Transcript

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

January 23, 2024 10 – 11:30 AM ET

VIRTUAL

MEMBERS IN ATTENDANCE

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

MEMBERS NOT IN ATTENDANCE

Jim Jirjis, Centers for Disease Control and Prevention
Aaron Neinstein, Notable

ONC STAFF

Seth Pazinski, Director, Strategic Planning & Coordination Division, ONC
Wendy Noboa, Designated Federal Officer, ONC
Al Taylor, Office of Technology, ONC

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

Seth Pazinski
All right, good morning, everyone. I am Seth Pazinski with the Office of the National Coordinator for Health IT. I will be serving as the Designated Federal Officer for today's call on behalf of Wendy Noboa. I want to welcome everybody to the Interoperability Standards Workgroup for 2024. Thanks, everybody, for joining and volunteering to be a part of the workgroup. Just as a reminder, all workgroup meetings are open to the public, and public feedback is welcomed during the call. For members of the public that are joining, you can type your comments in the Zoom chat feature throughout the meeting, or there will be time at the end of the agenda if you want to make verbal comments. So, I welcome you to participate through the chat during the meeting or through verbal comments at the end. I want to start off with roll call of our workgroup members, so when I say your name, just indicate that you are present. Sarah DeSilvey?

Sarah DeSilvey
Here.

Seth Pazinski
Steve Eichner?

Steve Eichner
Present, good morning.

Seth Pazinski
Good morning. Pooja Babbrah?

Pooja Babbrah
Good morning.

Seth Pazinski
Ricky Bloomfield?

Ricky Bloomfield
Good morning, I am here.

Seth Pazinski
Medell Briggs-Malonson? Hans Buitendijk?

Hans Buitendijk
Good morning.

Seth Pazinski
Good morning. Keith Campbell?

Keith Campbell
Present.

Seth Pazinski
Christina Caraballo?

Christina Caraballo
Good morning.

Seth Pazinski
Good morning. Grace Cordovano?

Grace Cordovano
Good morning.

Seth Pazinski
Raj Dash?

Raj Dash
Good morning.

Seth Pazinski
Derek De Young?

Derek De Young
Good morning.

Seth Pazinski
Lee Fleisher?

Lee Fleisher
Good morning.

Seth Pazinski
Raj Godavarthi?

Rajesh Godavarthi
Good morning.

Seth Pazinski
I know Jim Jirjis sent us a note that he was not going to be able to make today's meeting. Steven Lane?

Steven Lane
Good morning, present.

Seth Pazinski
Thank you. Hung Luu?

Hung Luu
Good morning.

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

Katrina Miller Parrish
Good morning.

Seth Pazinski
Aaron Neinstein? Kikelomo Oshunkentan?

Kikelomo Oshunkentan
Good morning.

Seth Pazinski
Good morning. Rochelle Prosser?

Rochelle Prosser
Good morning.

Seth Pazinski
Mark Savage?

Mark Savage
Hi, I am here.

Seth Pazinski
Fil Southerland?

Fillipe Southerland
Good morning.

Seth Pazinski
Shelly Spiro?

Shelly Spiro
Good morning, everyone.

Seth Pazinski
Zeynep Sumer-King?

Zeynep Sumer-King
Good morning.

Seth Pazinski
Naresh Sundar Rajan?

Naresh Sundar Rajan
Good morning.

Seth Pazinski
Good morning. All right, thank you, everyone. Is there anybody I missed? Hannah Galvin, thank you for joining. That completes our rollcall. I wanted to make just a few point for the awareness of you all before handing it over to the co-chairs to get into our agenda for today. First, I just wanted to highlight that the results of your efforts for the workgroup will take the form of a draft set of recommendations and a letter to the HITAC, and the HITAC will ultimately vote and come to a majority consensus decision on a set of recommendations that will go to the National Coordinator for Health IT. I also wanted to note in addition to that as members of the public, you are free to submit any individual comments via the ONDEC system related to draft USCDI v.5 as well.

The second point I wanted to highlight is that there will be homework between the workgroup meetings, and often, we will ask for a volunteer for a particular data class or data element to lead the discussion or open the discussion for workgroup members and ask for a lead to take the point or a few folks to take the point in leading and opening the discussion at the workgroup meeting. So, as you get the overview today from Al Taylor from ONC on draft USCDI v.5, if there are particular elements you are interested in and would like to take the lead on getting the conversation going in an upcoming workgroup meeting, please feel free to reach out to me, Seth Pazinski, or Wendy Noboa via email to let us know, and I will plug our emails in the chat so you guys have those. With that, I want to thank everyone again, and now, please join me in welcoming Sarah and Steve for their opening remarks and getting us into our meeting.

Workgroup Introductions (00:05:14)

Sarah DeSilvey
Welcome, everybody. I just wanted to take a moment to formally welcome all of the new folks here to the meeting. I was new here last year, actually new and co-chair here last year, and I can testify that it took me a little while to get the hang of it, but then it was just an honor and privilege to work with this very esteemed group of people on something so fundamental to our practice. I am a family nurse practitioner taking care of patients in rural Vermont, and it is my honor this year to be joined by my co-chair, the amazing Steve Eichner. You have a balance now in your co-chairs between clinical practice and SDOH health equity stuff with my work and with Steve. I will let you introduce yourself, Steve, but you do not need the introduction. Steve is going to bring the public health perspective that is so critical.

Steven Eichner
Thank you for those kind words. My name is Steve Eichner. I am the health IT lead at the Texas Department of State Health Services. I have been working in public health for 17 or 18 years, and in the history of the technology long before that. I am so excited to have such a dynamic set of folks to work on reviewing USCDI and providing feedback to ONC about how the USCDI terms can best be used to serve the healthcare community and the public health community as well. We have some exciting opportunities ahead of us, and I am excited to do it. For the sake of convenience, as there are multiple Steves in the room, I tend to adopt

the nickname “Ike,” I-K-E, so I want to note that we have at least one Steve in the room, and we will go that path to make it as easy as possible, and we are excited for you all to be here.

Sarah DeSilvey
Indeed. I think we are going to go over to formal introductions. Could we go to the next slide? So, this is an opportunity for us to very briefly introduce ourselves. There is going to be a 3-minute timer. I spared some of my context for you all in my welcome so I could deliver it here as a template. My name is Sarah DeSilvey. I am a rural family nurse practitioner. I also have the honor of being the Director of Terminology for the HL7 FHIR accelerator project called the Gravity Project, which has the charge of developing data standards to address the social determinants of health. I wear an additional hat in working with Yale CORE on CMS social determinants of health and health equity contracts, and that is my history of clinical practice. Rural Vermont is still at least half of what I do, so it keeps me honest, and I look forward to working with you. Ike, off to you.

Steven Eichner
Thank you again. Again, my name is Steve Eichner. I have been the Health IT lead at the Department of State Health Services here in Texas for a number of years. I am also actively involved in a variety of HL7-related activities. I also work across public health with a number of our professional organizations, including the Council of State and Territorial Epidemiologists and the Association of State and Territorial Health Officials, and I am really excited to be here and committed to doing some good work.

Sarah DeSilvey
Pooja Babbrah?

Pooja Babbrah
Great. Hi, everyone. I am Pooja Babbrah, the PBM and Pharmacy Practice Lead for Point-of-Care Partners. We are a health IT strategy company. My focus is mainly on strategy work related to pharmacy. I have been in the pharmacy industry for over 30 years now. I was on this workgroup last year, so, than you for having me back, and I was also on the Pharmacy and Emerging Therapeutics Task Group as well. I tend to say I work in the intersection of strategy, policy, standards, and technology, so that is my main focus. I am excited to be here. Thank you.

Sarah DeSilvey
Thank you so much. Steven Lane?

Steven Lane
Hello. I am Steven Lane, a practicing family physician and informaticist. I serve as the Chief Medical Officer at Health Gorilla, one of the QHINs on the TEFCA, and have been involved in this workgroup since its inception, many years ago.

Sarah DeSilvey
Ricky Bloomfield?

Ricky Bloomfield

Hi, good morning. It is great to be back. I am a physician in internal medicine pediatrics and a clinical informatician. I have been leading the clinical and health informatics work on the health software team at Apple for over seven years, I have been working on FHIR-related projects for over 10, and I represent Apple to the Argonaut Project and the CARIN Alliance, and I work closely with our government affairs team on policy-related issues. I am really excited to be a part of the group again.

Sarah DeSilvey
Thank you. Hung Luu?

Hung Luu
Good morning. I am an Associate Professor of Pathology at UT Southwestern Medical Center, and I also serve as director of clinical pathology at Children's Health, a pediatric healthcare system in north Texas. I have had the honor of working on laboratory interoperability through the SHIELD Initiative associated with the FDA, and I also receive some salary support through several grants supporting laboratory interoperability. I am also a member of the Clinical Advisory Committee Council for Health Gorilla.

Sarah DeSilvey
Thank you. I think Medell is not with us today. She needs no introduction. She is my esteemed co-chair on HITAC, unless I am wrong. Is Anna with us today? I do not see Anna in attendance. On to Hans.

Hans Buitendijk
Good morning, my name is Hans Buitendijk. I am senior director of interoperability strategy with Oracle. There are a couple of hats that I wear. One is that I am very active in HL7, participating in development of the standards that are supporting USCDI. I am also active in EHRA, which I am using as a sounding board for working with EHR vendors that have to implement the standards, so that is where most of the feedback and insights will be coming from. I will not list the different groups, as I will run out of time.

Sarah DeSilvey
Katrina Miller Parrish? Welcome.

Katrina Miller Parrish
Thank you very much. So, I am also a family physician and clinical informaticist working at Humana Insurance in payer operations interoperability. In the past, I have worked in private practice and academic practice with EMRs all the way back to Vista. I am director for clinical informatics currently. Previously, I was chair for quality and informatics at LACare Health Plan, which was largely a Medicaid plan, where I stood up the health information ecosystem, as we called it, and I have also served as the co-chair for the Data and Research Committee for the Institute for Medicaid Innovation.

Sarah DeSilvey
Welcome, thank you so much. Keith Campbell? Is he with us today? I did not hear him in rollcall. I do not think he is with us. Aaron Neinstein? Is Aaron with us today? I do not think so. Raise your hand if I say your name and I do not see you. I am trying to scroll. Christina?

Christina Caraballo

Hi, everyone. I am Christina Caraballo, Vice President of Informatics at HIMSS. Another role I play is as president of IHE USA, and I sit on the board of IHE International. I have also been a member of this workgroup since the start, with one gap year, and am a former co-chair. Thanks.

Sarah DeSilvey
Welcome, Christina. I am going to circle back to Keith.

Keith Campbell
Good morning. My apologies. So, my background is in internal medicine, and I also have background in informatics and computer science. I am the director of the SHIELD Program at the Food and Drug Administration, and also have had a long history of working in standards, including HL7, and many aspects of data representation and interoperability. Thank you.

Sarah DeSilvey
You are welcome, Keith. Kikelomo?

Kikelomo Oshunkentan
Good morning. Feel free to call me Dayo. Do not let the length of the name scare you. I am boarded in internal medicine. I work as a Hospitalist in a Level 1 trauma center here in Charlotte. I have extensive expertise in both the payer and provider sector, working as a Medical Director at Anthem, which is now called Elevance Health, in which I had a leadership role during the pandemic, spearheading a multidisciplinary COVID program and leveraging impactful data analytics during that time. After that, I pivoted to my most recent role as Chief Medical Officer at Pegasystems, where I served as the highest clinical executive in the organization, representing Pega's clinical solutions to health systems, health payers, and the life sciences to help optimize their healthcare outcomes as well as their provider experiences. That is a little bit about me. Nice to meet you all, and I look forward to collaborating with you.

Sarah DeSilvey
Welcome. I do see that we have had some members join us. I am going to save those intros to the end, just to keep going, and then I will do everyone who has joined in a set at the end. Grace?

Grace Cordovano
Good morning, everyone. I am Grace Cordovano, board certified patient advocate, specializing in the oncology space. My day-to-day is working with patients and families from point of diagnosis through survivorship or end-of-life care planning. I like to think I work at the intersection of real-world interoperability while reducing patient administrative burden, working at catastrophic life-or-death situations. I have had the privilege of serving on the Interoperability Standards Workgroup, the USCDI Task Force, I am an advisor to CancerX, and I am absolutely thrilled to be here.

Sarah DeSilvey
We are thrilled to have you. Rochelle?

Rochelle Prosser
Hi, good morning. My name is Rochelle Prosser. I am the founder of Orchid Healthcare Solutions. I am a registered nurse and a data scientist. I am also a founding member of CancerX and a staunch advocate for

cancer patients. Grace is a personal friend, and I am so happy to see her here. Just to keep it short, I have a 30-year history of nursing, caring for cancer patients, and trying to be in that space from payers to value-based care. So, I will just leave it at that, as there is so much more and so many other people to talk to.

Sarah DeSilvey
Luckily, we have a whole set of months where we can get to know each other. Raj?

Raj Dash
Hello, good morning. I am a Pathologist at Duke Health in Durham, North Carolina. I am the CAP. I served on a number of informatics/information technology-related committees over the past few decades. I am focused on standards, and I currently chair the Artificial Intelligence Committee. Thank you.

Sarah DeSilvey
Mark?

Mark Savage
Good morning. I work on a variety of projects in health equity, patient access and PGHD, social drivers of health, interoperability, and so forth. One other thing to highlight is that I am working with others on California's Digital Exchange Framework, which is combining not just the usual ecosystem, but also community-based organizations and social service organizations across California exchanging USCDI v.2, so it will be a great nationwide pilot. Thanks.

Sarah DeSilvey
Derek De Young?

Derek De Young
Good morning, everyone. I work in research and development at Epic out here in Verona, primarily in the interoperability space. I focus on payer and provider interoperability with an application we call Payer Platform. It is good to see Humana and Elevance on. I work closely with both of your teams in that area with the goal, of course, of reducing administrative burden, improving clinical care by combining knowledge sources together, and then, of course, making sure the patient has better access to data as well. I have participated in the TEFCA workgroup for payment and operations, and we participate heavily in the Da Vinci workgroups and the HL7 Da Vinci accelerator as well. I am happy to be here.

Sarah DeSilvey
Great to have you. Fil? Is Fil with us today?

Fillipe Southerland
I am here. Good morning, everyone. Hi, Sarah. I am Fil Southerland, director of health at Yardi Systems. We are an electronic health record in the long-term post-acute care space. I head up our electronic health record development and interoperability initiatives. I have a software development background. I previously ran one of the first technology startups in the long-term post-acute care space. It is good to be here.

Sarah DeSilvey
Good to have you. Lee?

Lee Fleisher
It is a pleasure to be here. I am a Professor Emeritus, former chair, and practicing Anesthesiologist at Penn Medicine. I am also a Health Services Researcher. Most relevant, I was the previous Chief Medical Officer and Director of the Center for Clinical Standards and Quality, where we used a lot of the USCDI and thinking through this for quality membership. I am a member of the NAMM working groups on the HITAC, and I have an advising firm called Rubrum Advising. Thank you.

Sarah DeSilvey
Thank you. Shelly?

Shelly Spiro
Good morning. I am Shelly Spiro, the Executive Director of the Pharmacy HIT Collaborative, which is a collaborative formed in 2010 by the National Pharmacy Professional Associations. I have been a pharmacist for 48 years in many different practice settings. I have also been an active member of the LTPAC HIT Collaborative since its inception 17 or 18 years ago. I was a member of this workgroup last year and I bring all aspects of pharmacy. I am very active in HL7 and NCPDP and work on many different projects within both of those organizations.

Sarah DeSilvey
Welcome, Shelly. Hannah?

Hannah Galvin
Good morning. My apologies for the lack of camera this morning. I am delighted to be here. I am the Chief Medical Information Officer for Cambridge Health Alliance, a public health academic system serving the Boston area. I am also the cofounder and board chair of Shift, the independent healthcare Task Force for equitable interoperability, where we are working to mature standards and implementation guidance around data segmentation and granular consent, and I will also be serving on the Sequoia Project's privacy consent workgroup in that capacity as well. I am delighted. This is my first time on the Interoperability Standards Workgroup this year, so I am looking forward to it.

Sarah DeSilvey
Zeynep?

Zeynep Sumer-King
Good morning. Thanks for having me. I am the current Vice President for Regulatory Affairs and Global Services at NewYork-Presbyterian Hospital, which is a large health system in the New York City region. Before that, just about a year ago, I spent a long time at the Greater New York Hospital Association, covering a number of different policy and regulatory issues, but really focusing a lot on health information technology and interoperability on behalf of the 200-plus hospital members of Greater New York. I spent a lot of time on the policy committee of the Statewide Health Information Network for New York, and I really look for ways in which to apply USCDI and other standards to the practical work that our hospital system does. I am happy to be here. This is my first year on the committee.

Sarah DeSilvey

Welcome. Rajesh?

Rajesh Godavarthi
Good morning. Thank you for the opportunity. I am very delighted to be part of this group. I am coming from MCG Health, an evidence-based clinical decision support company, and my primary role the last few years has been in interoperability and automation, especially in the HL7 Da Vinci groups on prior auth, and I have been part of many other committees than Interoperability Standards, and I am also a WEDI board member in a few of the committees. Thank you.

Sarah DeSilvey
Thank you. Naresh?

Naresh Sundar Rajan
Hi, everyone. Good morning again. This is Naresh. My apologies for not having a camera today. My background is in clinical informatics, and I have actually also gotten into computer science intensively. I currently serve as chief data officer for CyncHealth, which is a statewide health information exchange for the state of Nebraska and state of Iowa. We build products and tools that closely tie with interoperability and practice the USCDI on a daily basis, so everything that happens here changes operationally for us, so I am really excited to be part of this panel.

Sarah DeSilvey
We know Jim is not here today, so I am now going to go to make sure that we allow time for Medell and Anna. Medell, hi.

Medell Briggs-Malonson
Good morning, everyone. I am traveling here in Los Angeles traffic, so I definitely cannot be on camera. My name is Medell Briggs-Malonson. I am the Chief of Health Equity, Diversity, and Inclusion for the UCLA Health System. I am also an associate professor of emergency medicine at the David Geffen School of Medicine, where I still practice in the emergency department every single week. In addition to that, I am the founder and CEO of Contour Health Solutions, which is a national advisory forum for health technology companies, as well as investors, on how to develop and implement inclusive technologies that actually improve the overall health status and high performance, especially in divested communities. The last thing is that I do serve very proudly as the co-chair of HITAC as well, and this is my first time here on the Interoperability Standards workforce, although, of course, this tends to be a very important stream of work throughout all the things that we do throughout the country, so it is a pleasure to be here today.

Sarah DeSilvey
Welcome, Medell. Anna?

Anna McCollister
Hi, everybody. I am Anna McCollister. I am beginning my second year serving on HITAC. Prior to that, I had been involved in different workgroups over the years with ONC in various capacities, but this is my second year on HITAC. I have a diverse background in public affairs, economic policy, and foreign policy, but about 12 years ago, I switched gears as a frustrated patient with Type 1 diabetes. I decided that real-world evidence offered an important option to randomized controlled trials for those of us who live with

complex illness, so I cofounded a company to do big data analytics. We did a lot of stuff in cancer and other disease areas, identifying new outcomes measures. Through that, I got involved in health IT policy and public affairs. I worked with the Scripps Research Translational Institute and was one of the original co-PIs for the All of Us program.

I did a second startup focused on building a platform for crowdsourcing the design of clinical research, which was part of the All of Us program grant. I have served on a number of FDA advisory committees as a Type 1 diabetes patient, both with drugs and devices, and patient engagement as a consultant, and I have also served for about 12 years on National Quality Forum committees, looking at CMS quality measures in the endocrine and diabetes chronic disease space. I helped start a patient hacker movement in the Type 1 diabetes space called the We Are Not Waiting movement, which was designed to take the tools that we had in informatics and devices and put them together at a rate that was faster and more effective than what was happening in the industry.

For the past six years, I have worked as an independent consultant, focused mostly on engaging patients on issues related to data, data use, access, and governance, mostly with the goal of doing data governance for companies and groups in a way that earns the trust of patients. I am a new member of the board of directors for Sequoia, and I am also leading and co-chairing a new workgroup that is forming with Sequoia on consumer engagement strategy, identifying ways to effectively engage consumers and patients directly with companies to encourage interoperability and effectively enable patients to use their data in ways that they want it to be used. I am happy to be here.

Sarah DeSilvey
Anna, we are happy to have you. I am sure all of you feel the collective wisdom and experience of this group. It is a really robust and wonderful workgroup this year, and we are very excited for this work. Ike, any other thoughts before we pivot? You might be on mute. I think we can go to the next slide because we do have another topic of conversation. Ike, are you coming off mic?

Steven Eichner
We are good, thanks.

Sarah DeSilvey
Great, thanks. Next slide. Ike, would you like to handle this, or should I? Would you like me to lead it?

Steven Eichner
Go for it.

IS WG Charge and Timelines (00:28:22)

Sarah DeSilvey
Okay. He knows I am Sarah DeSilvey on repeat from last year. It is my honor to present our IS WG Workgroup charge for the year. Specifically just giving insight as a new member to HITAC and a new member to IS WG last year and brand-new co-chair, I have some tips and tricks at the end. So, the overarching charge of the IS WG is to review and provide recommendations on the current year's draft of USCDI, which, this year, is draft USCDI Version 5, which we know came out right before our last HITAC meeting a little bit ago, for those of you who are on HITAC. It is released and available on HealthIT.gov.

Specifically, we are all asked to take our wisdom, expertise, and perspectives in consideration of draft USCDI and provide recommendations on the following elements: Any new data class and element from draft USCDI that should be considered for the final USCDI v.5 release. And then, we are also asked to consider any existing Level 2 data classes and elements that were not included in USCDI v.5, but should be considered for the final USCDI v.5 release.

This is kind of an abstract statement, but as Seth mentioned early on, all of our wisdom, recommendations, and elements in A and B, become part of a final transmittal letter to HITAC in April. The final transmittal letter from last year is a really good resource to review as you are trying to figure out how to take this charge and apply it specifically because you can see how we all work together to create comments, opportunities, perspectives, amendments to USCDI, and a reflection of Level 2 elements to present to HITAC as a final version. Again, this is very speedy, concrete work, and all of your expertise will be applied to the task, and we are very excited to have you, and ONC is going to walk us through some of the particulars of this over the course of the next slides. Ike, anything to add?

Steven Eichner
No. I think you did a great job.

Sarah DeSilvey
Oh, thanks! One of the great things about this workgroup is that it really is an opportunity for all of us to talk in depth from all of our different perspectives, and again, I am really honored to co-lead this with a public health expert, giving a health equity perspective of my own, knowing that it is very, very critical. Next slide. Now I am passing the mic to my colleague Al, I believe, who will be presenting on draft USCDI Version 5, the primary document that it is our responsibility and charge to provide insight on in order to present that back to HITAC. Al?

Draft USCDI v5 Overview (00:31:25)

Al Taylor
Thank you, Sarah, Steve, and the rest of the workgroup. I am happy to present the recently released draft USCDI Version 5. Next slide. We are going to go over USCDI in general, talk about the new data elements and data classes that we added to v.5 and propose to be added to the final, talk about the other changes that we included in draft v.5, and then look at the timeline for where we go from here, now that we have released it. Next slide, please.

As almost everybody knows, USCDI is ONC's defined core set of data for patient care and patient access and exchange of data using health IT, the technology that we have all been working to build. It also establishes a baseline as a reference for other purposes besides exchange of data using health IT, and it expands over time using a well-defined, predictable, transparent, collaborative process. It is from public input that we get ideas for new data elements in USCDI for the next version. Next slide, please.

USCDI was established in the ONC CURES Act final rule in 2020, and it replaced the Common Clinical Data Set, which was a similar set of data that was used for exchange in certified health IT. The recently released HTI-1, or Health Data Technology and Interoperability, provided certification program updates, which included establishing USCDI Version 3 as the new baseline for exchange under these criteria that I am about to talk about. Everybody with certified technology must be updated by the compliance date,

January 1st of 2026, in order to continue to be certified, and USCDI Version 3, which is the new baseline, is the data set that is referenced in these five ONC certification criteria. Just as one note, we previously had referenced USCDI or part of USCDI in the electronic case reporting. That has been removed, and the reference is only to a specific implementation guide, not to USCDI.
There are other uses. I mentioned that USCDI is a baseline for other purposes. We already know of several outside functions and outside authorities that use USCDI as the exchange set. That includes at least two CMS programs, Patient Access and Payer-to-Payer APIs. TEFCA currently uses USCDI Version 1 as the baseline for exchange in several elements of TEFCA, and also, the California Data Exchange Framework references USCDI v.2 as the required data set. Next slide.

Further, the CURES Act final rule establishes SVAP, or the Standards Version Advancement Process, which allows health IT developers to voluntarily update their programs or products to newer versions, and then provide that to their customers. USCDI Version 2 was available through SVAP until December of last year, when USCDI Version 3 became the only available version of USCDI to be SVAPed. Some vendors and developers, though not a lot, had already updated to USCDI Version 2 before the end of that availability, and if you are interested in keeping track of that information, it can be found on the certified health IT product list that ONC hosts, and there is a special section of the CHPL that can update people on who has already updated to Version 2 or Version 3 when developers start doing that. In addition to USCDI Version 2, US CORE 5.0.1 and C-CDA R2.1 Release 3, which support USCDI Version 2 and actually sort of enable or implement Version 2, are also available through SVAP, and the developers who updated to Version 2 also updated to these two implementation guides, so they are capable of exchanging USCDI v.2. Next slide.

I wanted to highlight this because for new submissions, we get a lot of submissions through our ONDEC system, our ONC New Data Element and Class submission system, and it is important for submitters to understand how we would likely evaluate their submissions based on a number of different criteria, including the technical maturity of the standards, their use, and exchange, along with a really important aspect, which is the breadth of applicability. A data element that is very narrowly focused on a specific specialty is considered obviously less applicable, and therefore gets what some would a lower level, Level 0, and we had a lot of submissions that fell into that category. It does not mean that they are not technically mature, it just means that they only apply to a narrower use case, and since USCDI is the US core, it not considered to be a viable candidate at this time for a future version of USCDI. Next slide.

During the v.5 process, we received 62 submissions through ONDEC, which is about half of what we received in three prior years. We like to think that we are getting close to getting it right, but we also recognize that there may have just been more focus on other things like our proposed rule or, now, our new final rule with HTI-1, so we received these submissions in these data classes. Next slide. We also received over 300 comments on previously submitted data elements in these categories. We take all of the submissions and all of the comments on previously submitted data elements and come with a list. Next slide, please.

These next two slides are all of the data elements that were processed, evaluated, and determined to be Level 2, which is those most mature, most ready for implementation, and most broadly applicable. These two slides have two things I wanted to point out. These are all the Level 2. This is a universe of data elements that we considered when we developed what went into draft v.5, and each year, we publish a new

version. This is the same universe of data elements that we consider for each time around. So, new submissions and old submissions are all considered if they are considered to be Level 2.

The highlighted data classes and elements are data elements that are added to draft v.5 and proposed to be added to final Version 5. The little H next to these shows data elements that the HITAC has previously weighed in on in the last two years especially. They have advocated for the addition of these data elements. Some of those are now part of draft v.5, and some of them are still being considered. Next slide. This just goes over the second half of the set of Level 2 data elements and is a little teaser of what I am about to talk about, so we will go to the next slide.

Once we take the entire universe of Level 2, we apply some additional prioritization criteria because there are simply too many data elements to add to a particular version, even if they are all equally applicable, so we have to apply some further filtering. We prioritize two categories. One is the technical feasibility of addition, minimizing the amount of burden that IT developers have to go through, the providers that have to implement the data elements, and even first the standards developers like US CORE and C-CDA IG developers, who also have to implement new elements in USCDI. So, all of them count. All of those are considered in addition to some policy priorities that we set around healthcare disparities serving underserved communities, behavioral health, and public health reporting. Overall, once we have evaluated all those, we take all of them in total and assess whether or not the package of new data elements is feasible to implement, and that is what we mean by “aggregate list” for all the data elements included in a particular version. Next slide.

Here we go. This process that we have been using developed… We have added 13 new data elements to draft v.5. The icons here note the prioritization criteria that we used that apply to the data elements. There is a little squiggly line that is the section symbol. That indicates that there are aspects of ONC certification and regulation that were used as partial justification for adding these data elements. Since IT is already required or will be required to use or at least collect these data elements, we felt it was reasonable to add it to the next version, so these are new data classes, observations, and orders, along with the other data elements. We are going to get into some details about these as well. Next slide.

So, this is the whole USCDI Version 5. It is a lot to digest in one slide. I am not going to take the time to read through it, but the highlighted classes and elements are new to draft v.5. Next slide. Now I am going to get into a little bit of detail as far as the 13 data elements that we added. Next slide, please. The first one we added was two clinical notes. One is emergency department note, and the other is operative note. Both of these were advocated for by the HITAC in the last two years. We set the minimum. The LOINC code is used to identify the content in the emergency department note and operative note, and we have set the minimum LOINC code for one particular code representing emergency department note and operative note, but it does not mean that other coded concepts or other coded note types or narratives cannot be included in the exchange of information. Next slide.

The next one is lot number. This is the first additional data element beyond immunizations that we added to USCDI. As you know, lot number is important for vaccine safety, it is used in the VAERS program, and it is used to identify recall in the event of adverse events associated with vaccines. Next slide.

In laboratory data class, we added an additional data element, test kit unique identifier, also advocated for by the HITAC in previous years. Test kit unique identifier is important to identify differences in labs based on method and the part of the lab method that uses a unique test kit. It is important to help an interpretation because different test kits result in different reference ranges, so this is used to identify where that might be important. We established the applicable vocabulary standard in the FDA UDI system, which is the same one we use for implantable devices, and we think that it is a solid standard for test kits, which, as of 2022, have to bear an FDA UDI. Next slide.

In medications, probably long overdue is medication route, and this was actually originally submitted as a combination of dose and route two years ago, actually. We split it last year and added dose, but did not add route, and we have come around to add route to really help enrich the amount of data that is available for all medications. Next slide.

The observations data class is new, and includes two quite different data elements. One is advance directive observation, which I think about as metadata about advance directives. These are things like if a patient has an advance directive, where it is located, if it has been validated, what some of the components are, and what type of advance directive it is. It is not the advance directive document itself because those are different in every jurisdiction, but it only is information about it, and this complements the components of advance directives that we added last year with treatment intervention preference and care experience preference.

The next observation that we added is sex parameter for clinical use, which is a data element that adds context to a variety of different tests, procedures, and diagnostic imaging studies that have some differences in their results based on being male or female anatomically, and so, this is a data element that can be used across multiple different data classes, so it can be used to supplement a laboratory test, it can be used to supplement a diagnostic imaging test, or many other data elements that can be used. So, it is used across data classes, which is one of the things that we highlight for some data elements. They can be reused for multiple different purposes. Next slide.

We added the orders data class and the single data element of orders. Orders are meant to represent the act or intent of a provider to get something done during care. It does not specify what has to be in the orders, whether it is an order for a lab, an X-ray, or a consultation. It is only the container for the clinical content, but we felt like it was important to capture that part because provider's intent is sometimes part of a quality measurement, and obviously, provider intent is what drives the provision of healthcare. Next slide, please.

We added three new patient demographics and information data elements. The first one is interpreter need, and this supplements or is a companion to the preferred language data element, and it is simply an indicator of a patient's need for translation services. This is important not just for provision of care locally, but also for care that is being requested outside, so that proper interpreter care services can be put in place so that appointments are not canceled, consults are not canceled, and surgeries are not canceled because there is not an appropriate interpreter available to the patient. The other two are name to use and pronouns, which are important for providing culturally competent care to the LGBTQI community. This is not only used for that purpose. Name to use can include things like nickname, formal name, and preferred name, not just in the context of care for a certain population. Next slide.

Finally, we added two provenance data elements. The first is author, and the second is author role. The intent of these two data elements is to not only provide information about the source of data, something like a clinical note, who authored the clinical note, but also, this can be used to indicate that the information is patient generated or the patient is the source. This is important to distinguish between, say, a patient-reported allergy, which may or may not be clinically valid, or a provider indicating that an allergy is an observed allergy or known history of a reaction.

This is a new use case for author and author role that we did not really indicate when we first proposed to add author to USCDI Version 1 in our proposed rule. The reason it was not added was because some commenters felt like it was of limited use outside of, say, documenting clinical note authorship, and that the infrastructure was not in place to readily implement this data element, and one of the things that we are looking for is comments on whether or not things have changed sufficiently for the burden of development and implementation to be more reasonable this time around. Next slide.

In addition to these data elements, we made a couple of changes to some other existing data elements from v.4 and before, and I am going to highlight some of them, but I am not going to dig deep into every single one. Some of these are changes in definition, changes in examples, but do not change the scope of any of the data elements. Next slide.

This is a busy slide, but one of the key ones that I wanted to point to was encounter location. We added the HSLOC as the applicable vocabulary standard. It is used in multiple settings for multiple purposes, and is also well established. This is not news to us, as we added encounter location to Version 3, but we did not feel like it was solid enough, and now we think that it is and are looking for feedback on whether or not you all think we are right. To proceed and make two clarifications, one is the CDT standard. We changed the way that we reference CDT for dental procedures because we and the commenters felt like CDT was perceived to only be useful in dental EHRs rather than to represent dental procedures whether they are captured in a medical EHR or a dental EHR.

For immunization, we clarified the technical references to CDX and NDC, but did not change the applicable standards. We just clarified the naming of those standards. The rest of them are just simply what I would call minor changes to the definitions to improve clarity, and there was a spelling change. Some of these were just cleanup. We review the definitions, examples, etc. yearly, and we felt like these changes were due. Next slide.

This is just the highlight of encounter location. Next slide. This is how we changed the reference to CDT. We removed the reference to technology primarily designed to capture dental procedures and dropped it so that folks have a better understanding that CDT is useful in all EHRs, not just dental EHRs. Next slide. So, this is a high level of review of the process where we have developed USCDI through draft v.5 and some highlights to the data elements that we added. One of the things I wanted to mention at the beginning is that this is driven by public input, and also the public's response to our prioritization criteria, which we changed and actually added to or clarified during the v.3 cycle.

We added additional equity-based data elements to USCDI, and we have continued that and will continue to focus on particular areas around the prioritization criteria as we consider new data elements for v.6. If

we change the way that we prioritize data elements, we will certainly announce that and clarify that we are looking to go in a particular direction or focus on a particular thing this time around, and we will continue to do that into the next cycle. Next slide.

I just want to touch on the timeline from here. USCDI is a repeating cycle on an annual basis, and at any given time, we are working on two or more different versions of USCDI. We recently published draft v.5, and we are in the public comment period now. Once the public comment period is over, we will sort through all of the comments, we will sort through the HITAC recommendations letter, and see what changes we need to make to draft v.5, add, subtract, or maintain the data elements in draft v.5, and we expect to publish the final version of v.5 in July, and then the cycle continues. That is when we announce the open period for the v.6 submission cycle, and then we will go through it again. Next slide.

This is just a text version of the previous slide, pinning particular dates on it, and we already covered that. The highlight for this group and for everybody else is that the deadline for comments and public feedback is April 15th at midnight, which is a Monday, and that corresponds with the April HITAC meeting, which is where this group's recommendations will be heard and hopefully approved by the HITAC at that time, and then that recommendations letter will be sent to the national coordinator for consideration. Those recommendations will be considered for the draft v.5 cycle, but also for future cycles. In the past, as I talked about when I showed you the new data elements and also the Level 2 data elements, we may take action on a HITAC recommendation this year and may take action on a recommendation in following years, so the comments and input do not go away. I want to say that might be my last slide, but let me take a look at the next slide.

So, we wanted to add some specific questions. We do not just say, "Hey, what do you think?" We want to know what the public feels about all of the new data elements that we added to USCDI. Are they the right ones? Are the definitions, usage notes, examples, and applicable standards all what others feel are the best for these data elements? Also, are there Level 2 data elements that I have showed that should also be considered for addition? And then, if there are new data elements in draft v.5 that would pose significant barriers to development or use, we want to hear that as well. We have changed things from a draft version to a final version based on this input, and we expect these comments to have significant impact on draft v.5.

We also ask specific questions about three or four data elements. One is the author and author role in the provenance data class. Is this a reasonably implementable set of data elements? Has there been progress in the ability to capture and exchange author and author role over the last four years since it was originally recommended or proposed to be added to v.1? For lot number, should the lot number be more generically available? Medications have lot numbers, other things have lot numbers, and so, should lot number be more broadly applicable rather than just for immunizations? Finally, test kit unique identifier is a specific UDI or device identifier that we added that is specific to lab. What we are looking for is input on all the of the areas where this data element would be useful to improve lab data interoperability and the current experience of health IT developers in capturing, using, and exchanging this data element. These are some specific data-element-focused questions that we have for the public, and we hope that this group will also consider these specific questions in their deliberations for this set of recommendations. Next slide.

That is it. We can open it up for discussion, Sarah and Steve, however you want to handle this. There are a lot of questions in the chat. I am assuming there are some questions that we may or may not be able to answer or may have already answered, so I will do my best, however you want to handle the Q&A session.

Sarah DeSilvey
I timestamped some of the questions in the chat. I am going to try to get to those, and then we can go through hands if that is okay, just because I did not want to lose the comments that people put in the chat. I do want to state one thing before we go into this. There are already really amazing comments on content, perspective, definitions, and meaning, and that is exactly what we are all here to do, so what I want to do is save those thoughts on missing patient perspective, clarifying definitions, and uncertainty between different elements for the actual work of the IS WG because that is what we are all here for, and the great thing is that next meeting, we can hit the ground running and really talk about process right now because I want us all to understand the process of what has to happen next, if that is okay, and I am writing everything down. So, there was a question at 10:43 that I am going to go all the way back to from Anna McCollister. "How are the prioritization criteria determined?"

Al Taylor
There are a couple different things that go into the prioritization criteria. In previous years, this group recognized that when we asked for public input, we were going to get it, and we got a lot, so we are going to get a lot of recommendations for new data elements, and even before USCDI came out, there was recognition that there may have been too many for us to consider to be added, so we developed the technical criteria that we talked about as far as developer burden, standards development burden, implementer burden, and aggregate lift. Those are some concepts that we recognized that would immediately be the minimum set of issues we would need to sort through to decide which data elements go into the next version.

On top of that, we added a layer of policy priorities. These are sometimes administration priorities, HHS priorities, and ONC priorities, and that is how we came up with the focus on public health reporting, equity, and disparities. More recently, we added behavioral health to the mix to focus on data elements that were specific to behavioral health, and so, over time, we have changed those prioritization criteria some, and if we were to consider it, we would announce a change in priorities for next time, the v.6 cycle, but for now, we are considering the ones that I just reviewed.

Sarah DeSilvey
Thank you, Al. We have plenty of time to get to the hands. I am just going to review the ones in the chat. There is a question that I have gotten DMs about as well regarding how you would advance data elements up the levels. It goes back to that level conversation. Specifically, part of our charge is reviewing Level 2 elements, but besides comments, how do you promote inclusion of a Level 2 data element into a version? I suppose this is both from a public comment perspective and from an IS WG perspective. Al, do you want to take that one?

Al Taylor
I would not say that ONC actively promotes inclusion, but what we do is look at the data elements, identify the ones that fit into the prioritization criteria, and give those an extra look. We have also sometimes worked with the community or industry. An example is the work that we did to help shape the submissions by the

Gravity Project on the SDOH data. We worked with them, including a couple people who are on the call here, and they created a submission that fit into the model and the priorities that we had set and were working with, and I guess you could say that is promoting inclusion, but in general, it is kind of up to the submitter to submit a data element that meets these prioritization criteria, and when additional information is available, additional use cases, additional published IGs, and test data on the data elements, even implementation experience, those can be used year on year to upgrade a data element from a previous level to Level 2 for further consideration.

Sarah DeSilvey
Thank you. I want to add a little nuance because I am knitting in things from the chat. One of the things Al hits upon is something that was being said in the chat that I just want to make very clear. Often, it takes years and cycles of our work in IS WG reviewing Level 2 elements or pulling in experts, such as Gender Harmony, which was discussed in the chat, defining, refining, redefining, and adding nuance and clarity to existing Level 2 elements, and eventually, they may make it up to a USCDI version. I just want everyone to understand that we pull in experts. We pulled in DI experts last year on some diagnostic imaging elements, laboratory experts, Gender Harmony, SDOH experts, and health equity experts. That was my first hello, and IS WG was coming in from an SDOH perspective.

So, that iterative work is part of how we elevate things as well within this workgroup. Other than that, many of the comments in the chat are content expertise stuff that I do want to make sure we bring back to the conversation next time so we can address any process elements. There is a process question from Hans at 11:01, if you can see that, Al. It is lengthy. Maybe we can address that. That was the last chat question regarding process before we get to hands. It is reading.

Hans Buitendijk
It is not that long…

Al Taylor
I understand the question. This is a question that we have gotten before. The normal flow of USCDI is the standard set. US CORE and C-CDA are the vehicles to exchange those, and necessarily, their development has to follow a USCDI version, but we work closely with US CORE design teams beforehand, and before we publish a draft version, we meet with and discuss potential new data elements with the US CORE team to estimate the feasibility of implementing a standard or making a new version of that standard, US CORE or C-CDA, to make sure that we think the development burden is reasonable. After we have published a final version, then we work very closely. We participate in all of the design meetings once we have a final version of USCDI to develop those new updates to US CORE and C-CDA. So, it is not accidental, it is intentional that the US CORE and the C-CDA IGs are developed in a way that meets ONC's intent as far as data exchange goes, and that engagement has had a significant impact on what ends up being the balloted IGs that we just finished balloting for USCDI Version 5.

Steven Eichner
Al, thank you so much for sharing that. That is really useful. I think it would be helpful at a future group meeting to share a little bit of how those calendars generally align in terms of looking at what version of USCDI informs what version of US CORE and the like, not that there is a problem with the approach that we are using, but so there is a clear understanding of the approach that we are using because there are a

bunch of different timelines that are involved with SVAP and everything else, and looking at a timeline map to understand how everything really does align would be really helpful.

Al Taylor
Sure, I would be happy to do that. I will just say that for those of you who have been involved with the IG process, because it is a consensus-based process, it takes a lot of time. It takes about six months to design the balloted version of the IG, and then it takes another four to six months to reconcile the ballot. Once that version is published, such as what we have now for US CORE, 7.0.1, which will be published after reconciliation of the ballot, which was just closed, along with the C-CDA, those three together will be considered for SVAP for next time. If those three for Version 4 are added to the approved standards list, then they will be available for update to Version 4. Currently, Version 3 is available by SVAP, but it is also available for update under the HTI rule as well, so it is a little bit confusing as far as how USCDI Version 3 is used, but we expect that Version 4 will be available for SVAP in August or September of this year.

Sarah DeSilvey
Thank you, Al. I do like Ike's idea of a visual. I think that would help some of us who are visual folks. I do want to see if we can get to the hands. We have a few more minutes. Mark, you have been very patient. What is your question?

Mark Savage
Thanks. I greatly appreciate data elements that were added to draft v.5. I want to raise a question about elements that HITAC recommended that were not added, and to get a little better understanding of why. For example, I would lift up care plan, which was a modest recommendation, not a full-fledged care plan. There is family health history, travel info, which is really important for public health things like COVID and Zika. But for a strong recommendation or unanimous recommendation, can you help us understand why those do not get in? Maybe there is also a transparency issue here. It would be nice to hear more of an explanation about why, after all the IS WG does, particular elements do not get in, but I understand today is not the day for going into all of that detail. Thanks.

Al Taylor
Mark, what I can say about that is that we look at all of them, and we cannot pick all of them, or even a significant fraction of them, and that is something that would be considered for future versions, especially as various highlights are brought to those data elements. We did not intentionally leave anything out. We only intentionally selected a modest handful of data elements to add. That is about as simply as I can put it. It was not personal, Mark.

Sarah DeSilvey
Thank you, Al. Anna, you have been very patient as well. You are on mute if you are trying to speak. Anna?

Anna McCollister
Hi there. So, in follow-up to the answer to the question that you posed on my behalf, Sarah, about what the priorities are and how they are determined, one of the things that I will raise here again, which I have raised before and is probably more of a HITAC issue than one for this workgroup, is that I would love to see the impact of these data elements on patients be considered, specifically as it relates to patient burden. There is a long, understandable, and appropriate history of considering physician burden and developer burden,

but it seems to me like the point of this is to reduce the burden on patients, and the way that many of these rules get interpreted and ultimately translated can ultimately increase the burden on patients. ONC has been incredible over the years in considering patients and including those of us who speak from the patient perspective, so I do not want to be critical, but I would like to continue raising the issue.

There is a significant degree of health IT burden on patients, and I still have to serve as my own health information exchange and carry the data from one physician to the next, particularly as it relates to continuous glucose monitoring data and insulin pump data. None of that stuff is incorporated, and the need to have that, along with all of my lab measures, blood pressures measures, etc., and to physically carry that in different formats from one physician to another, and getting access to the clinical data in a way that does not require getting over so many different barriers around password resets and two-factor authentication, etc., are significant burdens, and over time, the cumulative effect can be somewhat overwhelming, and that is for somebody like me. So, again, ONC has been great in so many ways about including patients and considering patient perspective, but we really need to expand our consideration the burden that these data elements and requirements or the lack of data elements and requirements have on individuals and patients.

Al Taylor
Thanks, Anna. You kind of bring up two points, not quite two sides of the same coin. There is the burden of adding data elements to USCDI on the patients and, essentially, the reduction of burden by adding them because if they become more available because they are part of the view/download/transmit package, adding them to USCDI might actually reduce the burden because it is easier to find, get, and exchange, but I think that your point about either burden or benefit to the patient is a really significant use case that we would love to hear more from and that we would expect to hear more from patient advocacy groups like the ones you represent. So, we definitely want to hear about patient burden and how adding a particular data element increases the burden versus potentially decreasing it.

Sarah DeSilvey
Thank you, Anna and Al, and thank you, everybody, for a really robust discussion. We are going to have a very good time this year, I promise. It is good work and important work. I believe we are segueing to public comment, and then we will close out shortly.

Public Comment (01:22:29)

Seth Pazinski
All right. Hello again, everyone. As Sarah said, we are going to move into our public comment segment. If you would like to make a public comment, use the raise hand feature, which is located on the Zoom toolbar at the bottom of your screen. If you are participating by phone only, you can press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. We will give folks a minute to queue up to see if we have any public comment. Okay, I am not seeing any public comments queued up and I am not seeing any raised hands in the Zoom, so, Sarah and Steven, I will send it back to you to go over our workgroup plans. Go ahead, Al.

Al Taylor
Were we going to go over the spreadsheet? Hans just asked a question about it, but I was not sure if we were going to go over it as far as how we gather recommendations and thoughts from the workgroup. I have that cued up if that is in the cards.

Seth Pazinski
Yes, that sounds great. Let me hand it back to Sarah and Steve to go over the workgroup plans coming up, and then we can go over the Google doc.

Workgroup Work Planning (01:24:11)

Steven Eichner
Thanks, Seth. We provided a good overview today. Thank you so much to Al for giving the overview of the draft. We do have a general plan together, so we will be meeting together weekly over the next several months going through April 9th. We will be providing an update to HITAC at their next meeting. As Seth and Al mentioned, we will be using a Google worksheet to help us develop our initial set of comments, and then eventually transition into a shared document as we prepare our final draft as we move forward. Sarah?

Sarah DeSilvey
Thank you so much, Ike. It is a tight timeline. Luckily, we have a set number of elements, and I believe we do want to pivot to a view of how we do the actual labor of the work. I do not know if there is a next slide, but can we go to the next slide? That means Al is about to take over. The work that we do will happen both in this meeting and asynchronously, and it is done through a shared Google document that contains the five elements and any Level 2 elements we want to elevate and place on the Google drive for review. This then becomes the working draft of our final transmittal. This is the first view, but we will go far deeper into it next week, I promise. Al?

Al Taylor
Thanks. On the screen, this is basically the same spreadsheet we had last year, and I just wanted to orient you to it. I prepopulated the spreadsheet with the data elements that are new to draft v.5, because we are looking for comments on all of these categories, data element name, definition, and standards. We prepopulated that for people to review and comment. It is also available on the draft v.5 website and the draft v.5 standards document, which is also on the website. Only these 13 are added on this page. Whether the workgroup recommends anything on any of these data elements is entirely up to the workgroup, but we will gather some thoughts and gather the discussion over the course of these meetings.

Also, in addition to the 13 new ones, there is a tab for all of the data elements in draft v.5. That does indicate the ones that were added in draft v.5, but it includes all of the content, so we can accept comments on any of the data elements in draft v.5, but mostly focusing on the new data elements. That is all I had to talk about with the spreadsheet. This will be included in the homework email for people to start looking at it and start entering comments and discussion. Back to you, Sarah.

Sarah DeSilvey
Can you answer this question, which many people have, about where we are putting general comments for the working element? There we go, thanks.

Al Taylor
The member recommendations are where we can put well-formed thoughts or just musings. If we talk about it, we will capture our discussion in Column L, and then, further information on the recommendation… Actually, the concise recommendations should go in Column J, and the members' input as far as why the

recommendation makes sense should be entered in K, and then we will go through and process. We will start forming actual recommendations and populate Column L.

Steven Eichner
This is a shared worksheet where all workgroup members have simultaneous access, so one thing we do ask is that as you are making comments in the columns, please identify yourself by first name and last initial or other sufficient information that all users can understand so that if there is a need to go back for further information, we have some information about who to go back to. As we look at our meeting schedule, one of the things we will be doing is some deeper dives into particular elements and looking both to workgroup members and additional individuals to provide additional information or new information about the related data elements to help inform our conversation.

If there are particular data elements you are interested in speaking to or sharing detailed opinions on as a presenter, we would love to hear from you. If there are elements that you want additional information and a deeper dive on, please let us know. If you have a recommendation about someone who is not a member of the workgroup who can speak to any particular issue, we would love to hear that as well to help inform and make sure we are using our meeting time well, and that the workgroup has as much information as possible to inform our discussion.

Sarah DeSilvey
I believe we are at time, and I want to just have everyone rest assured that I was new last year, and I promise you will get the hang of it. It is a lot, but you are surrounded by people that care deeply about ensuring that your expertise is laid to bear, and we will see you next week. It is going to be a fun time. Thank you so much, and I will see you next week.

Mark Savage
Rock and roll!

Steven Lane
Great job, co-chairs.

Sarah DeSilvey
Bye!

Adjourn (01:31:09)

QUESTIONS AND COMMENTS RECEIVED DURING PUBLIC COMMENT

No comments were received during public comment.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT

Steven Lane: Resources: Draft UCSDI V5 - https://www.healthit.gov/isa/sites/isa/files/2024-01/Draft-USCDI-Version-5-January-2024-Final.pdf

Steven Lane: Web page view: https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#draft-uscdi-v5

Albert Taylor: Thank you @steven lane. Comments on Draft v5 can be entered on the USCDI webpage https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#draft-uscdi-v5

Steven Lane: Standards Bulletin: www.healthit.gov/sites/default/files/page/2024-01/Standards_Bulletin_2024-1.pdf

Keith E. Campbell: Sorry I had an audio problem.

Mark Savage: New design!

Sarah DeSilvey: So fancy!

Steven Lane: Key point from AI: Only USCDI v3 is available today for HIT certification under SVAP. The opportunity to update to v2 has now passed.

Steven Lane: It is a little tricky on the SVAP web site to identify the certified HIT products that have certified to USCDI v2. On this page https://chpl.healthit.gov/#/collections/svap, use the "Shortcuts drop down at the upper right > SVAP Information > view details in the SVAP Information column: Replaced | 170.213: United States Core Data for Interoperability (USCDI), Version 2, July 2021.

Sarah DeSilvey: You can see some of the level 2 HITAC recommended elements in the ISWGs 2023 transmittal letter as they were a direct outgrowth of the work we do and our charge last year

Anna McCollister: How are the prioritization criteria determined?

Michelle Ashafa: How do you advance data elements up levels? Besides comments how do you promote inclusion of a level 2 data element into a version?

Steven Lane: April, 2023 ISWG Recommendations to HITAC on Draft USCDI v 4 Presentation: https://www.healthit.gov/sites/default/files/facas/2023-04-12_IS_WG_Recommendations_Report_Presentation_HITAC_508.pdf

Christina Caraballo: The slide with the prioritization key is really helpful (equity, underserved, public health, add'l USCDI needs, ONC Cert). Thanks, ONC team!

Steven Lane: April, 2023 ISWG Recommendations on Draft USCDI v4 Report: https://www.healthit.gov/sites/default/files/facas/2023-04-12_IS_WG_Recommendations_Report_508.pdf

Katrina Parrish: Is this the best place to find the current, full USCDI List as of V4? https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v4

Seth Pazinski: @Katrina Parrish -- yes, that's the source for USCDI v4

Hannah K. Galvin: I think it would be helpful for us to discuss sex paramater for clinical use and Gender Harmony's recommendation on how this should be utilized in some detail; this is a broader change for the industry.

Steven Lane: USCDI v4 also here: https://www.healthit.gov/isa/sites/isa/files/2023-10/USCDI-Version-4-October-2023-Errata-Final.pdf

Katrina Parrish: 💯 @Hannah

Sarah DeSilvey: Yes, Hannah! We have had conversations on this in past ISWG's as a level 2 well. Gender Harmony came to present in 2022. Then in 2023 we discussed again with that historical context. The work of Gender Harmony is very appreciated! I really appreciate that this is reentered this year within USCDIv5! Happy to bring experts back to help guide and inform again.

Hannah K. Galvin: 👍

Hung S. Luu: +Sarah and Hannah

Anna McCollister: Wouldn't patients have a better knowledge of their allergy history than the physician who sees them for an unrelated clinical concern?!

Steven Lane: This workgroup has discussed the work and recommendations of the Gender Harmony Project over the past couple of years. It is great to see that ONC has decided to recommend advancing the Sex for Clinical Use data element at this time. This is one of many examples of data elements that this WG has recommended for inclusion in the past, only to wait and see them added in a future year. Provenance - Author is another example of a data element for which we have advocated for years. Great to see it proposed for inclusion this year.

Sarah DeSilvey: + Steven

Katrina Parrish: Request better understanding of "Encounter Location" (address?) vs "Facility Address" in draft 5, but not selected.

Pooja Babbrah: Great visual - so helpful to see the timing laid out this way

Derek De Young: Just a heads up that I will need to drop off a bit early today. I am very interested in the strategy of specifying a vocabulary standard vs when we do not. Just one example from an addition in V3: for Health Insurance -> Payer Identifier there is not a recommended vocabulary or plan list. This will make these elements less helpful for reporting and automation. We will likely end up with various different IDs for the same payer since there is not much consistency in this space.

Hans Buitendijk: As USCDI is translated into FHIR US Core and C-CDA during which clarifications and discussions may (and have) yielded variances between the scope that USCDI may imply and what FHIR US Core and C-CDA actually require to support. In this cycle, how does ONC plan to re-align USCDI with the published FHIR US Core and C-CDA versions that will be used in certification to minimize/eliminate any gaps in interpreted scope between USCDI and FHIR US Core and C-CDA?

Sarah DeSilvey: thank you Derek! Looking forward to leaning into your thoughts when our conversations as ISWG commence next week!

Mark Savage: +1 @Hans

Steven Lane: Historically ONC has been reluctant to make major changes between a draft and final version of USCDI. As such, if there are recommendations to add Level 2 data elements to USCDI v5 that have not been included in Draft v5, the WG will need to make a very strong (and loud) case for inclusion. As Al points out, however, recommendations are often included in future years.

Steven Lane: To Derek's point, there have been examples where a data element exists in or is added to USCDI before there is a specified required technical standard or applicable value set. These specifications can be added in subsequent versions of USCDI. So if there is now a standard for Payer Identifier that the WG would support adding, we can include this in our recommendations, even if not included in the draft v5.

Steven Lane: This group does have the opportunity to make recommendations regarding changes to the priorities for future versions of USCDI.

Steven Lane: ONC has been very open to and effective in working with other organizations, e.g., HL7 US Core, Gravity, Gender Harmony, to assure alignment and coordination.

Steven Lane: It is striking that, after all the work this group did last year discussing the potential inclusion additional diagnostic imaging data elements in v4, none of this is included in Draft v5.

Sarah DeSilvey: +Steven on all and specifically the DI elements.

Hans Buitendijk: Yet, that still yields variances, thus the question remains how that should be addressed.

Hans Buitendijk: It is important to ensure that there is no confusion as to what data is expected to be shared, thus continued alignment of USCDI with FHIR US Core and C-CDA as published is critical.

Grace Cordovano: It would be helpful to, in some manner, flag elements that may have been strongly recommended to HITAC on the USCDI website . For example, if I was to look at level 2 elements, it would be helpful to see an icon next to these elements.

Sarah DeSilvey: Agreed, Grace! I really appreciated the "H" symbol on the presentation today with that aim in mind. It would be great to apply that to HIT.gov as well

Pooja Babbrah: +1 Grace

Katrina Parrish: Could we see the full list of elements and classes that are in the pool of consideration?

Pooja Babbrah: I need to drop early. Thanks all! I look forward to diving in next week!

Hans Buitendijk: Will we create a google spreadsheet as before to start to capture our initial feedback as well?

Sarah DeSilvey: Hans, yes we will!

Mark Savage: In my experience, patients and patient advocates are talking far more about what's needed yet missing, than what's present and imposes burden. (My years at National Partnership for Women and Families, for example.) Same for providers. (My years at USCF, for example.)

Steven Lane: While it is heartening to see the ED and Op notes proposed for addition, as these were recommended by past workgroups, there have also been higher priority recommendations to add ALL the 12 note/document types included in the C-CDA R2.0/R2.1 standard.

Albert Taylor: @Katrina, the full list are in the slides before the prioritization.

Katrina Parrish: And I mean backlog - those that are not in V5

Albert Taylor: @hans, we have that and I'll show if briefly and use it for gathering recommendations and planning discussions.

Grace Cordovano: Example of element that would decrease patient administrative burden: pathology tissue storage location. Currently if a patient has a biopsy or tumor tissue removed surgically, there is no documentation of where the tissue is physically stored. Is it in-house? Is it stored in at a 3rd party off-site location? It's not documented anywhere in the medical record. Often times this requires numerous messages, calls, emails, speaking with numerous members of the care team and pathology Dept to find where a tissue sample may be located. Many times the pathology and care teams do not know where the tissue in question is stored. Documenting the location of storage for a patient's tissue samples/tissue blocks would reduce patient, provider, and staff burden.

Steven Lane: @Katrina - We have asked ONC for such a list in the past and have built and provided them with some starter documents for this. Today, the best you have is going through the website https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi and clicking on and drilling down on each of the tabs.

Mark Savage: *UCSF

Sarah DeSilvey: Katrina, slide 18 and 19 are great for past ISWH elements "the H sign" our past transmittal letter has great context for the rationale for level 2 elements that did not make it into v5. Looking forward to talking more next week!

Hans Buitendijk: Where can we put general comments for consideration, e.g., process or otherwise?

Steven Lane: There are MANY data elements on the Level 2 tab https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#level-2 that were not included in Draft v5 that should be reviewed by WG members to identify those that might be recommended for inclusion in v5. Thank you ONC for consistently marking items on the Level 2 tab that are included in Draft v5. (This was less consistent in past years.)

Albert Taylor: @hans, you can enter a new row with a general comment, tagging specific elements or classes as appropriate

Hans Buitendijk: Sounds good. Will do at the end.

Steven Lane: Also great to see the new flags on data elements for which ONC is specifically requesting "More Info".

Grace Cordovano: Happy to help any new comers!

Katrina Parrish: Thanks!

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

No comments were received via email.

RESOURCES

IS WG Webpage
IS WG - January 23, 2024, Meeting Webpage

Transcript approved on 1/29/2024 by Wendy Noboa, DFO.