Transcript

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

April 7, 2023 10 – 11 AM ET

VIRTUAL

Speakers

Name	Organization	Role
Sarah DeSilvey	**Gravity Project** **Larner College of Medicine at the University of Vermont**	**Co-Chair**
Naresh Sundar Rajan	**CyncHealth**	**Co-Chair**
Pooja Babbrah	Point-of-Care Partners	Member
Shila Blend	North Dakota Health Information Network	Member
Ricky Bloomfield	Apple	Member
Hans Buitendijk	Oracle Health	Member
Christina Caraballo	HIMSS	Member
Grace Cordovano	Enlightening Results	Member
Raj Dash	College of American Pathologists	Member
Steven Eichner	Texas Department of State Health Services	Member
Nedra Garrett	Centers for Disease Control and Prevention	Member
Rajesh Godavarthi	MCG Health, part of the Hearst Health network	Member
Bryant Thomas Karras	Washington State Department of Health	Member
Steven Lane	Health Gorilla	Member
Hung Luu	Children's Health	Member
Meg Marshall	Department of Veterans Affairs	Member
Anna McCollister	Individual	Member
Clem McDonald	National Library of Medicine	Member
Deven McGraw	Invitae Corporation	Member
Aaron Miri	Baptist Health	Member
Aaron Neinstein	UCSF Health	Member
Kikelomo Oshunkentan	Pegasystems	Member
Mark Savage	Savage & Savage LLC	Member
Michelle Schreiber	Centers for Medicare and Medicaid Services	Member
Shelly Spiro	Pharmacy HIT Collaborative	Member
Ram Sriram	National Institute of Standards and Technology	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer

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

Michael Berry
Good morning everyone and welcome to the Interoperability Standards Workgroup. I am Mike Berry with ONC, and I would like to thank everyone for joining us. All of our workgroup meetings are open to the public, and your feedback is welcomed, which can be typed in the Zoom chat feature throughout the meeting or can be made verbally during the public comment period scheduled for the end of our meeting this morning. I am going to do a quick roll call of our workgroup members. When I call your name, let us know if you are here. I will start with our co-chairs. Sarah DeSilvey?

Sarah DeSilvey
I am here.

Michael Berry
Naresh Sundar Rajan?

Naresh Sundar Rajan
Good morning. I am here.

Michael Berry
Pooja Babbrah?

Pooja Babbrah
Good morning. Here.

Michael Berry
Shila Blend?

Shila Blend
Present.

Michael Berry
Ricky Bloomfield?

Ricky Bloomfield
Good morning.

Michael Berry
Christina Caraballo is not able to join us today. Grace Cordovano? Raj Dash?

Raj Dash
Good morning. Here.

Michael Berry
Steve Eichner? Nedra Garrett? Rajesh Godavarthi? Bryant Thomas Karras? Steven Lane?

Steven Lane
Good Morning.

Michael Berry
Hung Luu?

Hung Luu
Good morning.

Michael Berry
Meg Marshall? Anna McCollister? Clem McDonald? Deven McGraw?

Deven McGraw
Good morning.

Michael Berry
Aaron Miri? Aaron Neinstein? Kikelomo Oshunkentan? Mark Savage?

Mark Savage
Good morning.

Michael Berry
Michelle Schreiber? Shelly Spiro? Ram Sriram?

Ram Sriram
Good Morning.

Michael Berry
Good morning all. I will turn it over to Sarah and Naresh to get us started. Thank you.

Finalize Draft USCDI v4 and Level 2 Recommendations (00:01:57)

Sarah DeSilvey
Hello everybody. Naresh and I are really grateful for you coming here on a Friday morning to complete our charge. Grateful for all the work that has happened this week. Our task is to resolve a few of the comments that we have remaining on the draft final recommendation. Shelly is here. We hope to get swiftly to it so that we can make sure that we can get that recommendation set. I do want to state just a reminder, the most important thing is for us internally to come to an agreement and to just make things as clear as possible. There is just one element that I feel actually needs agreement internally with the ISWG. Hopefully, the CMS friends will come if they can. Naresh any other further comments before we dive into the work? Grace is here.

Naresh Sundar Rajan
No, let us dive into it.

Sarah DeSilvey
All right, to the draft we go. I just want to note once we are navigating to the draft that although there were a few comments and elements that we were talking about reviewing offline, I think there was actually only one that was taken offline and that was Mark who kindly met with Carmela and kind of settled on some of the language in I think it was the provenance elements and a few other things. We still have to come to an agreement at least internally on some of the elements in the laboratory section. I am glad that Hung and

Raj are here to help us do that. If we can go to the first comments, we have everything kind of labeled. I think it was element number four. I am scrolling down.

I have labeled everything that needs review. Here we go. Mostly we just wanted to make sure that we finalized recommendation number four. We changed some of the language here. We do have a future recommendation down below. Is everyone okay with recommendation number four as it stands recommending the ONC work with CDC, CMS, state travel, local and territory agencies, and other key healthcare public health authorities to identify and evolve appropriate vocabulary status for facility information and facility type? Are we okay with this?

Steven Lane
Looks good.

Sarah DeSilvey
I think so. All right, accepted changes, resolving this one if we can as we go on. Okay down to the next. Here we go. Here I want to acknowledge the extensive conversation we had before. Really again the priority is that we as an ISWG agree on what is here. We have recommendation number 16 as recommending that ONC rename the patient summary of patient data class to patient care plan and the assessment and plan of treatment element to care plan summary. It looks like Steven has a question. Some site changes in languages. Now lets us go to Steven.

Steven Lane
Sorry. No, you go ahead and finish. I was just teeing up for as soon as we were done.

Sarah DeSilvey
Okay. We have changed the language from "suggest" to "ONC should". Perhaps this should move to the future section, but I just want to note that what we have heard and felt from the ISWG is that this language about what recommendations should happen are, based on what I am hearing, they should stay here with the recommendation because it is context. That is what I have heard so far. If we can just figure out any next steps to resolve this element. Steven?

Steven Lane
Yes, I agree that these comments should stay here as context. It is not about future work, but it is really specific to this one recommendation related to USCDI. I think that does make sense. The other thing I just wanted to point out is that I was on a Sequoia Project data usability workgroup call yesterday and this very topic came up. There was again the same thing, the concern about the name of this section and the importance of assuring that the care plan is clearly named so that everyone can agree to it. I think that this is a good recommendation. Thank you.

Sarah DeSilvey
Again, incredibly grateful. Thank you Steven for all the work of the subgroup that went into crafting this careful recommendation. Any concerns about leaving the "ONC should"s in this area? That seems to be the wish of the majority of the ISWG. If so, I believe we are ready to move on to the next element. Hans?

Hans Buitendijk

I completely agree that the "should"s are fine. Perhaps one tweak in the last sub-bullet. "Assessment and plan sequence" would remain "the narrative care plan summary". Is it clear enough from the recommendation that it was called "assessment and plan of treatment" and we are suggesting renaming it so that this is still tied clearly enough? To me it is, but based on some of the feedback I want to make sure that it is clear to ONC that this means changing the name and it remains a narrative.

Steven Lane
You might just try adding the word "as". The assessment plan of treatment would remain as the narrative care plan summary. I do not know if that captures it.

Hans Buitendijk
I am okay with it. I want to make sure that from an ONC perspective that is sufficiently clear.

Sarah DeSilvey
I do want to note, Carmela is out, and Al is out. I think we are okay.

Hans Buitendijk
Maybe we say rename the narrative care plan summary as proposed to be renamed. Something like that to make sure there is no confusion that it is the renamed care plan summary. I am happy while we keep on going to maybe phrase something that might work.

Sarah DeSilvey
Shelly, do you have any thoughts here?

Shelly Spiro
Not about that topic. In the recommendation section, we should make sure that we are including the HL7 patient care group to subject matter experts in this particular area as we begin to discuss this because they are much more knowledgeable on the content, especially the standards content, in relationship to care plans.

Sarah DeSilvey
I think that they are a notable and necessary part of the interested party section. We certainly cannot do it without them knowing how closely I work with the patient care workgroup on terms and gravity care plan. So, that is a wise recommendation. I can see from Mark if we put renamed before narrative, does that clarify things for you Hans?

Hans Buitendijk
Let me just play with that and I will get it back in the chat in a moment.

Sarah DeSilvey
Okay. Mike, if we can resolve all the comments so far? I feel like we are generally good with most of the things that have been updated. We are just working on the last little elements here. This will allow us to get a cleaner doc. We all agree on what we need to say, we are just trying to figure out the best working on that last bit, correct? It either can stay as it is or Hans will come up with a term or we will add the rename. Should we work on that and keep on going?

Hans Buitendijk

I just sent it.

Sarah DeSilvey
There we go. Care plan summary, the renamed assessment of plan of treatment would remain a narrative. That seems good to me.

Steven Lane
That is good too, yes.

Sarah DeSilvey
Yes. Thank you, Hans.

Hans Buitendijk
That is fine. Thank you.

Sarah DeSilvey
Wonderful.

Michael Berry
I cannot see the chat so can you tell me?

Sarah DeSilvey
Yes. I will put it in as a comment on the document and you can copy it from there, okay?

Michael Berry
Great, thank you.

Sarah DeSilvey
Yes. All right, then on to 17. I believe again this represents a lot of labor on top of a subgroup. I feel like many of the recommendations and changes we have made so far met ONC's desires for clarification. Again, I have heard us very clearly saying that we want the context and the subtleties of this to remain in the recommendation because it represents the wisdom of the ISWG. There are very few changes to this as it stands. There are some contextual statements the ONC should consider the following. All the texts that the work group worked on remain there if you scroll down. It is not changed per se. Any thoughts on accepting this recommendation as it stands right now?

Hans Buitendijk
Can you scroll up just a little bit more? Thank you. No further comments from me.

Shelly Spiro
This is Shelly. Just a clarification, is advanced directives going to be its own data class? I was not clear on that. Will it be an element under another data class?

Sarah DeSilvey
Can someone from the subgroup answer that question?

Hans Buitendijk

Yes. I believe from the colonization that whether it ends up as a separate data class or not, that it is effectively considered not a type of care plan in that a care plan has the characteristics of a narrative structured component like goals, outcomes, interventions, et cetera. The difference between the type of an advance directive versus multi-chronic care, a pharmacist's care plan, a general care plan, et cetera, is that the care plans that are defined are often owned by the clinician. There are the advanced directives that is essentially authored or at least under the direction as representative of the patient and their care plan or what their goals are, their preferred interventions or not, their desired outcomes, their care team as they see it, which then gets translated into one or more clinician driven care plans that are implementing to the best of their abilities.

I think they are both care plans but plans in that sense if you want to measure as a common data class with a type or two data classes that look very similar in the way that you implement it, in Fire it is going to be the same thing. It is a care plan. That is, I think, the struggle that we have. What is the clearest way to get that across? Contextually they are types of a plan.

Sarah DeSilvey
Mark and then Grace.

Mark Savage
I have been attuning that it is sort of both. To answer your question, Sarah, it is a data element but that does not preclude it from also being listed as a type of care plan in the care plan data class.

Sarah DeSilvey
Thank you. Grace?

Grace Cordovano
We did address this as a small group. If you look at the first point in the considerations, advance directive is not a singular data element but rather a data class and also to Han's point a type of care plan that is typically authored by a patient. Really whatever the best way to bring this on as an onramp to make currently available unstructured advance directive documents like PDF and scanned images, that is really the purpose of this recommendation.

Sarah DeSilvey
Thank you, Grace. Given the intense work that went into this in the subgroup and where we were at on Wednesday and where we are now, are we okay to accept this recommendation as it stands? Mike, I did update the language in the element above.

Michael Berry
Great. Thank you.

Sarah DeSilvey
I think we are good. It sounds like we are good if we can accept comments and move on. Thank you, friends. I believe these are just slight tweaks. Any concerns with adding an add-in recommendation 19 here? The following **[inaudible] [00:15:38]** and the Gender Harmony Project. This is again a repeat of what was recommended last year. I was not here but "we" as the formal ISWG.

Steven Lane

Good wording.

Sarah DeSilvey
Thank you. Moving on.

Mark Savage
Such a simple add.

Sarah DeSilvey
Yes. Okay, this is where we are leaning into the intent. Again, we are shifting from the amazing work that went in the subgroups for care plan advanced directive. Thank you so much. I am going to give you a woohoo Grace. We are now leading into the work that happened within the laboratory subgroup. Again, my most pressing thing is to make sure the wisdom of that subgroup is conveyed in this recommendation. So, if it is best for that subgroup to leave it as it is, that seems fine. Hung, any thoughts?

Hung Luu
I wanted to provide an explanation of where we landed on this recommendation. The issue is that for this data element, as it is in terms of the laboratory test perform based time, the definition actually was what we were looking for which is the clinically relevant observation time. However, the name is inappropriate for what it is meant to represent which is why we suggested the name change. I do understand Carmela's concern that there is now another Level 2 element out there also called specimen collection date and time. The reason we did not select that is because the definition did not fit. Something needed to be changed. Either we change the name of this one or we change the definition of the other one. I guess to satisfy that concern, would it be possible to add another bullet point saying that the data element should be combined together that way that removes it from Level 2 and combines it with this one?

Sarah DeSilvey
That seems an elegant solution.

Hans Buitendijk
I agree.

Steven Lane
I agree.

Hung Luu
Thank you, Hans.

Steven Lane
And it is also important to recognize that there is a test perform date and time that is not as clinically relevant as what is being proposed here, specimen collection date time.

Raj Dash
It is still clinically relevant; it is just not as important to most clinical workloads.

Steven Lane
Yes.

Hung Luu
The reason we wanted to change the name of this one is because we did not want this to continue to be floating out there saying that it is the clinically relevant time. We wanted to remove that for circulation but yet be able to make use of it if this solution is acceptable, if it is clear to ONC. I am not sure if Mike can chime in on that.

Michael Berry
I cannot but when the recommendations go to the USCDI team if they have questions, we know whom to call on.

Hung Luu
Okay. All right.

Sarah DeSilvey
Hung, I believe he worked on this approach with AI, correct?

Raj Dash
Yes, it was AI's recommendation that we rename the test perform date time to specimen collection date time as the most expedient and cleanest way to make this transformation.

Sarah DeSilvey
Yes. That is helpful for context within ONC to interpret and understand the direction. I think the added bullet helps. Any concerns with moving forward with the recommendation as it stands? Again, I am very grateful for the work of the laboratory subcommittee. None? Hooray. All right, then I think the only thing that was remaining here was just where to place the rationale. There is nothing much that has changed in this section. Hung, any concerns? Anything to add here on recommendation 25? Hans, since you worked so closely? Hans has his hand up. Hans?

Hans Buitendijk
Another one is do we need to add anything for clarification? Again, I am perfectly comfortable with how it is defined here and where we landed but it might be helpful in reconciling some of the terms used in the submission. I was actually looking this morning back again at the statement and the submission of the test kit unique identifier. In the recommendation where we immediately jump to the test kit device name and manufacturer name, which might not be a totally clear link. Perhaps what we need to do to make it clearer is that in the recommendation we use the term "unique identifier" in some fashion, but we are narrowing it down and adjusting it to the device name and manufacturer name.

In the submission it talks about the name, the model of the device, and the manufacturer, and then beyond that to the DI, but not the full UDI. It only talks about the device identifier. I am wondering whether that is part of the confusion. To me what is written here is very clear, but it might be for ONC not reflecting the links of the words that are used in the submission. Just raising that. Again, I am perfectly fine with how it is stated here but I might have been too much into the weeds and the trees and not seeing that forest part of it.

Sarah DeSilvey

Do you feel like we need to put that context in the recommendation? I mean it also is here in the record, in the meeting, in the minutes, for application to understanding the recommendation in context.

Michael Berry
I mean I think the rationale is already long, but it is very clear. I would not recommend changing it.

Sarah DeSilvey
Yes.

Hans Buitendijk
Agreed.

Sarah DeSilvey
I feel like we have heard concerns for clarity I think both in the minutes and in the rational. We are trying to address them. I think barring any other commentary I feel like it is okay to ask, are we okay with this recommendation as it stands given the rationale and the work that was done by the subcommittee?

Hung Luu
I like it.

Hans Buitendijk
Perhaps share it as well. I think we know where to find clarification.

Hung Luu
Yes.

Sarah DeSilvey
We will not go far. All right, I think we can clarify this one as approved. I believe we are off to 27 now. Mark if you can help me here.

Mark Savage
Yes.

Sarah DeSilvey
This is some of the work that we took offline with you and Carmela. I think the agreement was to have some slight updates in language but to let it sit as it stands. If you could help us walk through that would be helpful.

Mark Savage
Yes. I think I understand Carmela's prior comments. We agreed to leave them as is and then as I was going over it last night for the final time I saw those unexpected words at the end of the lead recommendation provenance author. I did not put them there when I was doing the recommendation. It was not in the spreadsheet. I went back and looked and somehow there was a rewrite entered below the final recommendation to add those words. That is not the point of the recommendation so I suggest we just either delete those words or even simpler would be just to stop after the first sentence and delete the second sentence. These are the ones we are recommending. The Level 2 is because of the contribution of BGHD. Is that clear Sarah?

Sarah DeSilvey
That is helpful. The thought is we do not know how provenance author got there. Well, we do know. It was maybe a copy and paste problem. Either delete provenance author itself or delete the whole second sentence. Steven?

Steven Lane
Mark, I am sorry I do not think I have been in that subgroup, but I do recall prior discussions where we considered the use of provenance author for specific data elements as the appropriate tool to capture when data is generated by the patient. I guess the trick here is the ONC has not taken our recommendations in the past. I think our challenge is how to craft this recommendation so that it is both likely to be accepted by ONC and is likely to allow us to capture that this is patient-generated data. It seems to me that the use of provenance author is one way that they might choose to do that but not the only way. I just raise that as context, not as words spoken.

Mark Savage
As I read words that were added, all it would do is it would effectively leave those as level two data comments and ask ONC to make sure that whenever they are advanced to USCDI, that provenance author is a part of them. Instead, the recommendation is that they should be raised from level two to USCDI V.4.

Steven Lane
That is fine. Whatever wording it takes to make that clearer, I support it.

Sarah DeSilvey
If the provenance author is important but the placement is incorrect should we include it as context as we have in other recommendations?

Mark Savage
I think it has been a source of confusion. I think the simplest and best approach would be just to delete that second sentence. Put the semi-colon after USCDI V.4.

Sarah DeSilvey
Any concerns with doing that?

Steven Lane
Sounds good. Thank you, Mark.

Sarah DeSilvey
Hearing none, let us erase the last sentence of the recommendation and have the semi-colon start after USCDI V.4. Thank you. All right, thank you, Mark. I believe we are now on recommendation 30. Do we have any CMS friends or CDC friends with us today?

Nedra Garrett
Yes.

Sarah DeSilvey
Hi Nedra. Thank you.

Nedra Garrett
Yes, hi.

Sarah DeSilvey
Hello. This is probably I would say the element that had the most conversation on Wednesday because there was some further clarity about the complexity of a clear recommendation regarding medication administered. We need to come to a resolution on what we all agree on putting forth now and what might need to be a work in progress. Shelly, I hope it is okay to call on you or Pooja to provide some of the context about the clarity on medication route and some of the work to be done on understanding medication administered.

Shelly Spiro
Yes. This is Shelly. We do have codification for route of administration. We do not have codification to identify that a medication is administered. You have a code for medication but identifying it as being administered you would have to say it is administered. It does not make sense to me. What code are you going to put to it? We are looking at identifying the types of lists that a medication would fall into such as a medication administered and attach a code to that particular medication that could be codified as it was medication administered. The same thing with discharge medication. We have to be able to identify that that RxNorm or NDC code has been administered or has been discontinued or has been dispensed.

Sarah DeSilvey
Thank you Shelly for the context. In review on Wednesday, as we dove deeper into the recommendation, there was some confusion about whether some of these elements contained in these three are ready for advancing and maybe whether some of them might require more refinement. Hans?

Hans Buitendijk
The question and confusion that I have, it seems like we are discussing two concepts relative to the Level 2 medication administrative code to entry. When I am reading the medication administrative code entry in Level 2, a code or set of codes that specify the medication that was administered, then at that point in time I understand that to be the record including the code for the medication that was administered. Tylenol was administered at 2:00, 200 milligrams, whatever.

What I am hearing Shelly express is that I would like to know among my medications that have been administered or requested or dispensed or otherwise, I need to recognize not the code of Tylenol or whatever but the fact that this is administered versus prescribed, which is a different kind of concept that would enable the kind of lists that I think I am hearing Shelly talk about so that I can create a list of descriptions or I can create a list of those that have been administered et cetera. That is a characterization of what I am documenting, an administration or a prescription or a dispense, et cetera. I think we need to clarify that because Level 2 seems to be talking about I would like to get an administration record that includes the medication code that was actually administered.

Sarah DeSilvey
Thank you, Hans.

Hans Buitendijk
Which one of the two are we talking about?

Shelly Spiro
Yes, I think that was more going to be on CMS who explained what essentially you are saying. We do not have the codes available. It is almost like they are two different concepts that you are explaining, the code as well as the administration.

Hans Buitendijk
The administration has a code in that the administration includes which medication I administered, which is represented by a code. That is where I think the term code and medication can be used in the context of the code for the list it belongs to versus the code of the medication that is given. Both are codes. That is where I think the confusion comes in.

Sarah DeSilvey
Pooja, if you want to weigh in?

Pooja Babbrah
Yes. I think part of the reason we ended up moving the dispensed medication was because there was confusion and I do not think we had necessarily the codes that we needed. I know we probably can continue the discussion, but my recommendation would be that this follows the same as the dispensed medication and we really dig into this probably the next time and make sure that we have the codes that we need.

Clem McDonald
The codes would be the same as they would be for the medication period. It is just the list it would be in would be "dispensed".

Sarah DeSilvey
This is the work I hear Shelly speaking to that is happening in the ecosystem. Shelly?

Shelly Spiro
Yes. It would be a code that is identified as a type. The medication falls into a type so the medication administration code would be the type that that medication code in RxNorm or NDC fits into. It is sort of like a modifier of the code because you could have a prescription that is dispensed, discontinued, or part of a discharge. There are different classes of what that one medication code falls into. We are working on trying to identify through the standards process in an NCPDP work task group and also we will bring to the HL7 pharmacy workgroup to look at this and come up with what coding system we would want to use for the type of medication that would distinguish it as medication administered or medication discontinued, discharged, and such.

Clem McDonald
I would like to suggest that you would not have different codes; you would have different fields.

Sarah DeSilvey
Thank you so much, Clem. We have Pooja and then Hans. I just want to state that at the 11th hour, which is where we are with this recommendation, it might be that we recommend as we have in other elements, a specific focus on this critical element all recognizing how important it is, and we advance the one we are super comfortable with, and we state as we have above, "ONC should work with stakeholders to …" just to make sure that we can come to an agreement at the end of the hour. Pooja?

Pooja Babbrah
Yes, I was just going to make one more suggestion. I mean if there are codes available for specifics, maybe it is just a matter of updating the definition for this one and then making sure that is clear. That is another option.

Sarah DeSilvey
I do not know if that is apparent. Ike?

Steven Eichner
Thank you so much. I think part of the issue here is we are confusing ourselves, or at least I am confused, about looking at administrative code type and then talking about the method or who is administering it. It is a confounding label in terms of trying to describe what is actually intended if that makes sense.

Sarah DeSilvey
I think that is some of what Hans was speaking about. Hans?

Hans Buitendijk
Yes. I am completely in agreement with Ike and Clem on this that we have two concepts. One is a type that can help you put it on the right list and the other one is the code of the medication that is either prescribed, administered, or otherwise. This is why I think we have to be very careful about how we do that in USCDI. I am not convinced, and I think I am hearing Clem as well, that the way it is being described, that that is going to be leading to coding. Now I have to unfortunately jump into how the underlying IT systems support this. You will see them as different concepts or data classes or in Fire speak different resources. You have the medication administration resource where everything that is being administered is being recorded. You have the medication requests where everything that is being described is being recorded.

Certain kinds of lists of certain kinds of medication are based on which one or both or where they may sit that are then enveloped to be included in that list. Honing in too much on a coding system in the definition I think might lead people in the wrong direction of how you actually need to model it to make the IT systems under it make it possible for them to manage it. I think we would have to be very careful mixing the two concepts and creating an assumption of how it is being implemented based on the wording and the approach being suggested by being a code with a code system that has certain values. That may not be the best way to implement it.

Steven Eichner
It is not how it is usually implemented either.

Hans Buitendijk
I completely agree but I did not want to say it that strongly. It is just not done that way.

Sarah DeSilvey
I am just going to restate the problem here. I am going to break it down. Are we comfortable with advancing the medication administrative code as an element as currently defined and structured in this recommendation at this time?

Hans Buitendijk

I would be uncomfortable with the way that is implied and intended. It is one thing if it is Level 2 as is, but I do not think that is what for some the intent of that field is supposed to be. Changing it on the fly I think is not going to be helpful and confusing.

Sarah DeSilvey
Shelly?

Shelly Spiro
Yes, I agree with Hans, but I would like to hear from CMS as to what they envision this to be. What is a medication administration code as an example and what are they using it for?

Sarah DeSilvey
They are not here today.

Shelly Spiro
I thought somebody was here.

Sarah DeSilvey
Nadra is here from the CDC.

Steven Eichner
It is the same code. There is a code that identifies the medication, and it is the field or the message in which it is sent that clarifies what is the meaning.

Sarah DeSilvey
Can I make a recommendation that we state for this particular element we want to support our colleges at CMS? Even this conversation recognizes there is clarity to be found. We recommend that we go from recommending to being added as such, as we have above, that we say ONC should work with stakeholders on clarifying documentation of medication administered along with the work that is happening in the pharmacy standards ecosystem or something to that effect. We need to move forward. We are in the final hour here.

Steven Eichner
Sarah, this is Steven Eichner. We are willing to support that with the addition that we might want to remove the last words "and public health". I will defer to Bryant a little bit as to how critical these points are for public health. My personal perspective is there are other data elements that I would put at a higher priority for public health than this. Again, I would refer to Bryant. Bryant, do you have a quick follow-up on that?

Bryant Thomas Karras
Yes. Excuse me. I am suffering from a cold, so I am trying not to talk much. It depends on the use case. Obviously, for opioids or controlled substances, there is a public health need to know if the meds were actually used or administered. For certain directly observed therapies, we are not going to rely on this data element. There is going to be an actual public health person watching the person take the pill and documenting it.

Sarah DeSilvey

I think it is okay to state it is important for public health. I see Mark saying this without saying, it is the most important thing because that was the driver from the CDC, CMS recommendation. I do not think stating it is important for public health means it is the most important thing. It just means it is an important thing.

Steven Eichner
This is the only item that we pull that has been identified as being important to public health. If we are looking at that as a prioritization item, we did not really rank the others at all if they are important at all.

Bryant Thomas Karras
I see what you are saying, Ike. Maybe we should go back and just put important to public health on all the data elements.

Steven Eichner
That was kind of my point. I thought it was interesting. It is not important. All of these tools have uses and probably implications or maybe even significant ones for public health. I was just looking at why are we calling particular attention to this one without providing an actual example of a use case? That context almost becomes important because making that linkage to public health may be a little bit unclear to folks that are reading as to why those elements.

Sarah DeSilvey
It might depend on whether we are actually recommending the elements.

Steven Eichner
Exactly.

Sarah DeSilvey
Yes. So, if we are saying it is an ONC, it should work. We have to dispose of this fairly swiftly. We have 15 more minutes in our meeting. We have only one more element to discuss. This is the most challenging one. Shelly, any final thoughts?

Steven Eichner
Sorry, my last add to that one is if it gets approved it should be used with the language we discussed the other day about stakeholders and public health because it is not necessarily stakeholders in that sense.

Sarah DeSilvey
Correct.

Shelly Spiro
The issue I have with this is the word code. Medication administration code does not make sense to me. It is the code. If you are saying it falls into a bucket or to a field, that is fine. Call it medication administration field. There is no medication administration code. That is the term that I have.

Sarah DeSilvey
I do want to note that working on definitions at this hour is not necessarily feasible because we are in nuance not definition time because we have such little time. Nedra, I want you to speak before I try to wrap this up.

Nedra Garrett
No, I just wanted to kind of express the public health importance of this. When we put forth the recommendations we also looked at them as a class, looking at the USCDI medication data class. We had actually specified that we need to have more specificity in that. This conversation is indicative of that. Obviously, the importance is there from an adverse drug event as Bryant said, opioid use and just medication access. I just wanted to add that just as kind of support for the class in general. For this particular data element, we do recognize that many of these need more specificity. That was all I wanted to say from that perspective.

Sarah DeSilvey
Thank you, Nedra. We are of course very grateful. I am going to have Hans speak but I am just hearing a general sense that we wanted to lean into this because we recognize that it is so important, but I think this is why we originally said yes. I think we are recognizing there is additional work to be done. Here I was recommending that it be an ONC focus of effort over the course of the next year as a priority for USDI V.5. That is what I am hearing us saying, which would sunset this as a recommendation per se to include but as a recommendation to work. We can work on the wording there. Hans?

Hans Buitendijk
Yes, just as the examples when we look at Level 2, the term administered, and administration goes back and forth between the topics. The notion of a list, a medication list, is not separately mentioned and I think that would be very helpful. If we recognize that as a separate concept then that can help to further understand what goes where and can compare it with the way that the search data is typically managed. I completely agree that this is based on the confusion and not the right time to suggest putting it into use USDI Version 4, but something to work on to get ready in a state where it is better understood.

Sarah DeSilvey
We can work with ONC to figure out whether it is a recommendation 30 or whether it is future work in the latter section. Are we all in agreement that is where we are landing again at the 11th hour?

Clem McDonald
I just think that there is this deep confusion about codes and fields that maybe we should have a lecture on somewhere along the line because it is where it is stored. Medication codes would be the same everywhere. If it is the field for administered or the field for prescribed, that is what tells you that part. You are not going to be changing the code for the drug from those different contexts.

Sarah DeSilvey
Thank you very much. This kind of goes into some of the status conversations we were talking about in our meetings prior. There is a fair amount of critical work regarding medication documentation that we know needs to happen. Steven, before we move on to the next one?

Steven Lane
Yes, do not move on. It seems like we are throwing the baby out with the bath water here. I mean medication route.

Sarah DeSilvey
Correct.

Steven Lane
That is good. The thing that we keep stumbling on is just this medication administered code. Let us not dump the whole thing because that one remains unclear to us.

Sarah DeSilvey
My apologies. That actually was my recommendation. If you scroll down you can see. Consider advancing medication route and advise ONC to work with stakeholders to clarify definition standards for the other elements for USDI V.5.

Steven Lane
How about say "recommend advancing medications"?

Sarah DeSilvey
Correct. Yes, it was in my comments.

Steven Lane
Right.

Sarah DeSilvey
Thank you Steven for grounding us again. We are in agreement as far as I hear us stating on medication route and then underneath we could state as a comment as we have in other areas, suggest that ONC should work with stakeholders including HL7, others, to clarify elements to describe administration status, discharge status, et cetera.

Clem McDonald
That statement that we would add a medication administrative code is completely wrong.

Sarah DeSilvey
That is why I was using the term statuses as opposed to codes.

Steven Lane
Mike, I like what you are putting in as bullet four. It looks like we should probably remove bullet one.

Sarah DeSilvey
Correct. Does bullet two stay?

Steven Lane
Yes. Two and three should stay. We want those included.

Michael Berry
Are we taking this out here as well?

Sarah DeSilvey
We would, yes.

Michael Berry
What was the rest of this?

Shelly Spiro
I would include HL7 and NCPDP. Both are stakeholders.

Clem McDonald
Bryant you and I were going to say the same thing I expect. You take it.

Bryant Thomas Karras
We usually use stakeholders to refer to all of them.

Sarah DeSilvey
Yes. We have not defined the specific stakeholders in the past. I think it is okay if we just say interest parties or stakeholders as we have in the past, I think it covers it. I think what I hear us saying is working with stakeholders to define elements for documenting medication administered statuses or something to that effect.

Steven Lane
I am sorry Sarah.

Sarah DeSilvey
To defer the defined medication administered statuses. That is just my attempt.

Steven Lane
I like it. Defined but also document. I mean we are trying to capture it, right?

Sarah DeSilvey
Yes.

Steven Lane
I think there is a missing word before medication administration status. I think you said defined. That is probably it, but it is also worth trying to capture.

Sarah DeSilvey
It is documenting. You define elements for documenting that element for medication administration statuses. Actually, many of the things we are talking about here, discharge, whatever, they are all different. Okay, perfect. Thank you Steven Lane for talking me back from the brink there. Okay, are we good with this as it stands?

Steven Lane
Team effort.

Sarah DeSilvey
Yes. Okay, this was a big one. If we could scroll back up for one second. I just want to look at it as it stands as a final thing. I want to acknowledge that Nedra I hope you feel us supporting CMS and CDC and the importance of this agreeing to go forward with what we know we all agree on and really stating very clearly that we need to support CMS and CDC and the ecosystem in these critical status elements that will help us across the ecosystem.

Nedra Garrett
Yes. Yes, I understand. That is all fine.

Sarah DeSilvey
Thank you, Nedra. We can resolve these comments Mike and move on to the final one that we can resolve at any point in time. I think the final element was the only thing that needed to be thought of here. This is it, friends. There was some thought of because this is a recommendation to CMS and not to ONC specifically that it would not necessarily be part of our recommendations to HITAC. That is the only thing that we have to discuss. How do we feel about that?

Steven Lane
Unless we are saying that we should recommend that ONC work with CMS to do this, it probably does not belong in our recommendations. I am sorry if I spoke out of turn.

Mark Savage
That was Mike's suggestion is just to wordsmith and say ONC should work with CMS.

Sarah DeSilvey
We have done that before.

Mark Savage
Rather than make a statement directed at CMS directly.

Sarah DeSilvey
That makes sense. That is the precedent we have had before. "ONC should" is how we have been saying things. Work with CMS to consider moving or to evaluate moving the CCN from the current. I think maybe "evaluate" is better than "consider" here.

Clem McDonald
I do not think we have spelled out CCN before in the recommendations yet, have we? That might be helpful to just spell it out.

Sarah DeSilvey
That is true.

Steven Eichner
Maybe change work to collaborate. It is Ike.

Sarah DeSilvey
Collaborate. Thank you, yes. All right, are we all good with that as it stands understanding that we can add the CCN full name and then parenthetical following? Are we all good?

Shelly Spiro
Is it time for a second woohoo?

Sarah DeSilvey

I feel like we need one.

Steven Eichner
This is Steve. Please look at the last component of that edit so that we are looking at the right conditional here. In other words, if we are looking at if the organizational hospital type is supported in V.5 or are we looking for them to include it in V.5?

Sarah DeSilvey
Raj, is the comment on that? Ike, I think I need help understanding.

Steven Eichner
Sure. Right now, if you read it, the **[inaudible] [00:54:35]** is work on the data but only if your organizational hospital identifier data is included in V.5. Is it the goal to include them in V.5?

Sarah DeSilvey
Okay, I hear what you are saying I think. I think to make it simpler it could just be ONC should collaborate with CMS to evaluate moving the CCN to the currently proposed distilled information data class to the organization data class. You could just state that.

Michael Berry
Period.

Sarah DeSilvey
Period, yes. Stopping there, am I correct Mike? Everything else is unnecessary. Ike, does that sound good?

Steven Eichner
Wonderful.

Sarah DeSilvey
Okay, great.

Michael Berry
Raj had a few comments that we should go back to.

Sarah DeSilvey
I know. Yes, I see. Mike, thank you for your patience. We are good with this one as it stands, correct? Okay, thank you for your patience, Mike. If you can take us back to 24, please.

Raj Dash
I do not know if this is needed because it is just requesting a slight tweak to the name for clarity. We had a quote pulled out for other laboratory data elements that these were required by CLIA so I figured we might as well be consistent.

Sarah DeSilvey
Do we do that in the recommendation? How about we just put as a comment Mike that in line with other recommendations, we add the comment regarding CLIA? Then we can just add that as we have based on the others. Does that sound good Raj?

Raj Dash
Sounds great.

Sarah DeSilvey
Mike, I would just make a comment here and say "add CLIA comment".

Michael Berry
Okay.

Sarah DeSilvey
We can work on that.

Michael Berry
Sounds good.

Sarah DeSilvey
All right. Okay.

Michael Berry
All done with this?

Sarah DeSilvey
All done with this. I think we will go to public comment.

Public Comment (00:56:38)

Michael Berry
Great. All right everybody, we are going to open up our meeting for public comment. If you are on Zoom and would like to make a comment please use the hand raise function which is located on the Zoom toolbar at the bottom of your screen. If you happen to be on the phone only, press star nine to raise your hand and once called upon press star six to mute and unmute your line. Let me see if anyone has raised their hand. We just have a few public attendees, but I would just like to take this opportunity to thank all of you once again on behalf of ONC for your great work. I know this has been a lot. I really appreciate it. It has been great working with all of you. Thank you so much. I will turn it back to our co-chairs. I do not see any public comments.

Sarah DeSilvey
All right, I just want to take a moment to say a collective thank you to all of you for working so hard on these recommendations over the course of this last time. You have been very kind to the brand new co-chairs of the ISWD to this work and your investment has made it possible for us to complete our charge. Going forward what we will do is create the presentation to HITAC. I am just incredibly grateful to work with you all. Thank you so much. That is my final statement. Naresh any final elements?

Naresh Sundar Rajan
Sure Sarah. It is a great effort with the team here and I really appreciate Sarah stepping forward on most of the conversations here and the backend of also an awesome team helping us a lot to onboard the new

co-chairs. It is a lot of work. Definitely thanks a lot to all those who contributed to subgroup conversations and finalizing this into a smoother execution compared to other whole group meetings that I have seen so far. Thanks a lot.

Sarah DeSilvey
Grateful to work with all of you experts and wise people. Thank you so much and we will see you at HITAC.

Adjourn (00:58:41)