

Meeting: CSTE Data Standardization –Social Determinants of Health -Data Element-Specific Team (DEST) Meeting

Date: November 8, 2024

Attendees: 64

CSTE (2)	PHAs (32)	CDC (26)
Becky Lampkins Meredith Eddy	<u>DSWG Co-Chairs</u> Laura Erhart AZ Molly Crockett MA	Alejandro Perez Andrea Steege Angie Agunloye Carmen Pugh Chirine Chehab Danielle Sharpe Doris McGinness Hannah Perry Jessica Purser Josh Bagley GDIT Kayode Olupinyo Keaton Hughes Kristie E N Clarke Marie Haring Sweeney Marion Rice Nicola Thompson Nicolette Bestul Noreen Kloc Peter Boersma Pradeep Podila Rachelle Oseni Renee Boehmert Renee Calanan Robert Pratt Sara Johnston Val Reagon
JMC (3)	<u>DEST Members</u> Allison La Pointe MN Andria Apostolou IHS Cher Levenson WA Chris Dumas SD EJ Klingler NYC Elizabeth Lando-King MN Eman Addish Philadelphia Erin Doyle NJ Genie Tang CA Hanna Chakoian MN Janet O'Connor SC Jason Geslois KS Jazmin Diaz CT Kayleigh Nerhood GA Kyra Veatch IN Lakin Mauch ND Li Jiao Harris County Linda Kelemen SC Lunden Espinosa IN Margaret Iiams SC Mario Beltran MI Meccah Jarrah OR Melissa Kealey CA Sam Hawkins OR Steve "Ike" Eichner TX Suzanne Gibbons-Burgener WI Taylor Bednarz Maricopa County Theron Huntamer NV	
Other/Unknown (1)		
Erin		

	Tina Lopez San Antonio Tyler Riedesel UT	
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**SOME INDIVIDUALS DIALED IN; THE NAMES ARE UNKNOWN, AND THEY ARE LEFT OFF OF THE ATTENDANCE*

HIGH-LEVEL MEETING NOTES (REFER TO MEETING SLIDES FOR MORE DETAIL AS NEEDED):

Social Determinants of Health (Call 3)

Meeting Ground Rules

- We welcome everyone's opinions and active participation from jurisdictions, CDC programs, CSTE membership, etc.
- As we work through data elements/classes, we strive for 80/20 consensus.
- This [DSWG Post-Meeting Input Form](#) is available at any time to provide additional input

Core Data: In-Scope for DSWG

- As a reminder of the scope of our work, we are to identify what data elements should be considered core data elements for transmission to the CDC. This is for routine, cross-condition, case-based surveillance.

Core Data: Out of Scope for DSWG

This data class has seen increased attendance from people who haven't been part of other DSWG calls before, which is great! However, this is a reminder of the things we are not doing on these calls.

- These recommendations that we are writing define what should be transmitted from a jurisdiction to the CDC.
- The wording and value set(s) we vote on here do NOT describe the best way to ask a question during a case interview or define how a data element must be worded within a jurisdictional surveillance system.
- The data elements we are discussing may come from a case interview, eCR, ELR, manual review of medical records, or a conversation with a healthcare provider.
- It's important to think about all the potential ways that case data are collected when we think about these data elements.
- The value sets we come up with on these calls also do not limit what can be collected within a jurisdiction. A jurisdiction may collect more detailed data and map those values into the value sets defined for transmission to the CDC. An easy example of this is that a jurisdiction may collect responses for various flavors of "Unknown," like "Refused to answer" or "Did not ask," but all those responses may just be sent as "Unknown" to CDC.

Core Data: FAQ

- When voting for core data, consider that naming something as core does NOT mean that it will be required to be populated for every case to CDC. It is okay to leave a field blank or unknown if the information is not available or not applicable to certain conditions. A data element should be considered core if it's relevant across many conditions, although there is no set number for "many."

CCCD

- The Calculated Case Counting Date was defined by the DSWG in previous work. It is defined as the earliest available of six component dates associated with a case.

- These dates are listed on the right side of the slide and encompass a range between symptom onset through date the case is entered or recorded by the public health agency.
- The important feature of CCCD is that it is possible to calculate a value for it for all cases, even if all components aren't available for each case. Essentially it is the earliest available epidemiologically relevant date for a case, which will often be the symptom onset date if that is something that exists or is known, but if it doesn't exist or is not known there are other dates that can be used instead.

Background: SDOH – Preferred/Primary Language

Primary/Preferred Language

- Primary Language has been defined by the HHS' Office for Civil Rights (OCR) as the language that a Limited English Proficient (LEP) individual identifies as the language he or she uses to communicate effectively and would prefer to use to communicate. Language assistance is to be made available at all points of contact with federally funded programs—enrollment, registration, and direct medical services.
- Primary and Preferred Language are regularly used interchangeably, both terms aim to identify the language the patient prefers for healthcare interactions. There doesn't seem to be a widely accepted distinction between using the term primary versus preferred, so when we're naming the data element today, the goal is to not get hung up on potential semantics between those two words.
- The goal is to reduce communication barriers and ensure equal access to care for all patients, regardless of their language proficiency.
- References:
 - [Hawaii Department of Human Services Resolution Agreement | HHS.gov](#)
 - [Limited English Proficiency \(LEP\) | HHS.gov](#)
 - [HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status | ASPE](#)

NHSN & Primary Language

- A few studies have addressed these factors and their impact on COVID-19, influenza, and respiratory syncytial virus (RSV) vaccination uptake by healthcare workers and LTCF residents. They reported poorer health outcomes are associated with patients who speak languages other than English.
- Because of this, NHSN required the submission of race, ethnicity, language, and interpreter use data in a systematic and standardized way to help specific sub-population outreach, including other language speakers within communities. In addition, NHSN has prioritized the requirement for systematic EHR documentation of preferred language(s) spoken by patients, and the need for medical interpretation services. These new requirements will enable health systems to better understand the link between language barriers, infection risks, and vaccination rates, ultimately improving healthcare access and outcomes for diverse populations.
- Reference: [NHSN and Social Determinants of Health | NHSN | CDC](#)

NHSN & Primary Language (continued)

- NHSN has asked all EHR vendors to use the standard accepted ISO 639 codes for living languages and, at minimum, provide the [NHSN Abridged Primary Language List \[XLS – 46 KB\]](#) of over 500 languages that includes more common languages spoken in the US. NHSN recommends that hospital systems add other languages to this list based on local geographic language needs, using the ISO 639 master list.

U.S. Core Data for Interoperability (USCDI)

- Some of the USCDI version 5 data elements related to preferred language include:
 - Preferred Language is the documented language that the patient would like to use when discussing health care.
 - Vocabulary Standard(s): IETF (Internet Engineering Task Force) Request for Comment (RFC) 5646, “Tags for Identifying Languages”, September 2009. Adopted at 45 CFR 170.207(g)(2)
 - Interpreter Needed: Indication of whether a person needs language interpretation services.
 - Vocabulary Standard(s): LOINC®, SNOMED CT®

ELR & eCR

- In ELR, PID-15 is the field used to document the patient's primary language. HL7 recommends using ISO table 639 as the suggested values for Primary Language. While this field is defined for ELR, this does not mean that the information will often be available at the laboratory for transmission in ELRs.
- In eCR using CDA, the US Realm Header is used to capture the preferred language for communicating with the patient. This data element also uses the ISO 639 Language Code Set.
- The eCR FHIR specification uses the US Public Health Patient Resource, which contains the Patient communication language. The definition of this element is the language that is used to communicate with the patient about his or her health. The ISO 639 code sets are also referenced here.

Case Notifications to CDC: Message Mapping Guides (MMGs)

- The Carbon Monoxide and COVID MMGs include a data element for primary language.
- In both programs, collecting language data is essential for promoting health equity, improving public health communication, and ensuring that vulnerable populations receive life-saving information and services in a language they understand.
- The same value set is used for each of these data elements. It contains 507 codes and is built from the ISO 639 language code system.

Discussion: Language

Discussion – Preferred Language

- Today we're going to talk about a data element for preferred language. First, we'll discuss thoughts on the definition. We could simply use "the language a person is most comfortable using for communication" that is like what's in the Carbon Monoxide or COVID MMGs, or if we wanted to align with the definition seen in USCDI and eCR we could specify it as “the language a person is most comfortable using for communication about their health.” Does anyone have any thoughts one way or the other?

Discussion

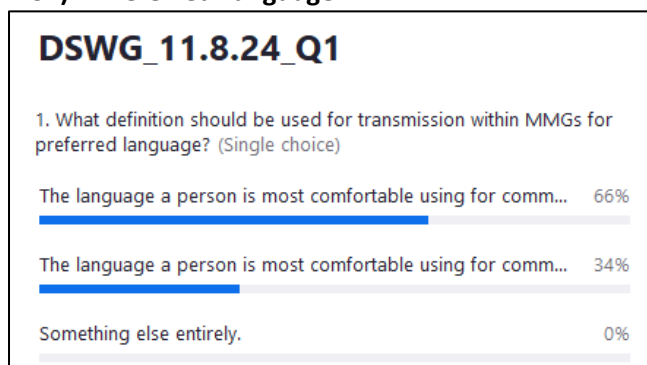
- Chris Dumas found this to be very confusing and sought input from a primary care provider or someone with direct patient experience. They noted that these experiences might differ significantly but struggled to understand how comfortable people feel about the approach, especially when language preferences at home might not align with the language used by healthcare providers. They expressed a strong interest in hearing directly from someone involved in patient care.

- Marie Haring Sweeney agreed with Chris and acknowledging that it would be valuable to determine the best way to provide care for individuals whose first language is not English. They also questioned the distinction between ISO and USCDI standards, wondering about the discussions behind language use within those frameworks, while admitting limited knowledge on the subject.
- Sam Spoto agreed with both points raised, explaining that the focus was on collecting data for the CDC, specifically around preferred language in case interviews. The idea was to ask individuals their preferred language to determine if an interpreter is needed. Additionally, the goal was to align language for health communication with what is theoretically collected in EHRs based on USCDI definitions, which is how information appears in ECRs. The question posed was whether to align case notifications to the CDC with these definitions from electronic records or if such alignment might not be necessary.
- Marie Haring Sweeney questioned whether testing had been done on this and felt that understanding the underlying data would be essential before deciding. They expressed doubt that those involved in creating the definitions were from non-English-speaking backgrounds, suggesting the definitions were likely based on majority perspectives.
- Steve Eichner noted that preferred language often depends on context and location, as individuals may adjust their language preference based on who is present. For instance, while someone might prefer one language, they may choose another if no translator is available.
- Marie Haring Sweeney questioned whether this involved a socially desirable response, where an individual might agree to discuss their health in English because the doctor speaks it, even if they don't fully understand. The individual might accept English for the discussion but may not grasp all the information conveyed.
 - Steve Eichner agreed and noted the potential for unintentional bias or discrimination, even if unintended, arising from practical limitations. They cited sign language as an example of a non-spoken language that faces similar challenges.
- Chris Dumas observed that, in their experience with non-native English speakers, individuals often agree to communicate in English due to a power dynamic. These individuals might say they prefer English or assume it's the only way to receive information, even if it's not their true preference.
- EJ Klingler commented that context affects language preference. For example, a person might choose English with a doctor, assuming it's the only way to get information, but feel comfortable requesting a Spanish speaker or interpreter with a public health employee who may be less formal. They questioned the purpose of collecting this language information—whether it is to help public health staff communicate more effectively and understand the best way to contact the individual.
- Sam Spoto clarified that the current discussion is focused on a data element to be included in case notifications sent to the CDC, collected across conditions. The way this information is gathered in healthcare is crucial because it might be used in case notifications. While there is potential bias in electronically collected data, that issue was considered out of scope for the current discussion. The focus was whether this data element should be collected in case notifications and, if so, how it should be defined.
- Steve Eichner questioned the utility of the information, especially if it could lead to inaccuracies or biases. They also raised concerns about how the data would be used practically at the national level.
- Marie Haring Sweeney acknowledged that the discussion was about core data, which must be collected for all notifiable conditions. However, they expressed concern and still felt unclear about whether this applied to all notifiable conditions.

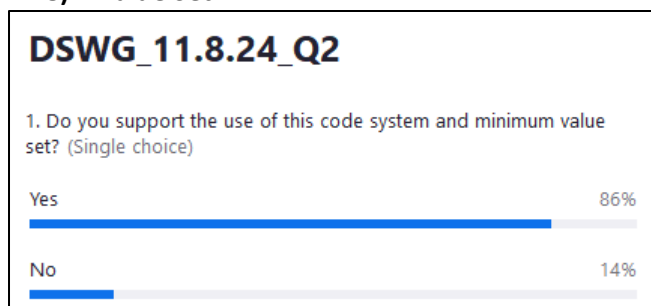
- Nicolette Bestul suggested that identifying a specific language needed for communication could be useful, as there's currently no good way to determine that. They agreed that this could help ensure communication is in the best languages, though they noted that since it isn't used currently, it's difficult to make a definitive case. They mentioned that language decisions are based on what is known to be necessary, but there isn't much data available on this.
- Steve Eichner pointed out a key distinction in the definition, noting a significant difference between the most comfortable language for general communication and the most comfortable language for discussing health. They suggested that it should focus on communication about the specific health issue, rather than health in general.
- Sam Spoto suggested that the language used for "health in general" could be pulled from an ECR, aligning it with the information transmitted electronically from medical records, assuming compliance with USCDI standards. They pointed out that this language would be specific to what is collected in EHRs. However, the intent behind the language in case notifications might differ. They raised the question of whether it would be preferable to use the same language as in EHR systems and ECR data elements, or if a different definition should be developed specifically for case notifications.
- Steve Eichner believed the decision will come down to utility. While using an existing standard would be easier, the utility might differ compared to a more specific question. They considered this a potential compromise.
- Marie Haring Sweeney asked how the NHSN uses language data, specifically in terms of its primary purpose and how it is applied.
- Sam Spoto noted communications within the chat including that some in the chat were leaning toward a more general definition, as it seemed more consistently answerable and likely to align with a person's comfort in a language for both general communication and health issues. The value of collecting preferred language for public health actions was recognized, particularly for non-English-speaking communities. Oregon had posed questions about language use at home and communication preferences were seen as relevant for primary care and public health providers. However, it was emphasized that the focus here was on defining a data element for case notifications to the CDC, not for individual patient care.
- Erin reflected that the more general definition seemed to make more sense, but also considered the perspective of using an existing definition already in EHR systems. By doing so, they could reduce the burden of creating a new definition, training staff in its collection, and addressing any potential confusion over differences. They questioned whether a new definition would still capture the same data or if it would be more specific. Ultimately, they felt that keeping the definition simpler would aid in data collection and reduce the long-term burden.
- Sam Spoto redirected the conversation ahead of launching the polls. She explained that the proposal was to use the minimum value set from the NHSN abridged primary language list. This would allow for the inclusion of additional languages specific to a jurisdiction, using the appropriate ISO 639 code. They then asked if anyone had thoughts on the value set approach.
- Sara Johnston emphasized the importance of distinguishing between how value sets are used when sending data to the CDC versus when collecting data within a specific jurisdiction. She noted that for CDC submissions, a broader value set is acceptable, as it doesn't prescribe what needs to be implemented at the local level. Jurisdictions may choose a more abridged version that fits their needs, but the CDC's acceptance of a broader list seemed reasonable.

Polling

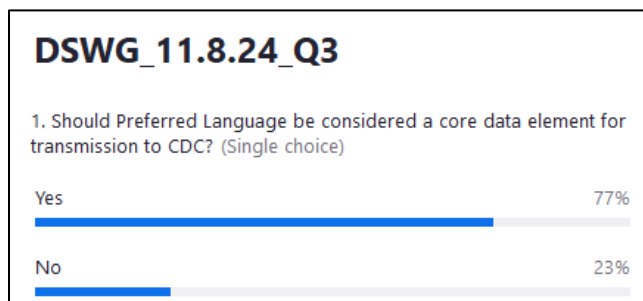
Poll 1 (n= 32) – Preferred Language



Poll 2 (n= 28) – Value Set



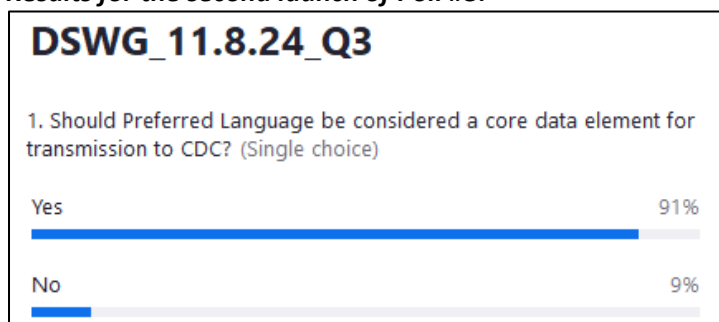
Poll 3 (n= 33) – Preferred Language Core?



- **Discussion**

- Sam Spoto acknowledged that the discussion was close to reaching 80% consensus on what should be considered core. They wanted to ensure any remaining questions about whether this should be core were addressed. They highlighted two main points: first, the value of sending this data to the CDC to identify common languages for specific conditions, helping to develop appropriate communication tools for prevention; and second, concerns about the accuracy and potential bias of data collected from medical records. They asked if anyone had additional thoughts on whether this should be core for all conditions.
- Renee Calanan asked for clarification on what "core" meant, noting they had been in and out of the conversation and wanted to confirm that being core did not necessarily mean it was required.
 - Sam Spoto clarified that being "core" meant the data element would be included in something like a new Gen V.2 MMG for all conditions. However, if the information wasn't available, it could be left as unknown or blank, and there would be no requirement to send it if it wasn't available.
- Sam Spoto requested the poll be launched a second time.

- **Results for the second launch of Poll #3.**



- Sam Spoto thanked everyone for the discussion and noted that the concerns about data collected from medical records, including potential biases, would be included in the write-up. However, they concluded that there was general agreement that it was a valuable piece of information to collect.

Background: SDOH – Education

Education

- As defined by the U.S. Census Bureau, Educational Attainment refers to the highest level of education that an individual has completed. This is distinct from the level of schooling that an individual is currently attending.
- Educational attainment is important to public health as it has been shown to correlate strongly with health outcomes, access to healthcare, and health literacy. Collecting data on education allows public health professionals to analyze patterns in health behavior, access to care, and susceptibility to certain health conditions across educational levels.
- References:

- [About Educational Attainment \(census.gov\)](#)
- [National Health Interview Survey \(NHIS\) \(census.gov\)](#)
- [Common Education Data Standards -](#)

Education: American Community Survey (ACS), Current Population Survey (CPS), National Health Interview Survey (NHIS)

- The U.S. Census Bureau American Community Survey (ACS) and Current Population Survey (CPS) collect information on educational attainment by asking respondents to specify their highest level of completed education. These data are reported annually and used to understand trends in education and workforce preparedness across different regions and populations.
- The National Health Interview Survey (NHIS) is a national survey conducted by the U.S. Census Bureau on behalf of the CDC National Center for Health Statistics (NCHS), and it also has a survey question asking about educational attainment.
- Reference:
- [About Educational Attainment \(census.gov\)](#)
- https://www2.census.gov/programs-surveys/acs/about/qbyqfact/EducationalAttainment_FieldofDegree.pdf
- [IPUMS CPS](#)
- [NHIS - Data, Questionnaires and Related Documentation](#)

Education: ACS, CPS, & NHIS Value Sets

- This slide shows a comparison of the response options for the ACS and CPS compared to NHIS. The response options are generally comparable, although the ACS and CPS contain a separate response for "nursery school" and have added granularity for those who have attended some college but did not receive a degree.

Case Notifications to CDC: Message Mapping Guides (MMGs)

- The Carbon Monoxide Message Mapping Guide (MMG) for case notifications to CDC includes a data element for education that indicates the highest degree or level of school completed at the time of the event. The responses in the value set range from "eighth grade or less" to a doctorate or professional degree.

Case Notifications to CDC: Message Mapping Guides (MMGs) (continued)

- The RIBD MMG also includes a set of data elements related to education. These include Is the patient (15-24 years only) currently attending college, their grade in school, and the name of the college or university. These data elements are not necessarily intended to capture information about education as a component of SDOH but rather are about risk factors or outbreak detection, which is not what this data class is trying to capture.

Discussion: Education

Proposed DE: Highest Level of Education

- The proposed data element here is "Highest Level of Education", which is defined as the "Highest degree or level of school completed by the person at the first epidemiologically relevant date associated with the case (i.e., CCCD)." This aligns with our language chosen for the Housing Status and Living Situation data elements.
- The suggested value set here ranges from "no schooling" to "graduate or professional degree".

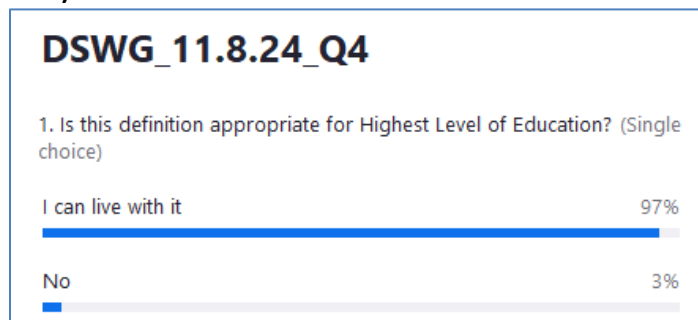
- No schooling: individuals who have never attended any school or educational institution, either formal or informal
- Less than 1st grade: individuals who have completed nursery school, preschool, or kindergarten
- Grades 1-11: individuals who have completed between first and eleventh grade in primary or elementary school, but have not progressed beyond eleventh grade
- Grade 12, no diploma: individuals who have attended high school (grade 12) but did not receive a high school diploma
- High school graduate: individuals who have received a high school diploma or an equivalent, such as a General Educational Development (GED) certificate
- Some college, no degree: individuals who have attended college or post-secondary education but have not earned a degree
- Associate's degree: individuals who have completed a two-year college program
- Bachelor's degree: includes individuals who have completed a four-year college program at a university or college. Examples include a Bachelor of Arts (BA) or Bachelor of Science (BS)
- Graduate or Professional degree: includes individuals who have earned an advanced degree beyond a Bachelor's degree, such as a Master's degree (e.g., MA, MS, MBA), Professional degree (e.g., MD, JD, DDS), or Doctorate degree (e.g., PhD, EdD)
- Does anyone have anything they'd like to discuss about this data element's definition or value set?
- **Discussion**
 - Suzanne Gibbons-Burgener wanted to clarify that if someone graduates without completing 12th grade—whether through homeschooling, an accelerated program, or graduating earlier—this would be considered incremental, and only one option could be selected.
 - Sam Spoto replied that this would be a single option identifying this person as having graduated high school.
 - Suzanne Gibbons-Burgener explained that someone who graduates early would be considered a high school graduate based on what they've attained. They also noted that, when discussing individuals of their own age, it might be unclear how certain factors are considered. They raised a question about how this applies to a new high school graduate starting school, particularly if they did one year of college. They pointed out that the term "college" is very U.S.-specific, while internationally it is referred to as "university." They asked if the definition should include post-high school education more broadly, such as trade programs, and questioned what exactly is being sought in this context.
 - Sam Spoto suggested replacing "some college, no degree" with "some post-high school education, no degree" to clarify the intent.
 - Suzanne Gibbons-Burgener noted that some individuals may not receive a degree but instead earn a certificate, such as in associate degree programs or other certificate programs, though the vernacular for these may vary.
 - Steve Eichner raised questions for whether the status should be marked as "unknown" or "non-reported." He also noted the differentiation between grade 12 and grades 1–11, particularly in the context of "no diploma" versus "high school graduate," was raised as a point of confusion. It was unclear whether this split was appropriate.
 - Sam Spoto noted that the approach for handling "unknown," "not asked," "not reported," and "refused" would be discussed with the larger DSWG. The goal was to determine the best approach for data elements and then decide if any data elements should deviate from the standard approach. This topic will be addressed later, but not in the current discussion. Regarding the grade levels, he

highlighted that some of the reasoning behind the categorization came from existing data sources like ACS, CPS, and NHIS. For CDC-level analysis, having a denominator to work with was important, and the proposed value set would allow using these data sets as denominators. The granularity of categories, such as "some college, no degree," was linked to existing systems, like ACS, which includes categories like "some college credit, but less than one year" and "one or more years of college credit, no degree." These categories could be combined to form broader categories if needed.

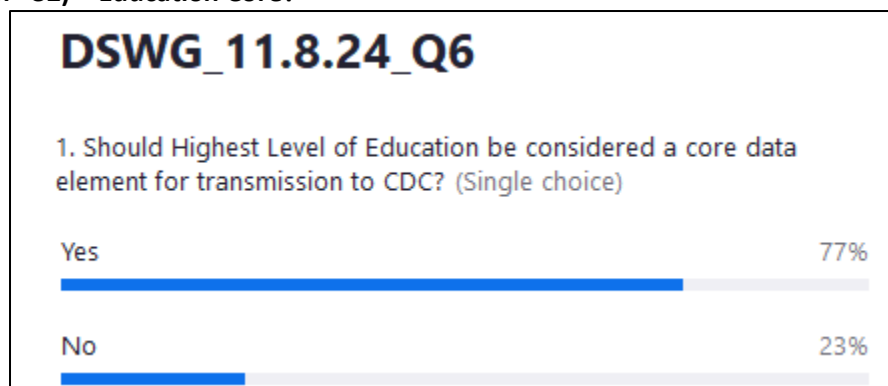
- Suzane Gibbons-Burgener questioned whether individuals with learning disabilities, who are permitted to stay in the system until a certain age but have not been granted a high school diploma, would be counted under "Grade 12, no diploma."
- Chris Dumas commented that as a former short-term high school special education teacher, they encountered individuals who remained in high school until they aged out and graduated without a degree, which is a valid consideration. However, they wondered if labeling it as "Grade 12, no diploma" might reinforce stigma. Additionally, trade schools aren't addressed here, but they should probably be considered equivalent to an associate's degree, especially with the current push for trade school over college. By categorizing trade schools as equivalent to a high school graduate, we're not reflecting their true equivalency.
 - A general discussion ensued on how to categorize trade schools, certificate programs, and apprenticeships in relation to high school diplomas and associate's degrees. It was agreed that trade schools and non-degree certificate programs should not be equated with high school graduation, as they are often viewed as being at the associate's degree level or similar in terms of education and training. However, perceptions of trade school education have evolved, and it was noted that job training and apprenticeships may no longer be seen at the same level as associate's degrees, reflecting changing attitudes toward vocational education.
- Erin raised the point that, from an epidemiologic perspective, education level in children may not provide much more insight than their age does on a broad scale. Education is often used as a proxy for factors like socioeconomic status or health literacy, but in analysis, education categories are frequently collapsed into just a few groups. While there are nuances in educational levels, the question was raised whether adopting a standard collection approach would facilitate comparisons to other data sets. However, there was also concern about whether such granularity is necessary or useful for epidemiologic purposes.
- Sam Spoto highlighted the importance of considering the necessary granularity of education levels for CDC purposes. While there are many levels of highest education attained, the focus was on identifying the epidemiologically relevant granularity required for analysis. The question was raised about what level of detail is truly needed at the CDC level.
- Sara Johnston emphasized that education level, when used in public health surveillance, serves as a social factor rather than directly correlating with exposure to disease. It was noted that education level is a useful proxy for other factors and is already measured by agencies like the Census Bureau. The importance of categorizing education levels to analyze population segments and to align with denominator populations was highlighted. The focus was on how this data would be used in public health surveillance rather than on the specific details of the value set itself, which may be more relevant for organizations like the Census Bureau.
- Sam Spoto noted there is a need to consider data sources when determining the granularity of education-level information. For example, if data is collected through interviews, more granular details can be obtained, but data from other systems may not provide the same level of detail. It was also pointed out that standardized fields for education level do not exist in systems like ELR, ECR, or

USCDI, making it difficult to consistently transmit this data. She acknowledged the work ahead regarding value sets and planned to revisit the topic in the next meeting and shifted the discussion to the next poll.

Poll 4 (n= 35) – Education



Poll 6 (n= 32) – Education Core?



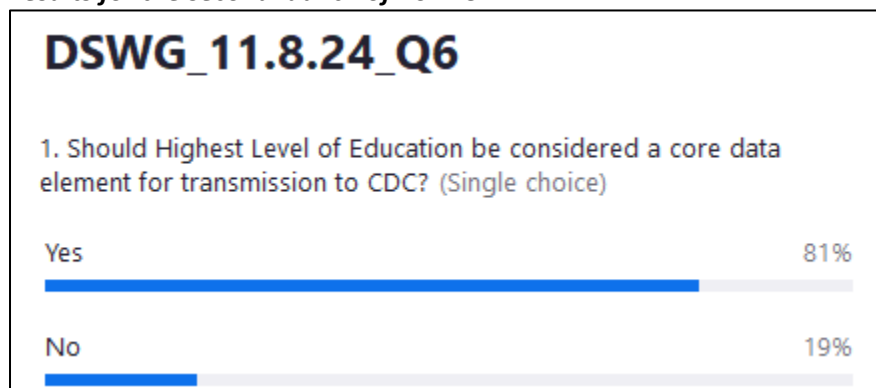
Discussion

- Eman Addish expressed understanding of why state, local, and territorial governments would need to collect education level data, particularly when considering health equity. However, they questioned why the CDC would need to collect this information.
- Sam Spoto posed a question to the group on whether the CDC wanted to provide any comment.
- Erin explained that many programs collecting data track progress on addressing health equity, particularly with state and local partners. In this context, education-level data could be useful for tracking health equity.
- Sara Johnston commented that education level data is useful for health equity reasons, both at the national and local levels. Understanding the populations impacted by specific conditions can guide public health actions toward the appropriate groups and

surrounding factors. Educational attainment can influence communication strategies and highlight populations that may face challenges in accessing services.

- Sam Spoto noted in the chat that one person mentioned these data elements support addressing health disparities in SDOH (Social Determinants of Health), while another person added that, aside from tracking inequities related to education, the development of programs and products could also be informed by education core data. With that, Sam determined to launch the Poll again to see if results had shifted.

- **Results for the second launch of Poll #3.**



Next Steps

- The fourth call for Social Determinants of Health calls will be held next Friday on November and 15th. We will cover the value set for education, insurance, and income.
- Upcoming team meetings and additional information can be found here: Link to [DSWG: Data-element Specific Team Interest Sign-Up](#)
- The next large DSWG call will be on December 13, 2024.