Health Information Technology Advisory Committee

The Office of the National Coordinator for Health Information Technology

Transcript

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

March 29, 2022, 10:30 a.m. – 12:00 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Steven Lane	**Sutter Health**	**Co-Chair**
Arien Malec	**Change Healthcare**	**Co-Chair**
Kelly Aldrich	Vanderbilt University School of Nursing	Member
Hans Buitendijk	Cerner	Member
Thomas Cantilina	Department of Defense	Member
Christina Caraballo	HIMSS	Member
Grace Cordovano	Enlightening Results	Member
Steven Eichner	Texas Department of State Health Services	Member
Rajesh Godavarthi	MCG Health, part of the Hearst Health network	Member
Adi Gundlapalli	Centers for Disease Control and Prevention	Member
Jim Jirjis	HCA Healthcare	Member
Kensaku Kawamoto	University of Utah Health	Member
Leslie Lenert	Medical University of South Carolina	Member
Hung S. Luu	Children's Health	Member
David McCallie	Individual	Member
Clem McDonald	National Library of Medicine	Member
Mark Savage	Savage & Savage LLC	Member
Michelle Schreiber	Centers for Medicare and Medicaid Services	Member
Abby Sears	OCHIN	Member
Ram Sriram	National Institute of Standards and Technology	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Al Taylor	Office of the National Coordinator for Health Information Technology	ONC Staff Lead
Denise Joseph	Office of the National Coordinator for Health Information Technology	ONC Staff Lead

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

Michael Berry
And, good morning, everyone, and thank you for joining the Interoperability Standards Workgroup. I am Mike Berry with ONC, and we are pleased that you could be with us today, and as a reminder, we always welcome your feedback, which can be typed in the chat feature throughout the meeting, or can be made want to verbally during the public comment period that is scheduled at about 11:55 Eastern Time this morning. I am going to begin roll call of workgroup members, so when I call your name, please let us know that you are here. I will start with our cochairs. Steven Lane?

Steven Lane
Good morning.

Michael Berry
Arien Malec?

Arien Malec
Good morning.

Michael Berry
Kelly Aldrich? Medell Briggs-Malonson? Hans Buitendijk?

Hans Buitendijk
Good morning.

Michael Berry
Thomas Cantilina? Christina Caraballo?

Christina Caraballo
Good morning.

Michael Berry
Grace Cordovano?

Grace Cordovano
Good morning.

Michael Berry
Steve Eichner?

Steven Eichner
Good morning.

Michael Berry
Sanjeev Tandon?

Sanjeev Tandon
Good morning.

Michael Berry
Raj Godavarthi? Jim Jirjis? Ken Kawamoto?

Jim Jirjis
Good morning. Jim Jirjis here.

Michael Berry
Thanks, Jim. Leslie Lenert? Hung Luu?

Hung S. Luu
Good morning.

Michael Berry
David McCallie?

David McCallie
Good morning.

Michael Berry
Clem McDonald? Mark Savage?

Mark Savage
Good morning.

Michael Berry
Michelle Schreiber? Abby Sears? And, Ram Sriram?

Ram Sriram
Good morning.

Michael Berry
Thank you, everybody, and now, please join me in welcoming Steven and Arien for their welcoming remarks.

Workgroup Work Plan (00:01:46)

Arien Malec
Good morning. So, we are down to crunch time. As a reminder, we have our advisory committee meeting next month, and we need to get down to the actual recommendations letter. Fortunately, we have done a good job of memorializing all the discussion that we have in recommendation text that is in the spreadsheet, so if you have not reviewed the actual recommendation text, I would encourage you to do that now. Today, we will continue our adventure of going through the spreadsheet and going through the items that we have

yet to have touched, trying to get down to definitive recommendations for each of the items. You can see the list here. We have some of the items that Clem has pointed out, that Hans has pointed out. I want to take another pass at the health status data class, as well as go through the other rows in the spreadsheet.

I would like us, at the end of this meeting, to have clarity about what we are going to put in the recommendations letter, so if there is something that is burning for you that we have yet to have addressed and we have not gone over it in this meeting, or if you do not see definitive recommendations texts, this would be your meeting to raise your hand and make sure the discussion we previously captured has been memorialized as recommendations, or at least that we have discussed how to memorialize it as recommendations.

Hans asked a questions about where we put any remaining suggestions/tweaks on the recommendations column, and that is a very good question, and I would just put it in the workgroup discussion tab for now and just make sure that you send us a note that we can pick it up and sweep in any updates, and then, if there are just editorial tweaks or things that we have already discussed, we can clearly incorporate them. If they are things that require discussion, we can either discuss them in this meeting or pick them up in our last remaining meeting prior to the advisory committee meeting. Steven, anything you wanted to mention? I think Steven is having computer problems.

Steven Lane
I hope you can hear me well. Thank you, Arien, and thank you, everyone, for joining us today. I really want to especially thank the members of the public who have joined us and encourage you to feel free to participate in the chat as it is going on, as well as take advantage of the time that is available at the end of the meeting to contribute. We have quite a number of public participants today. I really appreciate you being here. I also want to thank Arien, Mark, Hans, Al, and other people who have really been digging in hard to look at the recommendations.

One of the things that we did since the last meeting is we had a chance to meet with representatives of HL7 and to look very specifically at the work that would need to be done to get some of these recommended data elements over the line, to get them truly technically ready for nationwide exchange in terms of applicable implementation guides and standards, and I think we learned a lot, and a greater appreciation of some of the challenges that would be required in doing that, so we have to remember that our work is not only to advise in terms of what we think would be nice to have, what we think would be appreciated and welcomed by the community, but also what is reasonable in terms of all of the work that needs to be done to get things into a version of USCDI, so I think we will be hearing some of that feedback today.

The other thing before we dive in is a question that Hans continues to raise and has raised repeatedly over the last couple of years, looking for greater clarity on exactly what it means when an item is added to USCDI. What specific burdens does that put either on users of health IT or on vendors in terms of being able to manage all and every iteration of a data element, and I think that one of the things we will want to include in our recommendations is some specific clarity, this notion that if the data is collected, then it shall be transmitted and exchanged, but that adding these requirements, say, for a new type of a note or for a specific instrument that might be used as an assessment, that that does not require that every system have a process for collecting that data or having it, but just that they are able to accept it when it is sent, which is a subtle difference, but one that is very important as we look at what should be added to this core data

set as opposed to maintaining as optional elements. Arien, I do not know if you want to add to anything I just said.

Arien Malec
I do. Thank you for that. Maybe two other things. One, which has come up a couple of times in address as well, as part of that discussion, how do we handle existing information which has yet to be encoded? And then, just as a gloss on the point that Steven just made about supporting interoperable if it is collected as opposed to implied mandates to collect. This is part of a transition from USCDI as really representing the core data for interoperability and trying to transition USCDI so that it can handle the data that wants to be interoperated that may have taken place across the continuum of care among actors, providers, etc. who have different specialties and different sub-elements that they are the primary capturers for.

So, as we were talking about, for example, with note types, it is clearly illogical for a pediatric practice to capture surgical operative notes, but it is clearly not illogical for a pediatric practice to be able to consume such a note when it has been produced elsewhere, and so, we do not want the inclusion of multiple note types to imply requirements to generate all of those notes. And so, we have tried in our comments in the recommendations to be explicit there where that is an issue, but again, that is an area we can continue to push on, and likewise, we may need to be more explicit about when we are requiring some structure, and where that structure has not previously been captured, be more explicit about how to handle legacy data. But, with that, maybe we should just jump into it. Next slide.

Steven Lane
Yes, indeed.

Arien Malec
I think everyone knows this. Let's go on to the next one, and let us go into the spreadsheet.

IS WG Draft USCDI v3 Member Recommendations (00:09:40)

Steven Lane
I went ahead and hid a couple of columns in the spreadsheet, so hopefully we will be able to see it more clearly, and Arien, were we going to hand the mic to Clem and give him a few minutes?

Arien Malec
Yeah, we have Clem, and then Hans.

Steven Lane
Clem, I know you have put a lot of thought into this and have a lot to offer. I think we probably have time to discuss, at most, two or three items that you have on your mind. Do we have you on audio?

Arien Malec
While we are doing that, if we can have somebody pull up the spreadsheet.

Steven Lane
Clem, we see you, but you are muted inside of the app. There.

Clem McDonald
Okay, so there are a couple. They are real fast. Item 38, which is not specific to me, but we sent you a Word document today with three panels that relate to drug abuse/alcohol abuse, and I think these are especially important today given the high death rate from drug abuse. It is now three times the death rate from auto accidents. But, you have already kind of accepted them. They are Level 2, and in Item 38, they are listed. I just want to highlight that they are already in Item 38, and they are happily welcomed by HITAC.

Steven Lane
And, 38 is the instrument unique identifier?

Clem McDonald
Well, it lists a whole bunch of assessments.

Arien Malec
I think the list of assessments that we included in the assessments tab already includes the notes, and it may have been Row 38.

Steven Lane
Entry 36, I think, is what we are talking about.

Arien Malec
Cool.

Clem McDonald
Well, there is one if you search for alcohol.

Arien Malec
That is right, alcohol use.

Clem McDonald
Right, I am sorry, it is 36. So, as long as everybody buys that, I do not need to say more about it. I would just like to emphasize it is a really important deal today in the U.S. The death rates are just surging, for drug use especially. There is another item I would like to highlight a little bit. So, with LOINC, when you give a name for a code, a panel, or a survey, it includes all the questions underneath. Just be aware that SNOMED only has the summary answer in it, so they are a little different when they are both presented.

The other one I would like to talk about is vital signs. I do not think I prepared them, but there are qualifiers for measurements of vital signs it would be nice to have, such as standing/sitting, cuff size, that you could just use or not use at your pleasure. The current comment from me says we should have precoordinated one. I did not mean that. We had another five or six variables that users could use to qualify the measure. They could accomplish almost everything they would want, but I do not know if there is any stomach for that.

Arien Malec

Clem, this also came up in our discussion of averaging multiple observation values for blood pressure, which has been a frequent comment from public comment, both from the American Heart Association and, I believe, others, and in offline conversation, we noted that that would be best handled by these qualifiers. Al, I do not know if they are Level 1, Level 2, or not yet included in…

Clem McDonald
To comment on the average, we should clarify. What is really requested by the ANA is the following, that if the initial blood pressure is high at a visit, repeat it more times. I think it is typically two or three. So, I think we should clarify that. That is in their specification. It was not mentioned on any of the verbal discussions, but if you go to their website and look at their screen, to enter that, it is qualified by the fact that if it is high, then you should have to repeat it to get a better value.

Arien Malec
Clem, sorry if I answered my own question. Vital sign results, dates, and time steps are in Level 2, but qualifiers are not yet in Level 1 or Level 2, so maybe the net of that recommendation of yours is that we should include the LOINC codes for observation qualifiers in Level 1 or Level 2 for future evaluation for USCDI.

Clem McDonald
And, I can send you those qualifiers. Let's see, I think I had one other item that I wanted to enter. Oh, smoking status. I do not know where that stands.

Steven Lane
Wait, hold on. I want to capture this before we go. Arien, you said include LOINC codes for observation qualifiers in Level 2?

Clem McDonald
It is vital signs qualifiers.

Arien Malec
Vital signs qualifiers, yeah.

Clem McDonald
We could put them together, but it is things like cuff size for blood pressure, standing or sitting or lying for blood pressure, clothes on or off for weight. There are maybe six or seven of them that some people use.

Steven Lane
Sorry, without checking right now, are you saying they are Level 1 or Level 2?

Arien Malec
Sorry, the recommendation is to include it in Level 2 for inclusion in a future version of USCDI. It is currently not in Level 2 or Level 1.

Steven Lane
Okay, so it is about exploring whether they would qualify.

Arien Malec
Correct.

Clem McDonald
I would argue that they are everywhere. People use these. You can also precoordinate them, but it is more uncomfortable, and it is just a matter of having to pick from a bigger panel that they want to say.

Arien Malec
Yeah, Clem, just structurally, the issue that we have is that we have bound ourselves to a process where we need things to be in Level 1 or Level 2 before we can incorporate them into USCDI.

Clem McDonald
I understand. I do not like it, but I understand it.

Steven Lane
So, that is a recommendation, then? Does anybody have an objection to us including that in our recommendations for ONC to explore whether vital signs could make it up into Level 2 for future inclusion? I think while we are here, we should also discuss specifically the recommendations that we got from the AMA because they have come in twice, which was very nice, and I think we have had a conversation with Al about that, that averages of existing data elements are simply mathematical operations that any system can perform, and it is a little difficult to define. When we are talking about average, is it the average of three taken three years apart or three minutes apart? Is it an average of three, five, or 10? Is it an average for an entire ICU stay? Even though the notion of the average blood pressure is at Level 2, it would be theoretically possible that ONC, for the most part, has left it up to receiving systems to do the math and provide calculated values, such as an average of multiple blood pressures.

Clem McDonald
Steve, they are not asking for averages over intensive care. It is specifically stated that at a visit, if the first blood pressure is high, to repeat it a couple times. We could create LOINC codes to make that clear if it is important, and the word “average” is also a synonym for “mean.” There are already a number of mean blood pressures, but they have different meanings.

Arien Malec
Yeah, we are not talking about mean arterial pressure or a mean blood pressure.

Clem McDonald
Well, a typical mean blood pressure is the integrated mean from the systolic to the diastolic.

Arien Malec
That is right. So, what we are talking about is averaging multiple observations following an algorithm, and that is either going to be one of these modifier codes or it is going to be a new LOINC code that represents the use of the AHA algorithm for calculating blood pressure that assures respondents that it is not just a single observation value.

Steven Lane
So, what do we want to do with this?

Clem McDonald
I think we should keep it alive, but we ought to clarify it is not just the average of anything, per the AMA.

Arien Malec
Again, this either needs to be a LOINC code, so we need to defer over to LOINC to figure out how to represent it, whether it should be represented as literally a new LOINC code, or whether it should be represented as one of the observation modifiers. I think that would be the logical next step. And then, if I were LOINC, I would want to have a consensus, summary, statement, or algorithm from AHA to point to, something in literature that describes definitively the algorithm that primary care and others are expected to follow, which I assume exists, and then you would want to either have the modifier or the LOINC code point specifically to that validated instrument.

Clem McDonald
I agree.

Steven Lane
So, what does that mean for our recommendation today?

Arien Malec
So, I think we recommend that ONC work with stakeholders and LOINC to specify how this could be appropriately represented, whether as a modifier or a new LOINC code.

Steven Lane
And save it for a future version?

Arien Malec
Save it for a future version, yeah, because at this point, we would not know how to move it forward.

Steven Lane
Any hands up? Any concerns about that? All right. Was there another one you wanted to recommend, Clem?

Clem McDonald
Let's see. I may have the number. I forget how we landed on smoking status. And, in clinical notes, did we end up that there were some suggested ones, but they could use more available notes?

Steven Lane
So, we have two different recommendations that we have captured. One is to add the operative note, and the other is a repeat of last year's recommendation that systems should be able to recognize and incorporate any note identified in the LOINC hierarchy, and there has been a lively discussion with HL7 about that. I think there is a remaining concern that Hans has expressed that if we say you should be able to handle any note that that creates a substantial burden on developers. I think we have heard two different

opinions about that. One is that it really should not be such a big deal, that if you just say if there is a note, then there is a LOINC code, you keep them straight, and then there is another version of the interpretation, which is that this is really substantially burdensome. Hans, thank you for putting your hand up. Why don't you jump into that? We have two recommendations that we have captured, and I do not know if we want to modify that.

Hans Buitendijk
I think the backdrop of my comment is that it depends on if we are talking narrative notes, which is what we currently capture with clinical notes, because at that point in time, there is no defined structure, there is no structure to discrete data inside the narrative note. Then, it is "just a code" that, where you have it, uses the LOINC codes to indicate what kind of clinical note it is. That is one level, and that is more on the simpler level, if you will, going back to Arien's comments generally as well, but if the intent was to be that we have structured clinical notes, and at that point in time, those LOINC codes/document codes still apply, it is not that you apply to a set of structured data, then you get into the area of for the variety of 700, 900-plus, however many documented codes are out there, what are the agreed-to minimal structured sections otherwise required that you have, which is currently done for 13 in C-CDA, of which three are in certification and another one in the CMMI program.

So, I think it depends on which side we sit on. Narrative notes are much more straightforward. If it is intended to be structured, then you are opening up a larger box of "Hey, what is expected to be there?" in a structured fashion or not for that particular document or grouping of documents.

Arien Malec
Hans, we went offline recently, and at least my proposal is that we are talking about narrative notes only, that structured documents are a matter of implementation guidance and really a matter for the ISA, not for USCDI, and then, the other piece that we are talking about, which we already have memorialized here, is by calling for narrative notes to be LOINC-encoded, we are not calling for all EHRs to be able to capture all LOINC codes because that would be illogical. And then, the last point that I think we talked about offline was how do we handle legacy data, and there, I think our proposal is that this is a going-forward proposal, and that when it comes to legacy data, we should have a default modifier that is a catchall bucket for previously captured clinical narrative that might just say something like "clinical narrative."

Clem McDonald
Could I weigh in a little bit? I think that Hans has retracted his objection to the narrative version of clinical notes.

Arien Malec
That is right.

Hans Buitendijk
Correct.

Clem McDonald

Yeah. You can take a PDF in any system, whatever is in it, and all we are saying is there has to be a code on it, and we are doing that already across lots and lots of stuff, so I do not see how there is any burden there. They just take the code that comes in the message and stick it in the field they already have.

Hans Buitendijk
Yeah, I think the prior part of the discussion is that I think we were still not sure, or at least I was not, based on the text on the discussion, whether we are talking narrative and structured, and by clarifying that and making sure that in the current text, it is much more clear. That is more appropriate at this stage if we are dealing with the number of codes potentially out there. **[Inaudible – crosstalk] [00:25:32]** the notes. That is really what you are asking here.

Clem McDonald
Dave McCallie actually had a comment in the chat that spoke to that too.

Arien Malec
Yes. David, do you want to put voice to that, or should we read it for you?

David McCallie
I think I am in violent agreement with Clem and Hans that exchange of unstructured narrative is just a simple must-have. It is not hard. We already do it with everything else. The focus and obsession with structure is what has gotten us into trouble, and we have sometimes punished the adequate by trying to be better. Adequate is text, and if you have text, you have to be able to share it. I would agree with Arien that there might be a need for a catchall not-otherwise-classified note type for legacy data that did not have a LOINC code when it was initially captured because it is still valuable. People can read and understand it.

Arien Malec
Yeah, I have dropped the memorialization of the conversation we had offline into the chat, and I will take the action to go back through the recommendation text to make sure that we have fully captured this in the recommendation text. I think it captures the sense of the workgroup, unless there are significant objections, and Hans, you have your hand back up.

Hans Buitendijk
As you go to further crafting that, if you look at the first paragraph in the final recommendation, Column K, we recommend that USCDI V.3 include all note types coded in LOINC, document tautology, and if that progresses along the line to categorize the narrative unstructured notes, that might help indicate what we are doing with that code. We are really putting **[inaudible] [00:27:34]** on it to say that this narrative represents that kind of a note.

Arien Malec
Yeah, that is what this refers to, is alluding to, but we can say to categorize. We have already included "Recommendation is not intended to suggest that all certified health IT need to generate all possible notes." We need to also add in…oh, I think we already have that. I do not know if AI has done all the work.

Steven Lane

I just put that in. “LOINC should consider developing a code for legacy notes not coded specifically at the time of creation.”

Arien Malec
Perfect. I think we got that.

Clem McDonald
I have one comment about the idea of adding the FDA’s UDI to lab messages. I think it is a good idea, but there are some issues, for example, 55 percent...

Arien Malec
Clem, just a process question. I think we want to close this topic out. We have over to Hans, and then we can bring in the topic of lab.

Steven Lane
Okay, Hans, where do you want us to go?

Hans Buitendijk
Related person, name, and relationship.

Steven Lane
For 100. What is the number?

Hans Buitendijk
That is a good question. I do not have that on my cheat sheet here.

Steven Lane
Okay. It would be under demographics. Patient demographics? Is that where it goes?

Hans Buitendijk
It is 56.

Steven Lane
There we go, all right.

Hans Buitendijk
So, the question there is the way it is described, it is not clear what is intended to be achieved because there is a potential overlap with care team. So, other related **[inaudible] [00:29:34]** are they in the context of a care team or other defined relationship, like subscriber or otherwise, or is this a general-purpose relationship that you just want to know that they are the next of kin, but they have no role in the care team and otherwise? So, from that perspective, are we trying to update the care team class, really, and have the relationship type appropriately defined and expanded to achieve this, or are we truly talking about just a relationship with somebody else that you would like to document no indication of what the purpose is of that relationship, or the interest is of documenting it other than just documenting the relationship?

Steven Lane
So, my read of this is that "related person" is much more of a personal relationship as opposed to a care team relationship, so I think what you are asking for is for that to be clarified if this were to be included in final Version 3. Is that right?

Hans Buitendijk
Correct, and the question of if the intent is just the personal relationship, no implication of care team, financial guarantor, whatever else there might be for which you would need to have that relationship. If it is just that, it would be helpful to identify if the use case is a little bit better, where certain data is helpful to have, and I am not saying there is not, but just for clarity, on the purpose that then can help downstream to get it into the right spot.

Steven Lane
And then, clarify the use case?

Hans Buitendijk
Correct. Now it is somewhat unclear as to what direction is going, and therefore, I might end up in a different spot than intended. I certainly would not necessarily end up right now in "just a relationship," and which relationships, then, do I care about?

Steven Lane
Al, go on.

Al Taylor
So, I appreciate the request for additional clarity. That is one of the key things that we are looking for as we finalize V.3. The original intent of this was, I am going to say, at least twofold. One of them is to provide the definitions required for some records linkage, such as maternal child record linkage, and so, associating a demographic or associating a clinical element like a lab result, including blood type or some of the other clinical things, but to associate a demographic of a relative to a patient, so that is for records linkage. It is also to help with identification/patient matching. So, a patient with a particular person as a related person can help with matching, especially newborns, twins, things like that, so the patient matching and records linkage is the primary use case, and Hans, I agree that related person can be a part of the care team, and they oftentimes are, but that is not the intent for this, and we certainly are eager to provide some clarity around that.

Hans Buitendijk
That would be great because in the example that you use for record matching, that is the approach that is then taken on how to express the data relevant for that. For example, something like mother's maiden name is not necessarily using a related person relationship to do it because then it is based on the structure. So, having that clarity will be good because it can help make sure that standards land in the right spot.

Steven Lane
Mark?

Mark Savage

Thanks. I cannot find it in the filtering now, but I did make a comment weeks ago on this same thing, and it may help with the clarification finding that the terminology descriptions appeared to overlap, but the HL7 exchange standards appeared to differentiate the two, so I am just mentioning that as a place to pay attention about whether there is overlap between care team and related person or not, and in which place. Thank you.

Hans Buitendijk
Yeah, and if I can react to Mark on that, I think on the standards side, the distinction has been done for a variety of reasons to understand where to use what, so it would be a challenging one to adjust. That is why from this side of USCDI, by clarifying what the purpose is, we can end up in the right bucket, or even a third place if it is meant for record matching because then we need to look at it differently yet again.

Steven Lane
Great.

Mark Savage
At the very least, then, definitions need to change so when we just read the definition of the term, we do not get confused that they are referring to the same thing.

Hans Buitendijk
Fair point. Agreed.

Steven Lane
Is the recommendation as captured, or the two recommendations? Is that sufficient, or do we need to add to that? Grace, do you want to get a word in?

Grace Cordovano
Yes. I just wanted to comment that my understanding when we had this discussion was that this is the primary care partner who is potentially coordinating the care, who is the main contact for a patient, and just to give an example through the pandemic, because of COVID-19 no-visitor policies, no one was allowed inside, so who was the care team supposed to contact? There were constant barriers in communication. So, identifying who was helping manage someone with a chronic illness, someone who has multiple comorbidities, perhaps an aging parent, someone who has a life-altering, life-limiting condition, who is there on that day-to-day basis, then that can certainly be different from a designated executor of the estate, or a personal representative, or even the next related person. Those two categories of individuals may not be the primary care partner responsible for the day-to-day ins and outs of care for a particular patient.

Steven Lane
That is a really good point, Grace, which is to say is there a value set that should be recommended for this related person relationship, or are we anticipating that this would simply be a free text field?

Grace Cordovano
My hope is that we want to avoid that when the phone call comes in from a primary care partner, they do not get the “Well, because of HIPAA, we cannot give you any information,” so that would be one of the use cases here, to not block information from people that are responsible for the daily care coordination.

Arien Malec
Yeah, and again, I think what we can do is we can capture the content. We clearly are not going to have an interpretation of HIPAA in USCDI, but I think we can at least capture, from the perspective of interoperability, that this is the contact.

Steven Lane
Hans?

Hans Buitendijk
I really appreciate Grace's examples. They are good ones, and they actually would be ones that likely would end up in care team, and hence, if that was the intent of the person on this proposal, it should be phrased and clarified in a way to make sure it would end up in care team as opposed to the relationship of related person. That is much more generic and not intended for any particular person other than my father, my mother, my sister, my brother, whatever it might be, as that kind of relationship. So, that is why we have to be a little bit more precise than what we have today.

Arien Malec
So, do we have a proposed recommendation text?

Hans Buitendijk
From my perspective, if it is more clear whether it is one or the other, it is okay as long as it is clear what the intent is so we end up in the right spot in the standard.

Steven Lane
Al, do you want to comment on that?

Al Taylor
I was going to…I am not sure if "confirm" is the right word, but confirm Hans's reading on Grace's use case, that that is a way of being involved with the care. Being either a party to whom information can be disclosed seems to fall into the category of care team member, which typically will include something like custodian, decision maker, guardian, people that are generally accepted as those who can receive information. So, I think that sort of person would not be captured by relationship type, but rather by care team member role. We will make sure that we try and clarify, even clarifying some of the examples of care team member so that we can incorporate that sort of thing.

Arien Malec
So, what is the proposed recommendation here for related person name and relationship?

Steven Lane
It sounds like what Al is saying is that the relationship that Grace described is more of a care team relationship, and that the one for which this was proposed and brought forward is more of a demographics relationship.

Hans Buitendijk

That is what I am hearing too, and in the first paragraph in the recommendation, I think that is most captured.

Arien Malec
I am just trying to get precise about what should we capture under related name. So, I think we agree that we recommend that data capture for persons consulted in the care of the patient should belong in the care team. What is the purpose for this field?

Hans Buitendijk
The way I am hearing it, and I am curious whether Al can confirm that I heard it right, is that the purpose here is to effectively capture simple demographic relationships that do not reflect a responsibility from a care, financial, or other aspect of the care delivery or the care process, or health process.

Al Taylor
Yeah, and Hans, I can confirm that that is what we were thinking when we were putting this together. Mother's maiden name is one of them that is something of a patient-matching concept or use case, and it is to incorporate things like next of kin and mother's maiden name as two examples. And so, as far as shaping the recommendation, my suggestion is to either say, as we say right now, should clarify the intent, or if there is a belief that that particular scope that I laid out is not really what you think it ought to be, then have it be a more directive recommendation to something like change the scope from to, but if it sounds like the workgroup is satisfied with that explanation as the original scope, simply clarifying or confirming that would be a sufficient recommendation.

Hans Buitendijk
Interesting. On the two examples you used, in the standards, mother's maiden name would end up in a completely different spot than a related person to indicate that you are a family member.

Arien Malec
I put myself in the category of somebody who is thinking about how to design interoperability specifications, and I am putting my computer science hat on, and I need an algorithm to figure out when I am drawing from this field versus when I am drawing from other fields, and I think I am falling a little short.

Clem McDonald
Could I chime in?

Steven Lane
Actually, Mark has his hand up first.

Clem McDonald
Okay, sorry, Mark.

Mark Savage
No problem. So, I just want to flag that the language in the final recommendation for Entry 56 is not capturing at least what concerns me in Entry 57, which is the apparent overlap with care team, and we have been discussing that, but to Arien's question, what is the precise language, we have not really addressed that

overlap point in our final recommendation, and I do think we need to get some clarification at least in the definition so that it does not appear that they are referring to the same thing.

Al Taylor
Can I make a recommendation on that part?

Arien Malec
I think we know what it is not, but we do not know what it is. Al, sorry, go ahead.

Al Taylor
Mark, that particular point is really a good one, and my suggestion would be instead of just saying "clarify," I would maybe suggest that we use the term "distinguish" between related person and care team member.

Mark Savage
Fine by me, thank you.

Al Taylor
We should clarify definitions of the two to distinguish between the two.

Hans Buitendijk
And, I would actually add the third one is that if the intent is for purpose of matching, that needs to be clear, too, because that might be handled differently than either of the other two.

Steven Eichner
This is Steve Eichner.

Steven Lane
Steve, hold on. Clem had his hand up.

Clem McDonald
I think I would characterize the idea of matching as identification, and if anyone has used White Pages or any of these things to look up and find people's phone numbers, they include related people, and the purpose is to figure out if that is the person they are asking about. So, I think it is really an identification tool, or a demographic, or however you want to think about it, but I think that is probably what it is important for, and if that word could be found in the right place, it might make the distinction.

Steven Lane
All right. Ike?

Steven Eichner
Thank you. I think part of the issue is looking at how are we defining or how is care team…

Arien Malec
Ike, we cannot hear you.

Steven Lane
Speak up a little.

Steven Eichner
Sorry, is that better?

Steven Lane
Yes.

Steven Eichner
I think part of the issue is looking at what constitutes the definition of the care team today in how we are looking at that definition being changed over time, as well as looking at expanded consumption of the USCDI across new participants in health information exchange, not that we are going to resolve what the definition of the care team is here and now, but it may be something that we might institute as a recommendation as a secondary effort to look at revisiting, redefining, or reexamining what that means in the context of information exchange. Medical professionals, individual patient, and family members… Does a patient define what their care team looks like, or is somebody else defining it for them?

Steven Lane
So, do we need to make any further changes to this recommendation, or can we leave this where it stands?

Mark Savage
I think Al's comment about distinguishing…

Steven Lane
I got that. I got "distinguish."

Arien Malec
It is not a personal relationship, it is a demographic relationship. The intent here is to identify a simple demographic relationship with no implication for inclusion in a care team.

Steven Lane
Okay. How is that?

Hans Buitendijk
I would be inclined to add that clinical care team is very much on the clinical side, but there are administrative, like who is the subscriber, who is the guarantor, etc., that are typically not done in a care team, but there are still very specific relationships that are beyond the simple demographic.

Arien Malec
They are beyond this, right, so there is zero implication for any inclusion of any data here that there is administrative, clinical, any relationship to the ongoing care management.

Steven Lane
Should I just take that out and leave it at this?

Hans Buitendijk
It would be helpful to recognize that the purpose of them sounds like it is not only for simple demographic relationship. If there is an interest to also use the data for identification purposes, that should be clarified in the definition so that we understand that.

Arien Malec
I dropped a proposed text in the chat.

Steven Lane
I unfortunately cannot copy-paste from the chat.

Arien Malec
I have the two-computer setup to hit the spreadsheet and the…

Steven Lane
"It is limited to simple demographic relationships and not intended to imply participation in the care."

Arien Malec
Yeah, we can go offline and clean this up.

Steven Lane
Yeah. Arien, if you can tweak it, that would be great. All right, Hans, did you have another one?

Hans Buitendijk
I can skip the other one because that is a simple note on removing a reference that should not be there.

Steven Lane
Bless you, my friend. All right, good. Let's move on. Thank you both. Next up, we wanted to jump into health status, Entries 26 to 36 and 70, and I think Mark, you had some things you wanted to say about those.

Mark Savage
I just had one suggestion about 70. I thought 70 was the only one we were considering today, so that is all that I looked at, and that was the recommendation for ICF, and I just noted that the recommendation about ICF was attributed to all three of the data elements. We have already talked about disability status as a self-reported item using the six ACS question and the seventh from the Washington Group, so my comment there is I believe the ICF would not apply to that particular data element, and that for the other two, functional status and cognitive/mental status, that we recommended ONC explore whether the ICF value set should be included, as we have been doing with some of the other named value sets, but that would be a part of the sorting process on the back end.

Steven Lane
All right. Thank you, Mark. We have not had a chance to discuss this one, though we did get it into the spreadsheet, so I think what you are saying is that the recommendation is that ONC consider whether ICF

value set should be included among value sets for functional status and cognitive/mental status. Is that good enough?

Mark Savage
Good enough. It sounds like we do not need to say "and not disability status" because ONC is not going to be seeing what the original recommendation was.

Arien Malec
Right.

Steven Lane
So, you would like to include the exclusion?

Mark Savage
No.

Steven Lane
Okay, you do not think that is necessary.

Mark Savage
It is probably not necessary, especially since everybody is on the phone call.

Steven Lane
Indeed. All right, anything else on ICF? This was a long and enlightening presentation from Matt Elrod a few weeks back. We wanted to capture this. And, was there anything else in the broader area of health status that we needed to revisit from anyone?

Arien Malec
Clem has his hand up. Clem, you are on mute.

Clem McDonald
I just want to make sure that the drinking and alcohol assessments are in. I believe they are, but I would just like to hear a confirmation.

Steven Lane
I believe they were listed, yes.

Arien Malec
That is right. They are listed as example value sets.

Clem McDonald
Okay. I would still like to come back to smoking sometime rather than have it just be a list.

Steven Lane
Well, I think we wanted to go to lab next.

Arien Malec
Yeah, I was going to suggest we go to lab.

Steven Lane
Thirty-eight through 43. Everybody close your eyes while he scrolls up. So, we captured our recommendations, actually, in 42 and 43.

Arien Malec
So, I believe, Hans, you have some comments on test kit.

Hans Buitendijk
Yes.

Arien Malec
And, Steven, at the appropriate time, I have a radical suggestion.

Steven Lane
Ooh. Bated breath. Go ahead, Hans.

Hans Buitendijk
I am curious whether I want to hear Arien's suggestion.

Arien Malec
So, Hans, my radical suggestion is that we incorporate everything in Level 2 that is also part of the CLIA defined set for transmission, and there is actually a fair amount of stuff in Level 2, and given enough time, I can go find all the Level 2 attributes that are also included in CLIA. But, that is the radical suggestion on the table for me, but why don't we go through the test kit recommendation?

Hans Buitendijk
I am not sure whether test kit identifier is part of CLIA per se.

Arien Malec
Yeah, test kit is not part of CLIA.

Hans Buitendijk
Right. So, is your suggestion additive or instead of? That may change my comment.

Arien Malec
My suggestion is additive. My suggestion would be to add result status, date, and time. There are actually two Level 2 recommendations that are the same thing. Source site we already are proposing including. In Level 1, we also have the test interpretation, and we would propose including all of those because they are all also included in CLIA.

Hans Buitendijk

So, I have two comments. I will start with the test kit identifier. The challenge there is that for inclusion at this point in time, the ability to capture that at the level of interest, UDI, is very hard at this moment because that needs to start at the time of performing the test, and if you take the flow from the device that actually performs the measure, it does not pass it on as part of a test result and say, "Hey, I measured this and this is my UDI," if you will. That would be nice and ideal, in a way, but that means that in the process, somebody, by way of reading, scanning, or otherwise, needs to do that, and that has been a very challenging discussion, not to the intent, but the viability to actually make that happen.

So, the desire is understood, but that level of specificity is extremely hard to do in today's environment of how that data is or is not available. At best, you could get a higher-level, much more generic, not very unique identifier of the device the test kit used. And, that is just awareness in this context. You are starting to pull in data that goes from an observation, to the specimen, to the test results, to the device that is being used, etc. You are starting to pull in a lot more that is extra work to figure out how to do that right now that is not necessarily directly on the observation. So, just to keep that effort in mind that that is more substantial to bring it in.

So, those two things in combination is where I raise the question. Are we far enough along in this process? Again, I am not arguing the validity in the underlying concept because anything that is associated with EI starts to become relevant, but it is a much bigger chunk to chew off, so I would be very cautious to recommend to include that at this stage.

Steven Lane
Specifically the test kit unique ID? That is the one you are concerned about?

Hans Buitendijk
Correct. And, for the other part that Arien addresses, the principle of it is no concern. That fits very well with the goal of USCDI in our minds to be much more than a core set that really needs to be EHI. I think that the comment made earlier at the start of it is how do we make sure that this does not mean that everybody needs to support that? If you are an EHR, if you are an LIS, then you need that much more. If you are other systems, you need that much less. You might just need a couple of the attributes. If you are doing the actual formal reporting of the report, you have to. If you get further and further downstream or you are just unrelated to how it is still HIT, it is just not that important. So, it goes back to the **[inaudible – crosstalk] [00:57:05]** part.

Arien Malec
The intent is to include the items that are critical for interpretation. So, what was the actual date/time that the lab was performed? The value is pretty meaningless without that. We need the reference range. Reference range is not currently included in Level 1 or Level 2, so I think we want reference range to be in Level 1 or Level 2. Interpretation flag, again, reference range is more generally applicable than the interpretation flag, but the intent would be to capture the bundle of elements that are critical for the interpretation of a value in context.

Steven Lane

So, Arien, your radical suggestion in concert with Hans's concern about test kit unique identifier would substantially change our recommendation. Shall we take a stab at changing that? I see some hands up, including Clem.

Clem McDonald
There are three or four things that have not been mentioned. Firstly, every test kit does not have a code yet. In fact, I read the website talking about progress. The thing they are most interested in getting into their system is implantables, and I think only 30-40 percent of them were coded so far, so that is one thing. The second thing is talking to a major lab, 55 percent of their lab tests are not FDA approved. They do not have these codes. They are called laboratory-developed systems. So, I think what we really need to do is to get input from laboratories before we move too fast on this. There may be difficult process problems. Many laboratories will tweak their instruments to be the same. If they are two different instruments, that will not necessarily show up in the FDA stuff, but they have to switch at night sometimes, like when they have a stat and a non-stat. So, I think we should get deeper knowledge about this before we do it. I think in theory, it is a good idea, but we ought to make sure we are not stepping into a mudhole.

Steven Lane
And, Clem, I think your concerns are specific to test kit unique identifier, correct?

Clem McDonald
Correct. I like Arien's suggestion for sure, by the way.

Steven Lane
Okay. Hung?

Hung S. Luu
My concern is right now, this is already required. In the LIVD file, the test kit and instrument identifiers are one of the required elements to make the LIVD file work, and also, the public health agencies require the reporting of the instrument and test kit information to the public health agencies for COVID testing. And so, this is already a required element and a burden on the laboratories, and yet, there is no established functionality or requirement for the LIS and EHR systems to support it and to help the laboratories be able to do this. And so, people are already having to wrangle with this requirement despite the fact that we are not helping them with being able to meet the requirements by moving the functionality forward.

And so, I do understand that everything is not perfect, but at the same time, this is a real-world situation where people are trying their best to wrangle with it, and doing it manually. And so, even being able to have a field in the LIS and EHR to be able to capture this information and transmit it on rather than having it flow from the instrument to every instance would be an improvement over having to manually enter it in a portal or putting it on an Excel spreadsheet or flat file to pass it on. So, while I share the concern that not every test is going to have a UDI, they are out there for the COVID testing, and speaking with Epic, they do feel that this would be a good addition, and would provide some functionality.

Steven Lane
Hans?

Hans Buitendijk
Just to partly respond, having been involved in the definition of LIVD and the definition of ELR to address test kit identifiers, on the LIVD side, yes, in the standards spreadsheet, which is not yet otherwise accepted and required to be supported by others, but it is starting to get some traction on the FEA SHIELD efforts, it is possible to capture, it is just that it is hard to capture, so I like more the comment that David McCallie is making, that it is much more a "should" than a "shall." Also, having been part of the ELR updates that were necessary that were still going through some further work to include the ability to have test kit identifiers in the standard there, it is the same challenge that the standards could accommodate it, but the practice and the process is something that is just not there yet to get it at the level of detail that is interested, and do it in a way that is not a burden on those that are in between the generation of the test and moving it along. So, just as a general perspective, stating it is required, it is desired, work is progressing, but the level of requiredness is still not at the level that perhaps is desired.

Arien Malec
And Hans, I think we do have this notion of something a little higher than a "should" and a little lower than "required," which is "required at present" or "required if relevant." It is called different things in different standards bodies.

Hans Buitendijk
Yes, and that means you have to demonstrate you can do it, and in this particular case, the thoughts are typically around the EHRs, less around the LISs, the lab system needs to be able to do this, to get it in the right spot. The systems used by the clinicians to review the result…

Arien Malec
May not have it, right.

Hans Buitendijk
They are not going to be entered in there. It is all at the source or nowhere.

Arien Malec
Right. And then, the second question to your point is do the receiving systems routinely have a slot for it, and the answer is, broadly speaking, no.

Hans Buitendijk
That might actually not be as big a problem if they receive it, but they first have to receive it, and the source cannot provide it. That is more where the problem is.

Arien Malec
All right. So, that does then feel more like a "required if present." Two different problems. One is I do not have a slot for it. I have to go create a slot for it in order to conform to USCDI. The second is if it is required, and what do I do if it is not there, and I think we can handle that with "required if present." Sorry, I just wanted to clarify the concern on the table. We should probably go to Ike and to David.

Steven Eichner

Thanks so much for that. This is Steve Eichner. I think part of the question from a public health perspective **[inaudible] [01:04:55]** create things like a COVID-19 test, where it is a required field to be reported. As we look at the information flow that public health typically gets for that, typically, it comes out of an LIS in addition to potentially coming out of an EHR. As we look at USCDI standards, if there is a standard or a place for it in the USCDI, it does provide an opportunity for it to be included in EHR standards, and that enables hospitals and other users of EHRs to have a more specified place in which to receive it, which would then make it easier for them to transmit it to public health when required if it were available. It also gives the hospitals an opportunity to catch the information sent to them by an LIS or a LIM system, so I think there is value in including it in the USCDI. It may not be populated fully at this point, but it is a direction where we are going, and including a field for it seems to make sense. Thank you.

Steven Lane
David?

David McCallie
I would just agree that this makes sense that it is valuable and, in some cases, essential for proper interpretation of the lab test that was ordered and paid for and affects patient care, so if you have it, if your system can send it, you should send it. It makes complete sense, just like range of normal, abnormal flag, and all of the other fields that we have talked about. If you have it, you should send it, and the fact that it creates a burden is what regulations are for, is to create burdens for compliance for good quality care.

Steven Lane
Okay. So, Arien, test kit unique ID: Does it go in this new list?

Arien Malec
Let me just summarize what I think we are hearing from the workgroup. I think we are hearing from Hans that there is no burden to receive the data because the slot for it is often in systems, and the burden for adding the slot is low. I think we hear significant concerns about requiring it because it is not routinely available at source. I have not heard significant objection to a "required if available" designation. It is not clear that USCDI core currently has the "required if available," but there are a lot of other areas. So, for example, in lab, there are many things that are required if you have them or are relevant and are not required in other times, and I do not think that is unusual for laboratory data. It is a useful concept to include in USCDI.

Steven Lane
So, it sounds like it is back in.

Steven Eichner
Well, a little clarification. If the USCDI is describing a method of sending it if you have it, but not looking at whether it is required or not, just "If you have it, here is a method for transmitting it…"

Arien Malec
Yeah, that is exactly what we are saying by "required if present."

Steven Eichner

Right, that USCDI does not really have an impact as to whether it is required or not from a decision-making standpoint.

Steven Lane
So, did I capture it all, Arien? Oh, Al is up.

Arien Malec
The one more that is in CLIA and that also has comments in Level 2 is UM, unit of measure.

Steven Lane
Okay, perfect.

Arien Malec
And, interpretation. And then, we also would want a future iteration of USCDI to contemplate reference range.

Hans Buitendijk
And Arien, I just dropped in a note that my statement of it might not be as big of a concern. I want to double-check, but there are systems that I know it is not a concern, but systems that based on the focus of them, it would be more of a concern because they are specialized in a particular way where this would not come up as much, so that is why, and it goes back to if you have it/if you do not have it, etc. It is that entire stratification thing.

Arien Malec
My detailed knowledge in the space goes back a decade, so David's comment may be the more relevant one, which is, "Hey, we have had years." Al?

Al Taylor
So, this is a point of clarification. To be certified to an updated version of USCDI means the ability to capture and exchange a data element.

Arien Malec
Yup.

Al Taylor
So, the ability to capture means they can capture it, not that it has to be if relevant.

Arien Malec
Right, and it would not be…

Al Taylor
[Inaudible – crosstalk] [01:10:30] data element in USCDI.

Arien Malec

And Al, I think maybe one clarification there. So, useful correction, which is that we are certified to USCDI V.3 in the future, if we do not have this data element, we need to add it. Al, with respect to capture, it would be illogical to manually enter, in many cases… Maybe you could contemplate manual entry, but I cannot think of that many cases where, for example, a pediatric EHR would want to manually enter the test kit, unless you are doing… Never mind, I can think of multiple situations where you would want to enter this information. But, typically, we would want to have it captured from the perspective of interoperability of data flows from downstream systems that had captured that at source.

Steven Lane
All right. Please look at the language and let me know if it is adequate.

Arien Malec
Yup.

Steven Lane
Going once, going twice, sold. Thank you all. All right, that almost brings us to public comment. That is amazing.

Arien Malec
Yes. My objection to the onsie-twosie adds have been that it is not clear what we are adding to. What I have now recognized is the way we want to handle this is actually literally have each of the data elements included in USCDI. We would want to do the same cleanup for medication, but I do feel with this recommendation, we have gotten lab to the point where it is useful as a concept and not wholly lacking with respect to the fields that are included in USCDI.

Steven Lane
So, as you note, medication has a long list of items in Level 2, which we certainly do not have time to contemplate at this moment.

Arien Malec
Which we do not have time to contemplate, exactly.

Steven Lane
So, work for another day. This is one of those areas where we have specifically asked ONC if they might be willing to support and charge our workgroup in revisiting this, even potentially during this annual cycle, in preparation for Version 4.

Arien Malec
And, coincidentally, Al has his hand up.

Steven Lane
How about that?

Al Taylor

So, just as a reminder, not to answer your question, Steven, at least just yet, but regardless of what the workgroup ends up recommending, individual workgroup members, who, in addition to being members of the workgroup, are also members of the public, are more than welcome to input their individual comments, including representation from their agencies if that is applicable, into the draft USCDI V.3 data element or data class pages for consideration by ONC as an individual comment rather than a comment that comes directly from a workgroup. So, continue to promote that, or maybe "promote" is not the right word. Encourage, make available. That system is available for making feedback, comments, and additions to USCDI by the end of next month, so we have a whole month to do comments and feedback directly onto the website.

Steven Lane
That is great. Okay, other items that people really wanted us to have a chance to consider here as a workgroup? This is your chance. We have put together quite a number of recommendations, and they have all been captured, I believe, in our Row K, final recommendations, throughout the spreadsheet. Our plan is to work with the ONC team to turn this into a prose document that Arien and I are going to work on with the team over the coming days and hopefully get out to you all for review. I think our plan is to spend the first portion of the next meeting considering any feedback that people have on how those things have been phrased so that we will then be ready to submit a final to the HITAC leadership for distribution, and then Arien and I will be presenting that to the HITAC at our meeting next month. Grace, your hand is up.

Grace Cordovano
Yes, I just have one thing that I wanted to bring up: Tumor board notes. This was something we had discussed. I did submit this in ONDEC. I did send a follow-up email to Al. I am not sure where that stands, but my understanding is all notes need to be released, but I do not know if it needs to be specifically called out as an item in order to have it recognized. Do you have advice on that?

Steven Lane
So, are tumor board notes, first off, identified with a LOINC code?

Grace Cordovano
I can send something in the chat, or I can follow up offline.

Steven Lane
So, firstly, it would have to be a LOINC-coded notes. We have already suggested that all LOINC-coded notes be transmissible with their code, so, if so, I think we have that covered. If it is not a LOINC-coded note, it is work for LOINC. There is sort of an associated question as to whether tumor board notes are part of the designated record set, which is more of a HIPAA information blocking question than a USCDI question, but an interesting one at that.

Grace Cordovano
And then, similarly, clinical decision support outputs. That also was submitted to ONDEC, but more information was requested. I did provide more info, but I do not know if it was enough to suffice. So, again, outputs or any clinical decision support: Should there be a new note, or should it be captured in current notes that are available?

Steven Lane
Yeah, and I think some of these items could also come up in our discussions in our Task 2 work as we are approaching recommendations for the ISA, if these things are missing. Mark, your hand is up.

Mark Savage
Yes. Dr. Google tells me that the USCDI Taskforce addressed that question last year. Dan Vreeman responded, "Yes, there is a LOINC code for tumor board notes."

Steven Lane
Okay. So, it would seem that that would be caught up in our recommendation to be able to transmit any LOINC-coded note. I think the question, then, Grace, also is whether in the certified health IT systems those notes are getting coded appropriately, and I see you shaking your head. All right, in terms of upcoming Charge 1 meetings, I went through that. Basically, we have some writing to do, we are going to get you a document to review, we are going to discuss it next time, and then, in our next meeting, we are going to transition to Task 2, and all of you will certainly be invited to join the HITAC meeting when your work is presented, and we will welcome that participation if you like. Shall we cut to public comment a little early?

Michael Berry
That would be great.

Steven Lane
Is that acceptable?

Public Comment (01:18:19)

Michael Berry
Absolutely. We will put up the public comment slide. So, we will open up our meeting for public comment, so if you are on Zoom and would like to make a comment, please use the hand raise function, which is located on the Zoom toolbar at the bottom of your screen. If you happen to be on the phone only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. So, let's pause for a moment to see if anyone has a public comment.

Steven Lane
And, I will note that there are 17 members of the public with us today, some of whom have presented to us at prior meetings on topics we have discussed today, so I really invite any of you to step forward and provide input.

Michael Berry
I am not seeing any hands raised, so I will turn it back to Steven and Arien.

Steven Lane
All right.

Arien Malec
We get to give everybody back a few minutes.

Steven Lane
I think we finished early. This is pretty remarkable.

Arien Malec
I think your cochairs have some work to do. What I would like to do is make sure that by some clear date, every row of the spreadsheet is colored such that we have accounted for every recommendation and have a definitive set of recommendation text. Again, I encourage the workgroup members to review any of the uncolored rows currently. Apologies if color coding does not work for you, but you can certainly look in the Google docs to see the code that has been currently applied, and just make sure that we have definitive markings for the recommendations and disposition for anything that is outstanding.

Steven Lane
And, since we do have just a few extra minutes, I would ask the members of the workgroup for any feedback on our process to date. We have had a fast and furious traverse of our Task 1, and we are going to be moving on to our Task 2 as we close this out, and if anyone has any suggestions that they want to either share publicly or with the cochairs privately, we are more than open to those. This is your workgroup, and we want it to work well for you. Mark, your hand is up.

Mark Savage
Just the obvious. Kudos to you and to Arien. This was fast and furious, and it was all over the map, as is understandable for something like USCDI, and we are where we are because of your navigation, so, thank you very much.

Arien Malec
Thank you. It has been a fantastic workgroup, and there is always that magical moment where you start to figure out how to land the plane.

Steven Lane
All right. Well, we are not afraid to give you all eight minutes back. Go get an extra cup of liquid, and everybody be well. We will see you next week.

Mark Savage
Thank you.

Arien Malec
Thank you.

Adjourn (01:21:29)