-for-standards-version-advancement-process

Steve "Ike" Eichner: Al: Thanks for sharing the linkage between USCDI and adoption. Is there a graphic that reflects that process? That would be REALLY helpful!

Clem McDonald: what is SFAB

Abby Sears: I would be interested in a visual as well.

Steven Lane: @Clem - SVAP = Standards Version Advancement Process

Clem McDonald: thank you

Matthew Rahn: Can find more information on SVAP at https://www.healthit.gov/isa/standards-version-advancement-process

David McCallie: Are the IGs taking backward compatibility into account such that vendor skew in adaption rates of these changing standards doesn't make interop worse?

Clem McDonald: michelle , how does that relate to the organization NPI

Hans Buitendijk: @David: IGs are not necessarily backwards compatible creating some friction as they are settling. The FHIR IGs had some challenges with this in the Must Support space, but given early timing of a more current version that was an acceptable adjustment. C-CDA is more settled.

David McCallie: Is this identifier attached to the encounter, or to individual observations?

David McCallie: Seems like it should be an optional field - if you have it, send it; if not, don't

Steven Lane: @David - this is ALWAYS the case. USCDI does not require anyone to collect data, only to standardize and share it if they have it.

Mark Savage: From Level 2: Facility level data is associated with laboratory tests (the testing facility), and health care provider locations, including hospitals, ambulatory providers, long-term and post acute care, and pharmacy providers. Location data is used to support reporting of data for public health and emergency response (e.g., situation awareness reporting).

Steve "Ike" Eichner: There would be significant benefits to having an identifier across the board- especially for individuals that do not have something like a license number.

David McCallie: @steven - but FHIR fields require a cardinality so this needs to be clear upstream

Hans Buitendijk: But for Certified HIT you must demonstrate you can manage it, i.e., you must have a way to store it, display it, etc. Just not on everybody. But you must have the capability.

Al Taylor: @Hans is correct. "You" in this case means certified Health IT, must demonstrate the ability to collect and exchange a USCDI data element.

Joel Andress: If we had a national identifier uniform for all providers/facilities, we would want it included, I think. The conversation seems to be more about how to work around the lack of a single identifier system.

Hans Buitendijk: While PTAN and CCN identifiers are captured for billing/measures, not every HIT would have to be able to support that. Including it in USCDI yields the requirement for ALL HIT that wants to be certified it demonstrates they can handle it.

Hans Buitendijk: If the USCDI was truly meant to be a library of potential scope while we would stratify FHIR and C-CDA implementation guides that are targeted thus then these would be good to include in USCDI. But since today FHIR US Core and C-CDA is "one-size-fits-all" adding data to USCDI will require everybody to support everything. As USCDI grows that will increasingly be a problem, thus we somehow need to revisit that so USCDI can help guide establishing standards, but not require every CHIT to support everything always.

David McCallie: @hans +1

David McCallie: I think @Arien's point applies to many of the "assessments" that we've been discussing. Do we support the notion of generic assessments, or do we want to call out each and every specific assessment?

Hans Buitendijk: Discharge Summary has a medication list.

David McCallie: I suspect the right answer is a mix - we call out some, but recognize that generically many could be included

David McCallie: It makes sense to me to call out the specific need for "discharge medications" - since that is so important to continuity of care. The question is where to put that list?

Mark Savage: Wholeheartedly agree with Michelle about the priority of this need (medications). Don't have the knowledge to answer some of the specifics.

David McCallie: No provider would leave out "discharge meds" from a discharge summary. Is that sufficient?

Abby Sears: + Michelle and Mark

David McCallie: USCDI as structured is too broad to cover all these specific use-cases. Things that make sense in one context are irrelevant to another. USCDI can't capture that level of detail (by design)

Hans Buitendijk: Current C-CDA and FHIR US Core has the focus on the medication list on its own or as part of certain documents, but not administrations. At the same time, various EHRs already make mediation administrations available using FHIR APIs.

David McCallie: context of use - in addition to the medication details

Clem McDonald: from the web: The CMS Certification number (CCN) replaces the term Medicare Provider Number, Medicare Identification Number or OSCAR Number. The CCN is used to verify Medicare/Medicaid certification for survey and certification, assessment-related activities and communications.

Clem McDonald: THink *[sic]* Hans has got it. What we are needing is a specific medication lists that define what kind of list. however medication dispensed also need then and who dispensed.

Hans Buitendijk: For a deeper dive in FHIR US Core already subject to certification: http://hl7.org/fhir/us/core/STU3.1.1/all-meds.html

David McCallie: Medications administered during a long ICU stay will include potentially thousands of IVs and admixtures. Is the intent to include ALL administered meds?

Clem McDonald: think dave has an excellent question. Don't think we want to ask for that. And when we get into mixtures the things get VERY complicated

Hans Buitendijk: That is one of the reasons why the main focus has been on medication list at the order (current/historical) to summarize that.

David McCallie: @al +1

Joel Andress: We can work backwards

Joel Andress: define what is wanted for a medication list, and then identify the data elements necessary

Hans Buitendijk: Would that then be Medication Request?

David McCallie: data classes but not data use-cases

Hans Buitendijk: For a deeper dive into what data is expected for a medication on a medication list where everything with an "S" needs to be able to be supported when known (from FHIR US Core 3.1.1): http://hl7.org/fhir/us/core/STU3.1.1/StructureDefinition-us-core-medicationrequest.html#formal-views-of-profile-content

David McCallie: The data class has to be all-inclusive, but in any specific use-case, only a subset of elements makes sense

Abby Sears: I need to leave. Sorry.

Arien Malec: Also note the complexity of the sub-fields associated with "medication"

David McCallie: But any kind of note COULD be included if the sending system wants to, right?

David McCallie: To @hans point, does inclusion of "any" LOINC note type require the vendors to demonstrate the they can include ALL note types?

David McCallie: Implication on certification of “all note types” is unclear to me?

David McCallie: but the vendors must show that they can produce it

Hans Buitendijk: @David: That could be translated into the ability to create clinical notes for each of the codes (that's a lot 700+).

Arien Malec: From a certification perspective, we might be overthinking this. “Any” should not mean “All” — we should specify that an EHR represent multiple types but should be allowed to select for “send” subtypes that are relevant for the type of HIT.

Arien Malec: But to Hans’ point, every HIT needs to *receive* any LOINC coded notes.

Hans Buitendijk: Challenge is that "any" in current process is translated to "all".

Michelle Schreiber: so does this mean we will have to specify any "high value" note types in the future for inclusion in USCDI because we will not include all the LOINC ontology?

Mark Savage: What about more meetings?

Arien Malec: @Michelle — if ONC doesn’t accept our “all notes” for recipe and my proposal to demonstrate “can send multiple relevant” then yeah, we’ll have to specify one by one.

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

There were no public comments received via email.

Resources

IS WG Webpage
IS WG – March 8, 2022 Meeting Webpage
IS WG – March 8, 2022 Meeting Agenda
IS WG – March 8, 2022 Meeting Slides
HITAC Calendar Webpage

Meeting Schedule and Adjournment

Steven and Arien thanked everyone for their participation, summarized key achievements from the current meeting, and shared a list of upcoming IS WG meetings. The co-chairs reviewed the action items and offline work that WG members were asked to complete.

Due to the heavy workload of the WG, the co-chairs asked for member feedback on whether additional meetings should be scheduled or if the length of meetings should be increased. WG members agreed that adding meetings to the schedule would be preferable.

The meeting was adjourned at 12:02 p.m. E.T.