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

April 12, 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 always glad that you could be with us today, and a special thanks again today to our cochairs and our workgroup members for all their hard work on these recommendations on the draft USCDI Version 3. Those recommendations will be presented to the HITAC tomorrow, so we are looking forward to that. As a reminder, your feedback is always welcome, which can be typed into the chat feature throughout the meeting or can be made verbally during the public comment period that is scheduled at about 11:55 Eastern Time this morning. I am going to begin roll call of our workgroup members, so when I call your name, please indicate that you are here. And, I will start with our cochairs. Steven Lane?

**Steven Lane**
Good morning.

**Michael Berry**
Arien Malec?

**Arien Malec**
Good morning.

**Michael Berry**
Kelly Aldrich?

**Kelly Aldrich**
Hi, everyone.

**Michael Berry**
Hans Buitendijk? Thomas Cantilina or Jeff Ford? Christina Caraballo?

**Christina Caraballo**
Good morning.

**Michael Berry**
Grace Cordovano?

**Grace Cordovano**
Good morning.

**Michael Berry**
Steven Eichner?

**Steven Eichner**
Good morning.

**Michael Berry**
Sanjeev Tandon?

**Sanjeev Tandon**
Good morning.

**Michael Berry**
Raj Godavarthi? Jim Jirjis? Ken Kawamoto? Leslie Lenert? Hung Luu?

**Hung S. Luu**
Good morning.

**Michael Berry**
David McCallie?

**David McCallie**
Hello.

**Michael Berry**
Clem McDonald? Mark Savage?

**Mark Savage**
Good morning.

**Michael Berry**
Michelle Schreiber? Abby Sears?

**Abby Sears**
Good morning.

**Michael Berry**
And, Ram Sriram? All right, well, thank you, everyone, and now, please join me in welcoming Steven and Arien for their opening remarks.

**Arien Malec**
Hans notes that he is on. He just had trouble getting off mute.

**Michael Berry**
Thank you.

## Co-Chair Remarks (00:02:05)

**Arien Malec**
All right. As Steven gets his computer rebooted, we are going to focus on… We have the final or near final recommendations. We have a number of folks who emailed some corrections to the final recommendations, so if the workgroup members have any comments on the recommendations draft that we have, I think we

will start initially by talking about that, but we are going to spend most of the time thinking about the ISA prioritization and the topics. We have gotten a fair number of votes already on our proposed topics for the ISA portion of our work plan, so we are going to start doing some preplanning for the deliberation that we want for the next set of recommendations that we are obligated to provide back to HITAC. So, with that, Steven, unless you want to verbalize anything else, we should jump into it.

**Steven Lane**
Thank you, Arien, for kicking us off, and again, add my thanks to others' for the input that we have gotten. We actually got some really important feedback from a couple of you on the draft document that we sent out and are making some adjustments accordingly. So, does anybody want to raise their hand and jump in with any additional comments besides what you have effectively sent us through the email? If not, all the better. That will give us more time. I think Arien and I are going to be presenting. Oh, there we go, Kelly.

**Arien Malec**
Yeah, Kelly has her hand up.

**Kelly Aldrich**
Yeah, hi, everyone. Thank you. I was reviewing the documents, and I know that we are looking to be able to not be garbage-in, garbage-out. We all know this. And, one of the things that we have to be mindful of is being able to quantify who is doing the documentation for person-centered care, and I did not see anything reflected with the unique nurse identifier that we had a pretty good discussion around, and maybe it comes at a different point, so I was not sure if I should bring it up or not, so I just look to you all to give me some guidance on where that fits. Thank you.

**Steven Lane**
Yeah, thank you, Kelly. I do not know if Al wants to bring up that particular recommendation. I do not have it in front of me, but my recollection of the language was that we wanted to be able to identify the individuals using any number of identifiers that are available, and we did not specify specific ones. I think we perhaps made reference to a couple, but perhaps if we have a little list there, we could add the nursing identifier to that. I do not know what other people think. Let me pull up those documents.

**Kelly Aldrich**
Yeah, thank you, I appreciate the discussion. This is very meaningful as we look at safety and quality outcomes associated with patient data, and this is a policy initiative that we have been working on for at least five years now with the big data group out of Minnesota, and again, it has very meaningful implications for the nursing community.

**Steven Lane**
Yeah, I do not think that we would be referencing it specifically as a component of USCDI, but rather as a potential value set that could be used to identify individuals.

**Kelly Aldrich**
Great, thank you.

**Steven Lane**

Al, do you want to jump in on that one? Are you here? He may be having the kind of morning that I was having. All right, we will make note of that, Kelly, and go back and look for where that opportunity might be.

**Al Taylor**
Sorry, I am back. What I was not sure about was if the recommendation was to specify unique nurse identifier as part of the care team member identifier. We currently do not have any specifications for care team member identifier. I was not sure if that was where you thought you might capture that.

**Kelly Aldrich**
So, if that is to me, yes, that is where I thought we would capture it. The quality and safety initiatives were very easily able to capture the provider input because it is associated with billing, but there are other care team members associated with quality and safety outcomes, so I actually defer to you all. Where do you actually think that is the best fit?

**Arien Malec**
Care team member identifier is already in USCDI V.2, so I think this is really a question for the value set or the definitions of what goes into care team member identifier, and at some point, we may want to contemplate that care team member identifier, like we have in other places, is a combination of assigning authority and value, but NPI is often used, but we could also use nursing identifier as a care team member identifier. So, I think the good news is it is already in USCDI V.2, and this is mostly a question for structuring the representation of an identifier to make sure that it accommodates multiple types of identifiers.

**Steven Lane**
And, I knew that we had had a discussion about that, with Clem sort of leading the charge, but we did not end up with a specific recommendation about it.

**Al Taylor**
I just looked through.

**Arien Malec**
Yeah. We had a good discussion on facility identifier and settled on a facility or organization identifier with that same structure of combination of authority and identifier attached to the encounter, but as I said, care team member identifier is already contemplated in V.2.

**Al Taylor**
Just to add to that, along with the care team member identifier, the care team member role. Care team member role does not define the assigning authority like unique nurse identifier or NPI would, so those two things go together to identify which part of the care team, but again, neither one of them have a specified standard, like constraining it to just NPI or just unique nurse identifier.

**Arien Malec**
We will call on you, Clem, but what I was going to add, Kelly, was that there is certainly an opportunity to add public comment on that care team member data element. There are only a couple in there right now, and that would be a good route to go, perhaps. Clem?

**Clem McDonald**
I just wanted to reinforce what David McCallie just said. These have to be dynamic and local on whether one could use cell phone numbers or email addresses, which is done in a lot of circumstances in bigger deals than that. I just finished up my TurboTax, and that is how they identify me, or at least how I get in. I do not know if that will fit, but it will certainly be an easy thing to do.

**Al Taylor**
So, Clem, just as a point, an additional data element in care team member data class is care team member telco, so that is going to include both phone number and email, possibly website URL as well.

**Arien Malec**
David point is really that, again, for anything where we have an identifier, we should always have an assigning authority that is uniquely identified via URI, member CUID, or other method, and that by doing so, we would be able to accommodate nursing identifiers as well as NPIs.

**Kelly Aldrich**
And, I will just throw in there that this is not something that changes. When you sit for your boards, you are assigned this unique identifier from the international board state council, and so, I just want to point that out. This is not something that changes, so thank you.

**Steven Eichner**
But, that is if it is issued by an entity, not a different type of care member where there is not a certifying authority or central authority that is a license board or something of that ilk. That being said, I think the telco number is also not really a good idea because phone numbers do change in personal life, or we are looking at having to disclose a phone number or cell number that really is not appropriate. That use is probably something we do not want to go into at this level, but leave it as a placeholder. There does need to be some identifier, and a combination between some issuing entity and a unique number underneath that is probably sufficient.

**Arien Malec**
And Kelly, I will also add that both provider NPI and DEA are listed as Level 2 data elements that could potentially be advanced into a version of USCDI, so what you and constituency may want to do is try to advance that nursing number, get it on the table through the website so that it can be leveled next time around.

**Kelly Aldrich**
Thank you.

**Steven Lane**
Again, just from a standards perspective, I would prefer to have the notion of a combination of assigning authority and identifier, and then have a list of core identifier assigning authorities so that we can accommodate NPI, we can accommodate a DEA number, and accommodate NCSBN. Okay, cool.

**Steven Eichner**

Or, in the case of a Texas care provider network for mental services, if there is a care provider ID in that space as well, because we have the license or certify your providers for behavioral health services, that has the potential to fit into Arien's matrix.

**Steven Lane**
Great. And, I do not think we are here to expand the scope of our prior recommendations. We just wanted to get any further feedback on the recommendations as drafted, knowing that we will be back again next year to do this again.

**Arien Malec**
All right. So, any other corrections or amendments to the recommendations as stated? Otherwise, we will move on to the ISA portion.

## ISA Topic Prioritization Discussion (00:13:22)

**Arien Malec**
Excellent. Awesome. Let's go on to the ISA portion. So, I think everybody knows the ISA portion, but generally, what we are looking to do is update the ISA and make sure that we are feeding the ISA with important standards and interoperability specifications, implementation guidance, and others that are important for interoperability, and as a reminder, just because we have been so deeply enmeshed in the USCDI portion, the way I think about this is USCDI defines the standard catalogue of data with respect to which interoperability occurs, and the ISA portion describes the… So, think about the USCDI as the noun, and then, the ISA portion are the verbs associated with exchange. So, generally, we want to think about USCDI as bounding the information that wants to get exchanged and the ISA describing the use cases and implementation specifications according to which data are exchanged in between settings on behalf of the patient or providers for purpose of improving care or health. Boy, that up-front statement occasioned three separate hand raises, so we will go in order. David, what did I say wrong?

**David McCallie**
No, I think you said it right, but I think there is some subtlety there that we struggled to try to clarify in last year's group that I just want to make sure things have not changed. Maybe Mike can comment on it. The addition of a new standard to the ISA is one thing, and if there are standards that should be a part of ISA, that is straightforward for us to recommend that, but the other, more subtle thing is to address high-priority uses. I think we took it last year to mean we could identify areas where we need a standard, but the standard does not exist yet, so the use itself can be added as an area of focus, and that is different from finding a standard that exists and saying it ought to be in the ISA.

**Arien Malec**
Yeah, David, I think that is a fantastic clarification, thank you for that, and yes, that is definitely how we interpreted our charge last time, was to identify both areas of emerging use of standards as well as categories of exchange even if there was not a standard, and so, in some cases, for example, in our work on research, we identified research as a need, and then listed multiple standards, and we certainly are open to adding high-priority areas even in areas where there are not existing standards implementation guidance. Clem?

**Clem McDonald**

Both David and I were on the early ISA committee, and the early committee, I think, was doing the same thing as HITAC. We basically had an approval process to put them in, but it was broader. It included not just code systems, but also messages, etc., but that has evolved because now, ISA is really a free-for-all. Anybody can put anything in there. That is my understanding at present.

**Steven Lane**
No, I do not think so, Clem. This is the process by which most things get added. I think that ONC can certainly add things, but I do not think it is meant to be quite the open door that USCDI is designed to be. Al, maybe you can clarify.

**Al Taylor**
Well, it may be somewhere in between. The feature of USCDI which allows open comment and open submissions does not exist in the ISA, but the content is added based on anybody's input that seems reasonable. All of the input is vetted, and then entered by ONC by the different ambassadors for the different areas of the ISA. So, it is not quite free for all, Clem, but it is pretty open to any available standard. I know that you did not mean it like that, but whether they are required, optional, never heard from, never heard of before, they all can go in there just as a place to go to look for different standards and different areas.

**Clem McDonald**
No, I accept that, but I just want to highlight, though, that Joe Blow can type something in there, and that is part of the ISA for at least a while.

**Arien Malec**
I lost Clem.

**Steven Lane**
No, he is here.

**Al Taylor**
No, Clem. Approved users can enter comments on both ISA and USCDI, but approved users cannot enter new interoperability needs in the ISA. That has to be done by ONC.

**Clem McDonald**
Okay, thank you.

**Arien Malec**
All right, going to Hans.

**Hans Buitendijk**
I would like to get a little bit more clarification around the purpose of the ISA to have clarity around that because the interpretation of how the ISA is used might also influence what we suggest to put in there or not, and it is our understanding that the purpose of the ISA is primarily to identify for different use cases, hopefully at least what USCDI covers, but it can go well beyond that at this point in time, is to identify standards that are either best known or in progress, but there is not a requirement to use them. It is a place to go to investigate what you might or could use, but it is not in itself a requirement that it should be used

or shall be used, not until you get to a certification program or to another program where the actual requirement is documented and stated on which standard out of the ISA, or perhaps another one, it need not be in the ISA, is being used.

So, I think we have to be careful on what the meaning is of something being in ISA that you cannot conclude, that therefore everybody immediately adopts it, and that has its positives and negatives. The positive is that I like the idea that it could be a place where there is now implementation guidance standard where you want to fill out, or where you can have a variety of standards to indicate these are commonly known, or used, or the best available, but it might still not be mature enough to go into a regulatory or other program, and I think that is a unique characteristic of the ISA, that it is that library of what is out there and that we should be aware of that it is the latest and best known, and that is a good purpose, but beyond that, it is not an immediate indication that it shall be used and that everybody will adopt it immediately.

**Arien Malec**
Maybe just a couple of things there. No. 1 is yes, there is no implication that inclusion of something in the ISA is, ipso facto, a certification criteria or a "shall." Based on multiple recommendations of multiple incarnations of ISA workgroups, the ISA does have a maturity scale, so the ISA accommodates the maturity of standards, and at least one of the purposes of the ISA is as a catalogue where, if people want to solve a problem, they can look up in the ISA the best way to solve that problem based on maturity and adoption.

The other place that the ISA can be used is to serve as a catalogue with respect to future certification needs. That is, to the extent that there is a set of certification criteria, you would want to draw those certification criteria from the ISA, but no, Hans, I think that is right. It is a place where its primary purpose is as a catalogue to inform stakeholders about how to solve a particular problem using standards and as a place for tracking the maturity of the underlying standards implementation guidance. Steven suggests that we just show onscreen the ISA, so whoever is controlling the screen may want to do that. Al, you may want to comment.

**Al Taylor**
I just wanted to add that I think that Hans's explanation and your clarification was really good. The only thing I would add to that is that there is a piece of the ISA that shows whether or not a particular display standard is required, and then, on the point about the issue of the maturity and the adoption, those are similar, but not perfectly aligned with the leveling criteria in USCDI, and that might be something to look at as to whether or not to align those two. So, there is maturity, which is a broad topic, there is adoption level, and then there is a requiredness field within the ISA standards that does include that. And then, it points to where the requirement is, whether it is in certification, or CMS reporting, or CDC. There is that link as well.

**Arien Malec**
That is great, and David and I will go back to the famous Dixie ENHIN power team workgroup where we created a framework and rubric for assessing the maturity, which has mostly been adopted into the ISA. Christina?

**Christina Caraballo**
I was just going to say I think there is an opportunity for us to make recommendations on how to better tie ISA to USCDI. I think going back to a couple comments Al made, looking at the adoption level in ISA, it is

still a little unclear to me how this is determined. It might be interesting to do an exercise on how it could map to the levels in USCDI. Also, in the federally required part, we have a simple yes/no. Adding which federal requirements are needed could be another area that we could recommend expanding the ISA, and also potentially noting if it is required in USCDI. I think there is an opportunity for ISA to be that encyclopedia, but also help feed and identify things for USCDI. If we have a really nice alignment and we can pull out of ISA for USCDI when appropriate, I think that is just going to be stronger to be able to tie them together.

**Arien Malec**
Okay. So, just a bunch of emerging, really interesting bits. First of all, I completely agree, and I believe that is the reason why we wanted to come back what formerly were two Task Forces into a single workgroup because updating the ISA and updating USCDI are things that feel like they want to go on in concert. I see Hans echoing your comment about inclusion in certification criteria. Formerly, we thought we had one set of certification criteria. As we evolve the certification program, it is likely that we have multiple sets of certification criteria and multiple sets of agencies and programmatics that want to get tied to certification. It would be useful having a more specific set of inclusion. Hans and I are going back on practically whether ISA inclusion is a requirement to include in certification or not, and I would imagine it would be a policy failure if you had something that was included in certification criteria that was not included in the ISA, but as Hans notes, this may not have been formally specified as a requirement. Steven?

**Steven Lane**
I was just going to say just peeking into ISA right now, for example, I pulled up cognitive status, and while it is in there, there is no mention on that page that it is being contemplated as part of draft V.3, so I am just echoing Christina's comment that it would be good to have more of a tight linkage so that ISA changes are made to reflect what is going on in USCDI, and then, also, just agreeing with what you were saying Arien. It does make sense that something belongs in ISA with the appropriate specified standards before we add it to USCDI and before we add it to certification.

**Arien Malec**
Right. And so, Al, this is sort of a meta-ISA portion, and I think USCDI group and the ISA workgroups have done this in the past, where we want to really contemplate not just the inclusion of things in the ISA, but also the process and framework under which the ISA exists, and there are some things that I suspect are going to be nonregulatory advice. I do not think ONC is going to want to limit its activities in terms of certification, but it would be useful to state that it would be normal practice for the ISA to be the catalogue from which certification criteria would be drawn. All right, seeing no further hands up, maybe we can go to the prioritization spreadsheet.

**Steven Lane**
And, thanks to the ONC for putting this together. What they pulled forward was the items that I think were still in play at the end of your workgroup last year. Is that right, Arien and David?

**Arien Malec**
That is right. The catalogue that we drew from was the catalogue that we entered into this workgroup iteration based on ONC prioritization and activities that were under way, the catalogue from the previous incarnation of the ISP Task Force that was formerly a standalone Task Force focused on ISA updates, and that was the set of high-priority activities that we did not get a chance to get to, and then, the inclusion of

the HIPAA right to amendment and standards and certification associated with that. So, if we go to the next slide…

**Steven Lane**
There we go.

**Arien Malec**
There we go, yeah. So, we included all of these in the prioritization spreadsheet. I think we got a little more than half of the folks on the workgroup who have filled out prioritization just on a scan.

**Steven Lane**
We may be up to two thirds now.

**Arien Malec**
Yeah, I am actually looking at a live view. I believe the last edit was seconds ago. So, if you have not put your updates in, this would be a good time to go do that. And then, I created a very simple sum across the priorities to give an indication about what categories appear to be getting broad support. David, you have a question.

**David McCallie**
Yeah. I was just going to caution that you should take my prioritization a little bit with a grain of salt because I was not sure what all these things actually meant, so I would probably want to re-rank after we have a chance to talk about what we actually mean. And, No. 2, more importantly, are we open to some other things that we think should be on this list, or is this the only ranking choice?

**Steven Lane**
This is really just where we decided to start, with the work that had been done and one key item that had been raised in our discussions in the first phase of our work, but this is the time, right now, in the next week, for people to bring forward additional items that we might want to consider, and then, what we will do is put together a schedule of how we are going to tackle these, but the prioritization process is a key part of that.

**Arien Malec**
Yeah, we are certainly open, and hopefully people have heeded the call for homework to add items to the ISA, but as Steven says, this is the time to do it. If you are going to do it, do it now because we are going to lock in or plan for the remainder in March towards the next…

**David McCallie**
So, maybe I missed the email or did not read it carefully enough, but what is the process to nominate other topics for prioritization? Send an email to you guys?

**Arien Malec**
Yeah, send us an email or bring it up in this form.

**Steven Lane**

Yeah, our plan is to post yet another spreadsheet where we can actually dig deeper into these items. For those of you who were on the ISP Task Force two and three years ago, that was a process we went through, so I think the ONC team was also planning on putting together a spreadsheet where you could all add items and comment on them.

**Arien Malec**
Cool. Clem?

**Clem McDonald**
The list looks to me like a bit of a mishmash, like apples and houses. Some of them are specific, and a lot of it echoes some of the things we discussed in our meetings. That is not different. But, you have lab orders twice. There are just different looks at it. CDC is in there twice. We almost need some constraint or guidance on what we are really talking about and how to list them. There are individual codes/standards, and there are much broader things about just moving data.

**Arien Malec**
No doubt. So, this is a reflection of the concepts that have come input. This is an area where I would expect, No. 1, as Brian Bellendorf used to tell me, the Apache Foundation motto was "patches welcome," so if there are specific areas of clarification or specific areas of focus, I think we absolutely welcome that. And then, I would expect that as we dig into these areas, we would better clarify the high-priority areas and get into more precise clarity.

**Clem McDonald**
This includes none of the message side or the structural side that is in ISA. It might be worth it if everybody took a quick look at the categories currently in ISA because this leaves out most of them, or probably two thirds of them.

**Arien Malec**
Yeah, this is not intended to be a complete enumeration of what is in the ISA, it is intended to be an area of focus for high-priority use cases.

**Clem McDonald**
I understand, but I think it implies that everybody does not know the whole space. They are picking out their favorite things. That is all. I do not know if it is going to be a good prioritization unless everybody is aware of what could be.

**Arien Malec**
I would definitely recommend that people look at the ONC ISA.

**Steven Eichner**
This is Steve Eichner. Just to highlight one of the issues with electronic case reporting standards and current issues that public health and providers are facing, there is a disconnect between what standards some HR providers may be building in or not building in to their electronic health record systems to utilize the HL7-developed ECR standards, and that limits the ability of technologies developed by those providers to interface with the AIMS platform and providers successfully meeting/promoting interoperability

requirements as laid out in federal regulations. That is a significant gap with many real-world implications coming up quite quickly as we enter into 2023, where those requirements are really going to be in large force across the country.

**Arien Malec**
Indeed, and that is why we included it as a prioritization item.

**Steven Eichner**
I appreciate that.

**Arien Malec**
That was explicitly why we wanted to bring it up in this form. Hans, you have your hand up.

**Hans Buitendijk**
Thank you. Following up a little bit on Clem's comment, and maybe a clarification from that that we can have on where to look, looking at the ISA, it has a vocabulary terminology component, and then, it has areas where it addresses messages, documents, services, a variety of different syntactical ways to get data across. Since we have the USCDI Version 3 or the progression there, which matches effectively to the ISA vocabulary area, are we going to want to look here in this conversation, not as much as that part, where we could generally say align the two up and make sure that they are in sync, but really focus much more on the syntactical asset types of standards, security and other types of standards, where the means of communicating such data is being addressed, and this can be a top 10 list where we want to focus on and make sure they are most current, perhaps all this as well. But, that is the perspective. What in the messaging document serves the space otherwise transport do we need to enhance to make these use cases work and be reflective of most current standards that are in play?

**Arien Malec**
Yeah, thank you for that. So, the way that I interpret the mission or the charge for the Task Force is to identify priority use cases, and I think the note of vocabulary code set and terminology is well covered in the USCDI portion is well taken. We would really be looking at content structure and services exchange, but we would be looking primarily at the underlying use cases. So, for example, if folks are on the ISA page, the table of contents, look at content and structure. There is a section entitled "care plan," and then there are use cases associated with care planning relative to content and structure, and one might look at disease-specific care plan standards or documenting and sharing care plans for single clinical context, click through, and get to a tabulation of implementation specifications, standards, and focus level of maturity.

So, we would be primarily focused on the broad-level headings as well as the use cases associated with interoperability, and then, under that remit, we would look at where there are missing use cases or priority areas, and No. 2, Hans, to your point, whether there is emerging new implementation specifications or areas that need to be reflected in the ISA, as well as work on the ground relative to the existing items in the table of the ISA. So, for example, as far as I can tell right now, there is not a high-level category for right to correction relative to either services exchange or content and structure, and so, that would be an area where we would recommend the inclusion of a priority use case and then point that priority use case at the emerging work that has already been done in HL7.

If we look at the laboratory space, we have existing work on ordering tests, receiving tests, and exchanging in vitro diagnostic test and orders. This would be an area where we would want to look at the SHIELD and LIVD work and make sure that the set of standards and implementation guidance that is in the tabulation is up to date and reflects the current consensus as well as help steer ONC with respect to ongoing work to establish this as a priority area to drive to greater maturity and adoption. David has his hand up.

**David McCallie**
Yeah, I am going to send you an email with a list of things to consider adding, but I wanted to just throw one out for group discussion if anybody has a reaction to it. It occurs to me that one place we ought to look for use cases to help focus ONC's attention, which I think is the phrase you used, Arien, which is my sense of the real value of the work we are doing here, is focusing attention on an area that needs attention, is to check out and make sure that all of the use cases that are associated with FHIR accelerator programs are covered or are at least discussed if they are missing. As I think most of you know, there are six or seven FHIR accelerator groups which basically represent people that have decided to go work on solving a problem by extending FHIR and providing implementation guides, and they are, by definition, addressing emerging issues, and I think we should spin through that list of programs to make sure they are all captured in our discussions.

**Arien Malec**
Yup, that sounds good. Ike?

**Steven Eichner**
Thank you. There are a number of elements in the list that are focused on or heavily involve public health, and I cannot help but wonder whether we should request that a public health Task Force either be set up as a separate, parallel group to Interoperability Standards or as a focused subgroup within the Interoperability Workgroup to focus on those activities to make sure that we are getting good representation from public health, not just as a subset of this workgroup or HITAC at large, but there are really some complex issues that need to get addressed looking at certification that really require some in-depth work.

There has been a suggestion that certification of public health systems might be something worth exploring, but there are a variety of impacts that need to be considered not just in terms of what standards might be utilized, but what incentives might be offered to how development of certification programs might be funded, and what we are looking at is a cycle for getting to implement that, so that might be a recommendation to come out of this, is to collect those that are focused on public health and treat those as a separate, distinct class as we focus in on that.

**Arien Malec**
Yeah, no doubt, and in the last incarnation of this workgroup as a Task Force, we explicitly punted on public health even though we identified it as a high-priority use case because the Public Health Data Systems Workgroup was getting under way. And so, we do real-time discussion with ONC to make sure that we do not go over an area that is already well covered. I think to your point previously on ECR, it is a good point. We have the expertise in this group to be able to make some comment there, but we will continue that work of making sure that we are working with ONC and the other workgroups and Task Forces to make sure that we are not duplicatively covering areas that are already well covered in other places. Steven?

**Steven Lane**
Just a couple comments. One, Ike, to your note, at the end of the work of the prior ONC Public Health Task Force, there was certainly a recommendation to ONC to consider keeping that group alive or rekindling it to do additional work, as we really were crunched for time in terms of what we could get out. As far as I know, it has not been set up yet that that group would be reinstated, certainly not in this year's annual cycle, so this may be an opportunity as we tackle these issues here within this workgroup to have a focused session, perhaps inviting some folks from CDC, states, and/or HIEs that are involved in public health data transmission to come and talk to us specifically about what, if anything, they feel may be lacking from the ISA that perhaps we might want to recommend. Again, as we were noting earlier, anybody has the opportunity to provide direct input to the ISA, but as with our work on the USCDI, if an item comes here, gets some airtime, and turns into a formal recommendation, that may put some additional incentive behind it as ONC approaches it.

The other thing I wanted to mention is I just really wanted to encourage workgroup members to go back and read the reports that were distributed with today's meeting materials from the Task Force that worked on this last year. The format will look familiar to you, as it is very similar to the report that we are sending to HITAC tomorrow, but there were really just seven recommendations. It does not take long to get through them. There was the initial document that was finalized in June, and then there was a supplement to that the following month in July, so that workgroup did great work, and I think all of us should be sure to review that in detail.

I also want to thank Jim Jirjis for joining us, thank all the people who have been putting in their rankings on the spreadsheet as we have been talking. We have gotten great traction, and there are a couple people on the meeting who are still in the process of doing that. And then, also, Grace, your hand is up, but I was going to specifically call on you because you put a thoughtful chat up for everyone, and I wanted to give you a chance to cover that.

**Grace Cordovano**
So, wearing my patient advocacy hat here, I just want to hone in on the screen in the last one, where it says "the right to request corrections." So, there are use cases, and then a use case that supports a right. That last use case is broadly applicable to all data classes and elements in USCDI to all individuals with health information and in support of all individuals' right to have their protected health information, and eventually, electronic health information, amended in a timely manner, and "in a timely manner" is where I want to focus on. Right now, that is not happening, and that endangers patient safety, it compromises the integrity and data hygiene that we have for resource for guiding patient care, so I really want to reemphasize the importance from a patient and care partner perspective the last use case, which is in support of a right.

**Arien Malec**
Thank you for that, and Grace, this has really come out of your very thoughtful, focused attention in this area. The intent here is that we have the right, but we do not have the standards and implementation specification that help patients execute that right efficiently, and that it would be useful to be able to do so. And, we have had a lot of discussion with the meta-purpose of the ISA, but I really do encourage the workgroup to think about the output of our work as primarily helping ONC in a universe where there is no end of standards and implementation guidance to work on.

The most impactful output of this workgroup is focus and prioritization. In many areas, we do some legwork, we do a lot of pre-research for ONC, and memorialize that research in terms of a set of recommendations, and that is incredibly useful work, and then, the other major thing that we do is to put a big sign in a particular area and say, "Hey, go focus here. There is important work to be done." So, Wendy has put up the spreadsheet, a really, really simple focus on prioritization. We are asking workgroup members to rank order across these areas, so just go in and put your 1 through 12. If you have done your job well, you should have it completely filled out with numbers inclusive of 1 through 12. And, it has been fun. We have been seeing folks put their prioritization in on the fly, which is great. I put together, as I said, a very, very simple ranking. If we end up in the place where we do not have a lot of discrimination between areas, we can get a little fancier, but simple is better initially.

There have been a couple of questions. I saw that Les Lenert had a question about SHIELD and LIVD and its relationship to LIS, EHR, and public health systems. So, the way I would think about those two rows on the spreadsheet are that Row 9 or No. 9 is associated with the workflow of an order to result going from a clinician to a lab, back to the clinician, and to public health, so that is the workflow and lifecycle to an order to result. And then, SHIELD and LIVD really focus on the workflow of an IVD, analyte machine, etc. through to LIS, and in many ways, the SHIELD and LIVD work is…I want to say "responsive to," but that is probably not the right way to think about it.

It reflects a lot of really good thought in the work that Steven cochaired about two years ago, although time has no meaning in COVID, so maybe it was three years ago. One of the focus areas of that workgroup was on orders and results specifically, and called on ONC to partner and collaborate with FDA to make sure that we had an inclusive set of information flows that included analyte machines and IVDs to LIS. So, if you are confused about why we have two different lab orders and results workflows, one really follows the clinical workflow of order to result, and the second follows the laboratory and analytic workflow of sample to result, if that makes sense. Hung, you have much more detail there, so please correct me for anything I have gotten wrong there in terms of the difference between those two rows.

**Hung S. Luu**
Well, I think what you described in terms of the IV device to the LIS is more true of what you said on the laboratory analytical workflow. SHIELD is intended to be end to end, so SHIELD would be going from the provider placing the order all the way from the laboratory getting the order, performing the test, resulting it, posting it to the EHR, and then also continuing on to sharing that result from EHR to EHR to public health agencies all the way downstream to secondary uses, including research and real-world evidence. So, I would think of SHIELD as a little bit more inclusive of end to end, overarching.

**Arien Malec**
That is right, and again, just to underline this point, a previous incarnation of this workgroup noted that HHS has really all of the lines of regulatory oversight and authority that covers the full lifecycle of a lab order to result. That regulatory authority and oversight crosses a number of different agencies and offices inside HHS between CDC, FDA, ONC, and CMS with regard to CLIA, but all of the places where that workflow occurs is covered by some regulatory authority and oversight for HHS, and it would be useful for HHS to put together basically an umbrella that covers this, so that is really the intent there. I think it is worthwhile to think about these two things. Potentially, we can collapse them and use the SHIELD moniker to think about the broad workflow. Thank you for that.

**Steven Lane**
Arien, I think the notion of collapsing makes sense if you look at how people are ranking. Clearly, we have a few items floating to the top or sinking to the bottom, as the case may be. In this case, low numbers mean higher rankings. So, we have clear enthusiasm for looking at SDOH standards, and we have an expert in our midst who is very involved in the Gravity Project and knows just where they are going with that, and then, there is clearly interest in this laboratory area, and then, I think the third runner-up is this ECR standard.

**Arien Malec**
Let's let folks continue. I think Clem has yet to put his votes in.

**Steven Lane**
Yeah, there are a few people on the call that have not chimed in yet. I have sent each of you privately the link in the chat just so you can find your way there if it is hard to find your email, and yeah, we definitely encourage you to fill this out.

**Arien Malec**
Good.

**Steven Lane**
To David's comment, I thought we covered SDOH standards in the prior workgroup. What is new here… Yes, certainly, last year, we moved SDOH forward a bit. It got a toehold in the USCDI, and then we were told that Gravity had more work to do on their standards and would have another tranche of recommendations to move forward at some point. Mark, can you comment on where we are at with that? It seems to be the preference of the group to make an early focus or refocus on SDOH. What do you see from your perspective as being the opportunity there vis a vis the ISA in particular?

**Mark Savage**
Well, yes, the Gravity Project does have things in play, and I should do a better job of cataloguing that internally to bring it to the group, but we are considering use cases and implementation guides for this year. For example, on the implementation guide, it is population health and research. On the use case side, we call them a use case because they sort of build off the clinical care IG that is already built, so, things like social care use cases, and I can bring that back to the group. I just took a quick peek at ISA a couple of days ago, and this goes to the alignment point between ISA and USCDI. There are a lot of things that we have done that are not really reflected in ISA yet, and I am in the process of trying to catalogue that too and bring that back to the group.

**Arien Malec**
And, that is also David's point about how there might be some helpful work that we can do, it is just linking FHIR accelerators as well as the work that HL7 has engaged in back to the ISA, and again, even though it is not quite in our charge, we also have the right to go back and contemplate meta-recommendations, and so, just thinking about this discussion, it might be worthwhile making sure that in the accelerator work that HL7, NCPDP, or other standards development organizations have, it might be worthwhile creating more explicit ties back to the ISA to make sure that the ISA can be a real-time classifier.

**Mark Savage**
And, one other thing to add. Steven, to your question, for example, this first half of 2022, we are working on domains around health literacy, both personal and organizational, and insurance, underinsurance, under-coverage, that kind of thing, which I believe will be ready by the middle of the year, so I can bring all of that back to the group in a more orderly presentation for people's understanding, and perhaps integration.

**Arien Malec**
We will work shortly on putting together a set of focus areas for the Task Force with mini panels, as we did previously for the USCDI portion.

**Steven Lane**
Hans also had a comment regarding work that HL7 is doing on SDOH. Do you want to put voice to that, Hans?

**Hans Buitendijk**
Echoing a lot of what Mark said on the SDOH side, but then blending a little bit between SDOH, SOGI, and lab, there is a lot of work going on right now to enable communication of that as part of existing result streams and order streams in lab to address that, so there are a number of different things in that combined area that are in flight, both at the standards level as well as at the implementation guide level.

**Arien Malec**
Good. Grace?

**Grace Cordovano**
I am trying to get a better understanding of all of these use cases, with the exception of the right to request corrections, which was addressed. If all of these other 11 use cases have well-developed or somewhat well-developed standards, is it universally understood that they do?

**Arien Malec**
Again, there are going to be cases like the HIPAA right to correction where there are missing areas in the ISA. There is no categorization of that area. There are going to be cases where there is well-developed categorization of areas, but where the function of the work that we do is promote and highlight work on the ground. So, again, almost the two ends of the spectrum. If you go look at the catalogue of the ISA, we have existing items for SHIELD and LIVD, we have existing catalogues of ordering and resulting standards.

I do not think we are going to look at the ISA and conclude that the ISA is grossly missing reflection of the work on the ground. That would be an area where the workgroup output might be an area of focus, to say something to the effect of "Hey, ONC, with careful coordination of other agencies, offices, and centers within HHS could well do some foundational work on the policy front to push a bunch of this stuff over to high-maturity, and doing so would lead to significant improvement in care." That is one end of the spectrum. Every implementation spec that you might want to contemplate is covered in the ISA, but there is still a value of the workgroup to say, "Cool, it is covered, more work to be done to get it over the line and make sure that it is available nationwide." The other end of the spectrum is HIPAA right to correction. It is not

even covered, and it would be useful to make sure that the ISA at least contemplates that this right exists and that there are standards and certification implementation guides associated with that right.

**Grace Cordovano**
Yes, it does. As I approach deciding this, I was not necessarily looking at it from a standards approach. When I was asked as a member of this group to prioritize these, maybe having a column to say, "Yes, standards available" would have been helpful because I think David made a comment saying that this was already an easier choice to implement because it has standards developed. I did not look at it through that lens, so my choices might have been slightly different. I am looking at it at real-world and exchange in impact of patient care about it.

**Arien Malec**
I think it is fine. As I said, I think the primary output of this workgroup is prioritization and signposting more than it is detailed work on implementation guidance mapping, but it can be useful to catalogue work that is on the ground. Hans?

**Clem McDonald**
I have had my hand up for a while. I do not want to complain.

**Arien Malec**
Clem, there may be some issues with the thing, so if you want to jump in line, go for it. I think you have had some issues with your hand going back and forth. Go ahead, Clem.

**Clem McDonald**
Hans can go.

**Hans Buitendijk**
So, I think across the board, many of these topics are use cases, or there is a section of it in the ISA, but depending on what we are trying to achieve that is more or less available from a standards perspective, if you take ECR, there is the ICR standard that is already being used, so there is much more maturity of the standard that we are probably going to be talking about. If you are looking at lab orders in general, with SHIELD and the full spectrum, it is much more that you have a variation. You have the standards that are there and widely used, but on the other hand, for SDOH and SOGI use cases, they are not fully up to par to support that. So, 90% there, 10% in a critical area they are not. Or, in LIVD, there is a spreadsheet out there, but there is not a FHIR or other based standard out there. So, I think you are going to find across these that there are all kinds of different levels of maturity and availability in addition to some areas that are not recognized yet as a use case, like price transparency, which is not yet published, but a work in progress. So, I think we will find them all.

**Arien Malec**
Exactly. As I said, I think if the workgroup puts on the hat of the main function, the main output of this work is signposting and prioritization with a minor in identifying and uncovering areas that do not exist in the ISA. I think that is the primary output of this workgroup. Clem, go ahead.

**Clem McDonald**

I really am troubled by the process. So, somebody put up a list of things, and then everybody prioritizes them with inadequate thought of what the things should be. The big three are research, care, and administration, and research is not even hinted at in that thing, for example. So, I think we should start over at a higher level, and then figure out what we really should be having. ISA actually does list the standards that exist. To answer that question, you can see what is there. But, the other dimension that we fail on is that yeah, we have these standards and people are using them, but there are not checks on how well they are doing. I understand that in some big hospital systems, the coding to laboratory is supposed to be done and required to be done by the medical record group, not by the lab, which does not really compute to me. We could go deeper on some of the other non-lab standards to get more detail and structure and be useful. EKGs are an easy one. But, we are not.

**Arien Malec**
Yeah, so, Clem, just as a reminder, as we started the workgroup deliberation, we welcome additions to the list. We did cover research last time. If you have a preferred categorization and other categories that you think are worthwhile for the workgroup to get into, I think that is very helpful. The problem with something like the ISA is that it is almost infinite in terms of scope, and we are finite, timebound workgroup, so we are going to have to focus in a couple of areas, which means that almost by definition, there will be many areas that we will not cover. But, if there are areas of priority in priority focus, Clem, I would definitely encourage you to submit those as areas of focus.

**Steven Lane**
Submit and prioritize. Go ahead and contribute to the prioritization. David, you made a good point, which is that there are standards evolving outside of healthcare that might be appropriate for ONC to consider and review. Do you want to comment on that in the context of provenance?

**David McCallie**
Yeah. I am not an expert on this at all, but several people had sent it to me as an emerging standard from the major content vendors like Adobe, Apple, Microsoft, and others around verifying digital provenance and authenticity for PDF files, documents, etc., a cross-vendor standard that would allow a consumer to trust that they are looking at data whose source is provable, and it occurs to me that healthcare data should be a subset of the domain that is covered by that standard. We have provenance standards within healthcare, but they are obviously not widely supported once you leave the healthcare enclave, so consumers who download a document, for example, via their portal might like to be able to prove that it is an authentic and unedited document when they present it to some other person outside of healthcare.

**Arien Malec**
And David, just as a note, not every element in the ISA is healthcare-specific, so there are name standards through IETF workgroups and others that are referenced, for example, security standards and encryption standards, so that would be an area where I think the right thing to do would be to submit the PDF provenance standard as an additional provenance standard to be included in the ISA and address it that way.

**David McCallie**
Right, that is my point. It should be something that we promote up if we think it is a valuable use case, and I am betting more people… Anyway, you got it. I think there are several other ones emerging outside of

healthcare that I will send you in your email, but I will mention one is ISO 200-22, which is a payment remittance standard that the Federal Reserve is going to require adoption for in U.S. payment systems, and there is a workgroup dedicated to healthcare uses of the new payment standard that is not a replacement for the HIPAA-mandated, but it is a remittance standard.

**Arien Malec**
This is super confusing in healthcare, but we have remittance advice, which is the output of an adjudication process by the payer, and then you have actually got payments and remits which are the flow of monies and documentation of the flow of monies, and so, an E-35 is not itself a reflection of a monetary flow, it is a posting of the output of an adjudication process that then triggers into the monetary flows, and so, for people that are confused there, that is the connection.

**David McCallie**
But, my point is that they are working on a healthcare use case.

**Arien Malec**
A healthcare normalization of the actual payment and remit.

**David McCallie**
Right, and it just should be something that is tracked.

**Arien Malec**
No doubt. Patches welcome.

**Steven Lane**
I did want to remind everyone that the general ISA site, like the USCDI pages themselves, does have a comment function at the bottom of every page, so any member of the public or the workgroup, of course, is welcome to go in and comment on items that are there and provide input to ONC, and ONC has a regular cycle of reviewing those comments and updating the content in the ISA. Grace, you made a point early on that there is a page that shows you recent changes to the ISA, so if people are following this, it is a nice place to go. Here, I am going to find that page and stick it in the chat so people can follow that. But again, our role here really is to provide overarching commentary about what is in the ISA, where it should be heading, and anything that needs redirection.

And again, with regard to this voting process that we have begun, as additional items are added to this list, if there are any that people want to add, such as the provenance standard, we will invite everyone on the workgroup to go back and redo your prioritization. In fact, you are welcome to do that simply now after our discussion. This is not meant to be set in stone, but we as the workgroup chairs will probably assess the ranking on a regular basis to help us determine where we want to focus. Again, it is still the case with all the responses that we have that the primary interest seems to be, with insignificant differences between them, the SDOH items, and the lab items, so I think that it is fair to say that we will start there as we plan ahead for next week, so, Hung and Mark, if you guys have some specific ideas about the best, most fruitful approach that we could take there in terms of both reviewing what is in the ISA today and what are opportunities to advance it to support these use cases, I think that would be great.

**Arien Malec**
Yeah, and again, just to repeat something that I previously said, if this sounds squishy or unscientific to you, the main function here is for us to be able to focus in on a specific few areas to make high-quality recommendations. As a workgroup, we cannot cover the entire topic of the ISA because it is far too big. We necessarily have to pick a few areas, go deep, make high-quality recommendations.

We certainly are open to making meta-ISA comments around the structure process of the ISA itself, and I think we have gotten some really good, helpful feedback, 1). Calling out that there is a need to coordinate ISA updates and accelerator or other activities that are going on within HL7, NCPDP, X-12, and others, 2). That we need to be more explicit about the tie between USCDI and the ISA, 3). That it would be helpful in addition to listing whether something is required in a certification criteria or programmatic to be more explicit, as we are likely to have multiple centers, offices, agencies, etc. making certification or tying ISA elements to programmatics, it would be useful to note or annotate which programmatic is attached to which standard, and then, 4). The note that we should be thoughtful about standards development that is occurring outside of healthcare that has healthcare implications and making sure that we have places to add that work back to the ISA, as David noted, provenance information for PDFs and others, and payment and remit information could well be one of those areas.

**Steven Lane**
So, thinking, again, about SDOH and lab as our areas of current greatest interest, Mark, from your perspective, or really anyone else, other than reaching out to Gravity and HL7 to get a sense of the lay of the land there and request opportunities for ISA advancement or expansion, does anyone else have any other ideas for how we might approach that area?

**Clem McDonald**
I would like to. The ranking here is based on 12 points from Mark. I am all for that, but how high can we go? Can we put a hundred in, and then be sure that one got high scores?

**Arien Malec**
No, we will go back. I see Ken, for example, has a simple ranking. We will remove that one if it is not a complete list, but the goal is just to force rank. That is all.

**Clem McDonald**
Well, I am also confused because LIVD is done and SHIELD is not yet constituted. It is a group of people interested in that space. It is not a standards organization, and they could be very successful, but they have not published anything yet.

**Arien Malec**
We can get the lay of the land there. Hung, go ahead.

**Hung S. Luu**
Yes, I was just going to ask if speakers would be welcome because in terms of the lay of the land, we have prepared a relatively short, 10-to-15-minute presentation we have given around to different agencies to level-set and introduce people to the concept of SHIELD and what it is we are trying to accomplish, and also where new regulations or standards would be helpful.

**Clem McDonald**
Is it a corporation? What is the entity?

**Hung S. Luu**
The entity is SHIELD.

**Arien Malec**
It is a collaboration, Clem, between FDA…

**Clem McDonald**
No, what kind of entity is it. Does it exist as a corporate thing?

**Hung S. Luu**
Right now, it is a government/private collaboration.

**Arien Malec**
Yeah, it is a collaboration between multiple agencies inside HHS. At this point, it is primarily an intragovernmental collaborative with some academic input, and then, increasing external organization. Steven put in a link to SHIELD through ASPI. As I said, right now, it is primarily the notion of intra-HHS collaboration across the different HHS bodies that deal with or have regulatory oversight for lab information.

**Steven Lane**
Hans, your hand is up.

**Hans Buitendijk**
Yeah. Just to add to the last comment Arien made, SHIELD does involve private-sector participants as well. It is not limited to interagency discussions, but there are EHR vendors, there are device manufacturers, LIS, **[inaudible] [01:18:50]**, and just a clarification, I am one of the office editors on the LIVD guide in FHIR. I still have work to be done, so it is definitely not done yet. I wish I was done.

**Steven Lane**
Hans, that being the case, it would be great to get an overview of the LIVD work that you and others have done to bring us up to speed with what was the genesis of that, what is the work that has been done, what is the current state, and the future plan, again, with an eye towards what, if anything, might we add as a workgroup to that discussion.

**Arien Malec**
And Hung, I would imagine Dr. Papas would be somebody else we would want to invite to testify. You can think offline about that.

**Hung S. Luu**
Yes, exactly.

**Arien Malec**

We can work with ONC as well because he is the ONC lead for the SHIELD work.

**Steven Lane**
Mark?

**Mark Savage**
Thanks. I wanted to lift up my comment in the chat and get some guidance. We are talking about use cases as a way of thinking about ISA, and we are working on a reference implementation to connect individuals and community-based organizations with social service agencies that may not have FHIR servers in their notes with clinical care settings using FHIR APIs. We think of that as a use case, in a sense. Is that the kind of thing that is also relevant for the ISA?

**Arien Malec**
Again, I think the function here is to say there are some priority areas. Let's go make sure that we are signposting those priority areas. With respect to the structure of the ISA, generally, the ISA is structured around real-world outcome-based use cases, and then, under those real-world outcome-based use cases, you would point to implementation guidance or specifications associated with that. So, for example, if you had guidance associated with adapters to social service agencies and not-for-profits that did not have current FHIR capabilities, that would be an area where we might want to point that use case at the implementation guidance that is about how to connect social support organizations in. Does that make sense?

**Mark Savage**
I think so. Thank you.

**Steven Lane**
Other comments before we open this up to the public? All right. Well, before we do that, let just again encourage people to get to us with additional areas that you think should be potentially added to the list for prioritization, to enter your prioritizations if you have not yet had a chance to do that so that we can plan ahead. Again, at this point, it seems like SDOH and the lab area have the highest level of enthusiasm, followed by the ECR standards and care plans/chronic disease management, which we have not talked about at all. Can we put up the public comment slide and invite people to chime in?

## Public Comment (01:22:48)

**Michael Berry**
Yes we can. 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. Once called upon, press *6 to mute and unmute your line. Let's pause for a moment to see if anyone raises their hand.

**Arien Malec**
As we are waiting for public comment, just a meta comment that again, the focus of the prioritization is to focus our time with respect to testimony and deep deliberation, so if you are looking, for example, at HIPAA right to request corrections and you are appalled that it ranks so low, the easiest way to address that is to create a very simple set of recommendations. For example, "We recommend that the ISA include HIPAA

right to correction as a priority use case, and point to the relevant work in FHIR accelerators." So, as long as we are not devoting significant time and energy, we are certainly happy to carry forward recommendations in areas that are "lower priority." As I said, the main focus of the prioritization function is to let us focus our time and attention on going deep on certain topics. Is there any public comment at this time?

**Steven Lane**
Corey Smith, who is a member of the public, just raised their hand and has something to say.

**Michael Berry**
Hello, Corey. You have three minutes.

**Corey Smith**
Can you hear me?

**Michael Berry**
Yes.

**Corey Smith**
Great, thank you. I will keep this very short. Good morning or good afternoon. I am Corey Smith, the Vice President of Informatics and Digital Products at the AMA, and just wanted to respectfully request the group takes another look at average blood pressure, which has been submitted for USCDI V.3, and I think I saw in the draft recommendations it was not being promoted into V.3. I think we have had our clinical folks come and support that, and just again, we have done a lot of work over the recent years to elevate the importance of average blood pressure clinically and in the standards world, and would just respectfully request that the group take one more look before making the official recommendation. Thank you.

**Arien Malec**
I appreciate that, and I think we have made some progress. I understand that AMA and AHA have worked with LOINC to make sure that there is a standard nomenclature for addressing the average of blood pressures, and we do make recommendations here, as this is an area of priority. So, I just appreciate that public comment.

**Steven Lane**
Yeah, and to be clear, we do include a recommendation in our comments to HITAC for tomorrow that the ONC work on that, so we heard you.

**Arien Malec**
We heard you.

**Steven Lane**
I do not see any other public comments. One of the nice things about Zoom is that we can actually see those ourselves, which is nice. All right, well, that brings us nearly to the end of our time. Again, we want to encourage people to submit suggestions. I think, Arien, the point that you made about how to go about advancing an idea like the right to corrections, keeping that very simple, is a great approach, and hopefully

we will have another document up that will give people a chance not only to provide these quantitative rankings, but also to provide more detailed commentary and even enter questions regarding the topics, as well as to add additional topics.

I think what we may want to do is invite you all to re-rank prior to our next meeting. We will take the ranks as they exist at this moment and use those to drive our work for the next couple of weeks, but if you can sleep on this, put it under your pillow, continue to consider now that you have a better sense of how we are going to use this input, that would be most helpful. So, this is the list of our upcoming meetings leading us to our final recommendations back to the HITAC in June, so we have a busy time ahead, but we will only use it if we have work to do.

**Arien Malec**
We will absolutely have work to do. And again, when we get the detailed commentary, Grace and others, that is a great place to put if we have quick, easy recommendations that are well formatted. We just encourage people, once we have that list up, to drive those recommendations in. Again, that is an open invitation for people who have additional priority areas to include those, and again, I just want to reassure people that the ranking is entirely about focusing our time, energy, and focus to be able to go deep on topics to be able to put together recommendations. With that, maybe we should conclude our meeting.

**Steven Lane**
It is allowed. Right on time. Thank you, everyone, for your time and attention. We will see you next week.

**Arien Malec**
Thanks, all.

**Michael Berry**
Thanks so much. Bye.

## Adjourn (01:28:33)