



U.S. Core Data for Interoperability Task Force

Transcript
March 21, 2018
Virtual Meeting

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Good afternoon everyone and welcome to the U.S. Core Data for Interoperability Task Force. We will call the meeting to order starting with roll call. Christina Caraballo?

Christina Caraballo – Get Real Health – Co-Chair

I'm here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Terry O'Malley?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Steven Lane?

Steven Lane – Sutter Health – HITAC Committee Member

Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Clem McDonald? No Clem yet? Brett Oliver?

Brett Oliver – Baptist Health – HITAC Committee Member

Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Ken Kawamoto?

Ken Kawamoto – University of Utah Health – HITAC Committee Member

Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Valerie Gray? No Valerie yet? Laura Heermann Langford? Not yet? Leslie Kelly Hall?

Laura Heermann Langford – Indiana University – Public Member Laura Heermann Langford – Indiana University – Public Member

Here.

Leslie Kelly Hall – Healthwise – Public Member

Here. Leslie is here. Thank you.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Laura and Leslie correct?

Laura Heermann Langford – Indiana University – Public Member

Yes.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Nancy Beavin? I thought that I saw Nancy on. We will doublecheck later. Kim Nolen?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Kim called to say that she could not make it today.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Okay. Thank you. Rich Elmore?

Rich Elmore – Allscripts – Public Member

Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Eric Heflin? I think he's going to be late as well. Dan Vreeman? No Dan yet. Mike Perretta?

Mike Perretta – Docket – Public Member

Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

And Rob Havasy?

Rob Havasy – HIMSS – Public Member

Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Okay Christina and Terry I turn it over to you.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Hello everyone. Christina do you want to start off? Or me? What do you prefer?

Christina Caraballo – Get Real Health – Co-Chair

It doesn't matter. I guess I can since Terry so graciously took the lead of our presentation this morning. Thank you, Terry. Today we will discuss the HITAC presentation and the slides that we delivered earlier. The specific charge was how the USCDI would be expanded and by how much. That is what we will look at today as our next agenda item.

Earlier we focused on providing our draft recommendations for the proposed categories. Now we will move forward with the next three areas. Today we will discuss the expansion process share the preliminary recommendations that we presented in today's meeting and we will have the goal of determining the criteria for expansion. We will look at next week's discussion to confirm criteria.

Can we move onto the next slide please? At this point we can give an overview of the HITAC presentation. We received good feedback and had a few comments but not too many. We went through our specific charges at the beginning. Starting we reviewed each of the categories and introduced the three new stages that the task force has proposed. We put it into a format where each slide was formatted in a similar way for the proposed category

starting with the principle purpose of the category and what it does moving to what is needed for entry into the category –

[Interruption]

Christina Caraballo – Get Real Health – Co-Chair

Oh excuse me can people hear me?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

No you're doing fine.

Christina Caraballo – Get Real Health – Co-Chair

My phone -- something was going on and it asked me for an access code. Sorry. Going back to the slide format the third high-level area that we had was what happens in the middle and then what it takes to get to the next category. We clearly defined that with each of the proposed stages. Terry did you have anything to add is a high-level overview of today's meeting?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Not so much anything to add but more to just toss it back to the task force. Were there are things that you guys thought were missing? Do you think there were things that were brought up that we haven't paid attention to? Any general or specific comments about the content? So, really, it's an opportunity to hash through what happened for those of you who sat through it.

Steven Lane – Sutter Health – HITAC Committee Member

I thought that you guys did a great job. This is Steven. I really appreciated the way that you laid it out. I thought it was very understandable and well received. I did want to just comment that there was a public comment registered by somebody where they suggested that we think about a process for retiring items from the USCDI if they become outdated and no longer necessary. I thought we should put that in a parking lot somewhere to come back to.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yeah that is a great idea.

Brett Oliver – Baptist Health – HITAC Committee Member

Yes this is Brett. I would 100 percent agree with that. We could find ourselves several years down the road with more data for at least the providers and nurses than they can handle

especially in finding things duplicative. I would like to eventually like to talk about some process to remove a data element.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Great. Who is up? Ken?

Ken Kawamoto – University of Utah Health – HITAC Committee Member

Yeah hi. I enjoyed this morning's meeting. I thought that everyone gave great presentations. I think the TEFCA folks brought it up too but having a formal way to get some of the requirements into what the subcommittee is doing would be useful just to make sure that things do not get lost in translation. I think that supporting what they are doing is going to be important for us.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Agree. And Laura you're up.

Laura Heermann Langford – Indiana University – Public Member

To comment on the retiring I completely agree with that and would support us looking at that. And implied in the presentation that we had in our processes that the whole concept of review needs to have very strong. Because if we are not reviewing it -- our process really talks about new things and the annual release. But I do not know that we talked a lot about that review. I just wanted to be sure that we highlight that. We could put a whole "this is how you retire an item," but there is not a process of reviewing it then you will never get them retired.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yeah this is a really interesting area. It's worthy of as much time as we can give it. We may not be able to give it all we want between now and April 18. Okay great. And Leslie.

Leslie Kelly Hall – Healthwise – Public Member

Yeah thanks. I have a couple of comments. First of all I think Arien and the group on the TEFCA talked about the what and the how a lot. I think that it was a great reminder of the work that we are doing which was the how. And it should be outlined with TEFCA's open-ended committee's response to talk about making sure the processes were pretty consistent and that there were ways to have the technology considered without having it be an overdue burden. I think it was a good and mindful approach that we could be compatible with in our recommendations.

I would like to also talk about Christina's idea in the meeting in response to TEFCA that would also apply to this. It is back to the idea that there is no logical sponsor for the patient. They don't have the same commercial gravitas as the industry. So although both of the recommendations started with the industry ecosystem and being commercial friendly having

a way to be very deliberate on how our process or data is considered for interoperability and movement and data exchange. There needs to be in overarching and deliberate approach.

Christina recommended that there might be a QHIN for instance dedicated to that. Perhaps we need to consider either a deliberate process or a distinctly different process in our recommendations. I think that we have hashed that through a bit. I think Clem was the one who said "Hey guys. Let's just make sure it considers all stakeholders in whatever we do." But we often have said that in the past and the patient still gets left out. So I would like the group to consider and discuss how we make sure both in this process and in recommendations we might cross collateralize with the TEFCA team that the patient's voice considerations and sponsorship is deliberately inserted into these processes.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Right. Thank you, Leslie. And Michael you are up.

Mike Perretta – Docket – Public Member

Hi everybody. I hope this is not too off key. I think that the materials looked pretty good. They made sense. They followed a logical progression and there were no surprises. The only thing – and I put this in an email – was that I think that we would be well served with a graphic. I think I've seen a couple of graphics that walked through the different progressive steps of getting data classes up to the USCDI. I think that would be pretty helpful.

Lastly, I think we would also be well served if we included some examples. I mocked up something about immunization data progressing that up into the USCDI. If we had something like that and explaining the criteria of how those data classes move up the ladder would be helpful I think.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Great. Thanks for volunteering all of that. And that comment made me think about some potential homework and what is the reaction to taking the current draft set of data classes and each of us laying it out where we think it currently fits in this progression?

Mike Perretta – Docket – Public Member

Please do not blame me for creating homework.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Well I had to lay it off on somebody. No good deed goes unpunished. But is that something we think we could set up somewhere?

Mike Perretta – Docket – Public Member

I would happy to help out as best as I can with the graphic or examples. But I think it would be beneficial to have those examples. I would love to hear what everyone else would think.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yeah, I think it will make the graphic richer. I think that will support a discussion next month about the timeline discussion. How long does it take to get through this process? Well it depends on where you are in the process and where you start. And then in my mind that circles us back to Leslie's point about advocacy for the patient's issues and point of view and how we make sure that happens. There's likely to be the least amount of push behind those elements unless they have brought value to somebody else. At least that is a concern.

Mike Perretta – Docket – Public Member

I would also like to add that I definitely agree that we need an exit to make sure we consider patients as an active participant of the USCDI authorship. We can't have the Epic concerns of the world coming across and saying "X-percent of the U.S. population has a record in Epic so we at Epic should be the ones who dictate how the USCDI is drafted." I think that is an unfair way to move forward. I definitely agree with that and would echo that.

Christina Caraballo – Get Real Health – Co-Chair

I would agree with that, too. Also, to Leslie's point, something else that you brought up was having that voice. One of the things that Denise proposed was sharing the use cases that are with the USCDI, and looking at how we ensure the work being done on both is mapped to one another, or is done in unison as opposed to fragmented since they're very dependent on one another. One of the things that Terry and I were looking at is how we ensure that our work fits into the TEFCA and some of the recommendations that were being made for the TEFCA.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Leslie, before I call on you, let me make another comment on that. The two potential data classes where we really overlap a lot with the TEFCA are unique patient identifiers, data matching, and data sets. What do we need to do that as best we can? And then, the other is the individual's permissions of use for their data authorization. Those might be basic building blocks for patients' engagement. That is our initial thought. Leslie?

Leslie Kelly Hall – Healthwise – Public Member

I think that's great that you guys talked to the other team chairs and are going to work on crosspollinating these recommendations. There's one thing that Denise mentioned, that they'd recommended that, in the RCE as well as the QHINs, there is patient representation. I think that goes a long way. We know that what also goes a long way is how the budgets are resourced to support stakeholders that are not well represented, like the patient. So, I would ask that ONC provide us with how they will support these recommendations, once approved, in terms of resources being allocated.

And then, furthermore, I'd ask ONC to then specifically state how much of that budget will be their acting as advocates for the patients they serve as the government of the people. I think that would be important to then allow us to react to that and perhaps even ask that as a

general question overall at the HITAC committee. What are those resource groupings coming from ONC to promote this work?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yeah, great comments. It makes me think we might try to turn the HITAC meeting into something a little different and create a slide with a series of questions to ask of ONC and the HITAC, rather than having them ask us questions. But, we will think about that. That would be number one on the slide probably.

Okay, any other thoughts, comments, concerns, omissions, or stuff we ought to be paying attention to? Okay. We can always swing by if someone gets a new thought. May we go on to the next slide, whatever that is?

This is our work for today. Let me explain this a little bit. You guys only got to see this this week and, first of all, our apologies to the task force for presenting something that we had not really discussed in any detail, and certainly with not any set of firm conclusions or consensus. I tried to acknowledge that, but this comes across as a recommendation.

Anyway, here is what we recommended. So, maybe we want to talk a little bit about – are these the recommendations we want to make for the expansion? Are they the right ones? Should they be tweaked, turned, or removed? Do we need more? Are we happy with them and we'll just go ahead?

Unidentified Speaker

Do we understand what the levers are that ensure that this work gets done once it becomes a part of the USCDI?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yeah. My understanding is that there are lots of policy levers. For example, CMS can say, when your reporting data for XYZ, this is what you have to report. It'll be in the USCDI. So, it is things like that that are tied to payment, regulation, and quality measurements. So, it's kind of the fickle way ONC gets things done. That's my understanding of the process but I would be happy to hear anyone else's. Leslie?

Leslie Kelly Hall – Healthwise – Public Member

I just have a clarifying question. Is expansion, in this case, meaning more and deliberate volume of the existing standard recommendation or width of charge, breadth of charge, adding more functionality and more data across the USCDI? Which one, or both?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

That's a good question. Christina, do you know the answer?

Christina Caraballo – Get Real Health – Co-Chair

I'm just looking at your question come through one more time. Would you mind repeating the question?

Leslie Kelly Hall – Healthwise – Public Member

I am asking whether expansion is adding more levers that make that particular USCDI data structure, or data class, go to scale? Or, does expansion mean the breadth of data classes included? Or both?

Christina Caraballo – Get Real Health – Co-Chair

I don't know. Would it be a combination? I would think it would be a combination.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yeah, I think so, too.

Christina Caraballo – Get Real Health – Co-Chair

That would then mean, in our recommendations as we go from stages, which implies a more expanded use of that data class to get to scale, we would have some way to have an inserted process that allows, at each stage, for that particular data class, to get more expanded. For instance, the notes example. We say that notes should come through as this particular USCDI. And, in the original recommendation at the very beginning, that note looks like it is pretty much an ambulatory note. But, by the time it might get to another stage, other organizations or sponsors have included new ideas for notes that might mean the operating note inside an inpatient facility.

So, that adds breadth. We would need, then, to have a deliberate process that includes adding breadth to a particular data class through either additional stakeholders or expansion of definition. And then, also as you go through this process, the ability to move the scale.

Leslie Kelly Hall – Healthwise – Public Member

I think that is a really good point. I think that goes into the criteria to move through the USCDI and not the expansion itself. But, with the way the task force has looked at it in our discussions, in order to move through the criteria you have to advance by meeting the criteria that we're going to determine in each of the stages. So, I do not want to confuse the actual expansion of the USCDI, meaning how we get data classes in each of the categories, with the process of them moving through.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Leslie, this process is not clear in my mind, nor is how it will be supported or where it's going to take place. Is it sort of an S&I-like project, where a group of stakeholders get together virtually around a proposed data class and hash out what it ultimately looks like? But, I suspect, if the process is anything like that, it will mean there will be some juggling. There will be a need to find enough content in the data class to increase the value of getting it, but not so much content that it really increases the cost of getting it. That would defeat the net value

proposition. So, I am not quite sure how that's going to work out. And, I'm not quite sure how we wrap clear guidelines around that process. But, we will need to think about it.

Leslie Kelly Hall – Healthwise – Public Member

Thanks.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Well, you are welcome. Steven.

Steven Lane – Sutter Health – HITAC Committee Member

Yeah, I have a couple questions. I think I know the answers, but I thought I get them out on the table. One was whether or not there was a minimum time that we felt that a datatype needed to spend in any one of the stages of advancement, and whether there was any interdependence of the items in a given stage, or in stages along the way. The reason I'm asking these questions is, I think it's important that we develop a process that's sufficiently nimble to be able to respond quickly if there's a new datatype that emerges that we feel needs to be fast tracked through the process.

As I think about expansion, I think that one thing we want to be sure of – because the world changes so quickly around us sometimes – is that we do have some sort of a fast track mechanism and we don't have artificial or unnecessary checks along the way that might limit our ability to respond in that way.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Hm. So, your initial question is, do you think there is any minimum or maximum time any data class spends in a particular stage?

Steven Lane – Sutter Health – HITAC Committee Member

Right. That and whether – what I was really trying to get at was, if something shows up and is really important, and we want to fast track it, is there going to be problem with it jumping through the stages quickly, or jumping ahead of other items sitting in a given stage for a given period of time?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Hm.

Christina Caraballo – Get Real Health – Co-Chair

That actually made me think of something different. I think that's an excellent point that we wanted it to be very flexible. I don't think there was a specific timeline for the data classes to progress through each category. But, what you said with the maximum time just made me think maybe we should have part of our recommendations that, if a data class in a category for X-amount of months or years, that it is flagged so that we can say, "Why is this stagnant

and does this belong here?" That will also let us look at making sure that we are evaluating if there are still needs for the data classes as they progress. Kind of like another check and balance.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Christina, that makes me think. Do we really need a clear process for how that is done? TKA customized framework – because we need a process that then has a goal at the end and says, "Okay, gang. By three months from now we need to have a highly specified date set." If it doesn't, then it goes back – the other thing that makes me think of is, there's no reason why classes can't be kicked down to the earlier stage for more work or rework.

This doesn't have to be a unidirectional process. Except, hopefully, once you get into the USCDI, the only way is nationwide deployment. More things to think about. Rich.

Rich Elmore – Allscripts – Public Member

Terry, I was thinking about your description about what the assumed levers are for this. I think some examples you used were – I interpreted it as being a CMS initiative that wanted to accomplish something, or something associated with payment reform. This might drive some of this activity. I think there is a fundamental point that I would be interested in getting the view of the task force on, which is – the approach that I'm seeing here is kind of a build it and they will come over time, iteratively, working through the data classes, based on priorities.

This is a little too theoretical for my taste. I am wondering if we should have a different view of the USCDI, which is to say that there is some new initiative, some new way in which CMS wants to capture information and have information reported – whatever it might be. And a necessary sequence to that strategy of theirs, is going to be to run through a USCDI process, and they have to be able to defend the value and that it makes sense.

But, it gives a practical side to this and it ties into the levers you were talking about, as being what can really drive USCDI. I think it's a different model than a conceptual theoretical – I don't know who the really smart approver is who sits on top of that as a regulatory body, but it feels like it will take a long time. And, at the end of the day, I am not sure who would receive value for the work that's being delivered.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yeah, that is a really good point. That concerns me, too. Who is the convener? Who's the sponsor? Who's supporting it? Who's pushing any particular data class? So, the weight of the market might be one mechanism, one flawed and incomplete mechanism. But, short of some criteria that says this has bubbled up sufficiently high that we should pay attention to it, it's a little seedling that needs water, sun, and fertilizer. How do we get it to blossom? Yeah, without that, I too do not understand the process.

Rich Elmore – Allscripts – Public Member

Yeah, we've seen this movie many times before, where there is an initiative and there are high aspirational goals and there are really smart people in healthcare. But, the execution

and getting it to actually work in a practical sense, and then getting it to scale, takes some focus. Someone, some organization, or some group need to coalesce around that to say, "Hey, we want to try to make this happen." I do not know that the USCDI is the focal point, I think that it's the supporting infrastructure for other initiatives. I'm putting it out there assertively to get the conversation going. I mean, I'm not sure I feel as strong as perhaps my comments come across. But, I'll turn it over to others.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Okay. Good point. Laura?

Laura Heermann Langford – Indiana University – Public Member

Yeah, thank you. I completely agree with the previous speaker, I too am thinking through, how do we keep this real? How do we keep it nimble? When we were talking about the process, and we don't really know what that is, I think that gets back to my earlier comments about needing to understand the review. Even in that, when I think about the review, some earlier comments – do we set guidelines or set rules? There has to be a body that's doing some oversight on this, but it needs to be maybe – I don't know.

I participated a lot with the S&I framework initiatives and different things there. I'm not sure they always became real. I'm not sure they were always something that was implemented. So, when you think about this as create it and they will come, well they will if it is helpful. Otherwise, it will take regulation. I think that's where to find the sweet spot. If we can keep it nimble and keep it real, keep it something that's helpful, to get to the end goals, then I think it wouldn't need regulation.

People are desperate to find tools and solutions that help fix some of these problems. But, if we put it out there in a way that makes it so heavy, onerous, and not real – and by not real, meaning – I still go back to the original set that's out there as the USCDI. I'm not even sure all those items would pass these phases that we've put in. They may need to go in and be evaluated and say what phase they're in so that gets a little bit more reality to it. I don't have any answers here. I'm just throwing out some other thoughts. Thank you.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Well, welcome to the next round of homework. We will see where they stack up. Okay, Leslie?

Leslie Kelly Hall – Healthwise – Public Member

Perhaps we can look at the structure that is being recommended as a part of TEFCA, and see if that is a governing structure that would be sufficiently neutral, would provide a voice for the patient if tweaked, and can evaluate, especially on the volume of use and end users, through that process. I don't know that that's the right answer, but it's certainly offering up a structure that has regulatory authority, implementation authority, and nationwide interoperability. Perhaps when you two speak with the TEFCA chairs you could ask how could this be considered. It might not be the right answer, but it might be worth consideration. I,

too, fear that we have played the same movie over and again. And yet, the work is important to be done. Thanks.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yeah, amen. Rich.

Rich Elmore – Allscripts – Public Member

A minor point on the last bullet. I think interoperability standards advisory probably will create some confusion, in that that is – think of it more as an inventory with some indicators, some maturity, and other aspects of a particular standard. I think that what we are trying to do here should not be an inventory. We have too many of those. I think that it has to be the very narrow list that actually warrants work and focus to try and get it right, constrained enough, so that it can be actually delivered very focused.

Just for all of those kinds of reasons – I am not debating whether not – at least not with this comment – whether or not there is a regulatory oversight element. I'm not sure that I understand yet what the drivers are going to be, so maybe it's premature to be talking about regulatory oversight. But, I think ISA. I would just recommend maybe it may confuse.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yeah, and that was something I threw in. I agree. It's not we're building another ISA. It's that the ISA has support, guidance, and oversight, and is being run daily by ONC. We kind of need the same thing. That's what regulatory body oversight == what that all means. It's not very clear. I agree. Something will be done with that. Another thing that --

Christina Caraballo – Get Real Health – Co-Chair

Terry?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Go ahead, Christina.

Christina Caraballo – Get Real Health – Co-Chair

Just to build on the clarity on that regulatory body oversight and the reference to ISA. When we were discussing this, one thing came up. It's not that ONC is managing it. It's that under the ISA, they're bringing together the right stakeholders, creating the proper workgroups, to address issues as they arise. It's that type of oversight, where someone owns the document to look at the gaps and look at what needs to be moved, so that they can convene the right folks in a task force, like this one, to continue with the momentum. That is what we were thinking, in addition to what Terry said, by the regulatory body oversight requirement, so it doesn't just sit on a shelf.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Thank you, Christina. So, I have somewhat different thought about what we should be doing to get items through to the USCDI. That's to almost look at the business case. Why does this have value to anyone, and what is the value that it has? If it doesn't have sufficient value, then it has no business being advanced. Maybe we need a higher bar on value. To Leslie's point earlier, we have seen this movie before. We've put a lot of things out. They've been driven through standards and no one uses them because there's just not really a compelling business case behind at this point.

So, what if we were to ask, "How are you going to use this? What is this going to mean to you? What's the benefit that's going to come to you? Would you use it if it were created?" And, if the answer is no, then no. Next data set, please. But, really get to the real driver through this process, which is going to be the ultimate value to the end user. If they don't see enough value, then why are we building it? Leslie.

Leslie Kelly Hall – Healthwise – Public Member

I don't think it's a binary, or single recipient/single sender, kind of thing. It is multiple stakeholders, and there could be – I can't remember who made this point. The cost and the actual value could have uneven burden and benefit. I think that's just life in interoperability. So, how do you count the number of stakeholders that are positively or negatively impacted? Are those counts weighed or are they counted, depending upon who that stakeholder might be? So, it is important that we define what value means, and the value to which stakeholder involved.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Rich?

Rich Elmore – Allscripts – Public Member

Thinking about the prioritization criteria that we have been talking about, and the way that it is developed, and thinking about the last two speakers' comments, I'm wondering if, as opposed to having a funnel, we've got a sieve. Is too much falling through that we have not really helped to narrow the focus, to heighten the chance for success? Do we need to do something to make the prioritization criteria more of a funnel?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Do you have an example or a hypothetical?

Rich Elmore – Allscripts – Public Member

Yeah, I would say that there are probably some gates at any of the stages of maturity. I don't have something formulated, but I think it's a certain point in time. You would need to know that both of the standards exist are in production use before it's able to the subsequent class. At various classes will be various gates on this that will be important. Is it being captured with internal workflows, or is it available electronically? Those are going to be critical to passing some other gates. Maybe the workflow suggestion, the diagrammatic suggestion, and putting these things more in as criteria for advancement as opposed to

prioritization criteria. Some of them are more qualitative, and then others are more black and white. So, capturability and all of that – ability to be captured – all of those kinds of things would fit into a straightforward yes or no criteria.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

How do we weigh the aggregate stakeholders when they come up on the scale?

Rich Elmore – Allscripts – Public Member

Well, I think that's our job. I feel like, so far, we haven't really grappled with that. It's probably smart not to try to do that right out of the gate. But, I do think we have to grapple with it or I don't think we're helping ONC with the work of prioritization.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

That is a long, dark, twisting rabbit hole.

Rich Elmore – Allscripts – Public Member

Isn't that what they're asking for, Terry? Isn't that what ONC is looking for in this process, at least partly?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Maybe. But, all stakeholders weighed the same – that was sort of Leslie's point. Leslie, please jump in.

Leslie Kelly Hall – Healthwise – Public Member

Well, perhaps the criteria that we select would equalize the uneven stakeholders rather than weighing the same. So, for instance, you could have likelihood of adoption by patients, likelihood of adoption by providers, and likelihood of adoption by payors, etc. for each stakeholder. Feasibility. Political viability. Potential to foster new use cases for a broad number of stakeholders. A low potential for negative or unintended consequences. Things like sustainability or something that says it improved exchange overall if adopted, and not just this particular item. But, it improves exchange. It betters other use cases and it expands multiple stakeholders. I think we could potentially get to the waiting by articulating the criteria in ways that evens the playing field.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Interesting approach. Again, such a different metric and there's going to be issues with how we measure that.

Leslie Kelly Hall – Healthwise – Public Member

Right. Yeah.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

But, it's the same issues that are going to exist for whatever metric we try to come up with. No one has come up with a universal value scale that I am aware of.

While we are thinking, let me go back through the slide from the top. Let's see if the thinking that led to what's on the slide makes sense. So, the limit on new additions to the USCDI was an attempt not to overburden the implementers. This is a pitch to the vendors, and saying we are going to overwhelm them if we drive so many data classes into the USCDI that they just don't have bandwidth to adapt their systems in a reasonable time.

Rich, I think that's something you – maybe I'm putting words in your mouth. But, the idea that we need to be sensitive to this final gate, which is the USCDI, which we viewed as being – once you're in there, everything that the feds can do to move this data class through is going to be done. So, is that a reasonable concern? Any obstructions to that? Eric?

Eric Heflin – Sequoia Project – Public Member

Yeah, so not to your specific question, but – I can actually wait until others go, if you want, so you can cover your question. I had a comment about a prior --

Terry O'Malley – Massachusetts General Hospital – Co-Chair

No. Go ahead.

Eric Heflin – Sequoia Project – Public Member

Sorry, I didn't want to interrupt your flow. On Slide Five, I think one thing is missing here, from my perspective, and perhaps it is covered elsewhere. I do think that we should have some type of a definition of success. All these recommendations, to me, look like they're very difficult to measure. How do we know if you achieved anything? How do we know if you met the requirements? I think that can all be accommodated with one additional bullet, if the rest of the workgroup feels the same, which is that the expansion should be based on use cases.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

And by being based on use cases, you are meaning successfully demonstrating --

Eric Heflin – Sequoia Project – Public Member

Yeah, to elaborate, meaning that specifically a use case, or a group of use cases, should be analyzed, brought forth, and approved by an appropriate entity such as the industry, the ONC, or perhaps, ideally, a combination of the ONC and the industry. And then, the USCDI expansion should be applied to conduct a gap analysis to determine if any of the priority-based use cases, starting from the most important Use Case No. 1 through the next use case and so on, in priorities-based order, have any gaps that are data related.

If so, that would inform the USCDI expansion by saying, for example, this national priority Use Case No. 1 had three data gaps in terms of data sets, code systems, value sets.

Therefore, we recommend that be addressed and perhaps that these specific value sets be used to accommodate this priority use case, etc. So, that gives us a mechanism for saying, A.) this code system is relevant and important and should be done, and B.) it lets us determine whether we have additional gaps, or potentially, and maybe even worse, overlaps where there are multiple data sets that could be used to satisfy the given requirements of a given priority base use case. So, a use case gives us a method of judging whether we are done or not.

Christina Caraballo – Get Real Health – Co-Chair

Eric, to that point, we are hearing use cases come up a lot. And, at the beginning of this, we looked at use cases and stakeholders, and found that there were a lot of those. I'm wondering if, in order to track this, instead of identifying the use case and then putting a data class under that, for each of our data classes, maybe we could suggest, as part of a framework, we actually list identified use cases that the data class supports. Then, it does not become about one use case, but clearly shows how a data class set can support multiple use cases. And then, it maps it in the reverse way.

Steven Lane – Sutter Health – HITAC Committee Member

I agree. Steven.

Eric Heflin – Sequoia Project – Public Member

This is Eric. I am kind of curious why Steven agrees on that, and also why you are suggesting that. I think, in principle, to cut to the chase in my comments, that could work as well. I'm just curious why you two are advocating that the data be mapped to a use case instead of a use case mapped to a requirement to have an associated data set.

Steven Lane – Sutter Health – HITAC Committee Member

You have the floor, Christina.

Christina Caraballo – Get Real Health – Co-Chair

Articulating in the chaos of the snow day and my fuzz brain. Sorry. It goes back to the concept of the fact that we want this framework to support multiple stakeholders and scale well. One of the fundamental things that we've discussed is that, if we can show that not the loudest voice gets what they want, but the collective voice has a say in what progresses through the USCDI, and what is important, and what the industry should be looking at. That's where I think that identifying use cases under a data class, so we can clearly see, and the industry understand, that by creating this data class, these are the benefits to multiple people, as opposed to just focusing on one use case.

I think it enables us to look at the data class more broadly, especially as we think of how it's used across the nation. But, it doesn't take away from still continuing to ensure that we're focusing on very important use cases as they are identified and as they arrive, even the ones that we know.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Steven and Christina, I wonder if we could combine those two concepts? And perhaps we could suggest that we, as a task force, recommend mapping to use cases both ways. That way the use case – we can, through that process, determine if there is a gap that we or others could help remediate. Or, for example, there is no value set that can express what is needed. Also, as you just mentioned, we can show the broad applicability, or narrow as appropriate, for given data classes. Would that make sense?

Steven Lane – Sutter Health – HITAC Committee Member

I'm trying to hold my fire until I am called upon.

Christina Caraballo – Get Real Health – Co-Chair

Go ahead.

Steven Lane – Sutter Health – HITAC Committee Member

I'm trying to be good. Yeah, I think that looking at it both ways make sense, Eric. I think that the reason I chimed in to support Christina is that, in my experience, sometimes – if you put the use cases up front, it sometimes leads to unnecessary delay and more discussion than I think is always warranted. Sometimes, it's very valuable. And, it may be that, just as a clinician, my view of this is pretty simplistic. But, I see so many opportunities.

Under the rubric of the treatment use case, we just have all kinds of data elements, the vast majority that were included in the draft USCDI, that all kind of fall under the treatment cases. I would not want to hold up our process while we spend a lot of time writing up sub use cases and whatnot. Just taking care of patients is plenty of use case for me to want to push these things through the process. I think that's probably what I was expressing, was that viewpoint and prejudice.

Eric Heflin – Sequoia Project – Public Member

This is Eric. That makes sense. The reason I'm focused on that is, even though I'm a technologist, I always feel that projects that start with technology tend to not be as successful as ones that start with the clinical or business objective to be accomplished. That's why I tend to philosophically think of everything we are trying to do as an industry really being driven by our goals that we have in mind. Okay. Well, thank you.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Laura, you have been extremely patient.

Laura Heermann Langford – Indiana University – Public Member

That's okay. I keep forming thoughts as these folks are talking. It all fits. My first comment was going to be talking about the point that talks about limit of new additions. But, the use

case discussion really goes to that. I can see both points of view and I value them. I think I can support them both. But, if we look at even our criteria use cases, we're called out in there. The use case seems like a chicken and egg problem here. Which one comes first? So, we probably do need to accommodate both.

The thing that I was thinking with use cases as well was this whole point – to go back to when we were looking at the slide – there should be a limit on new additions. I'm a little bit hesitant to say that's a recommendation, because it implies that someone should go out there and create – what's that limit? Is it 50 things? Is it 100? I don't think we mean that. I think that we mean judicious additions, and that that would be supported by need, use cases. And anything in there already something that we say we need.

Anything that's in there already is something that we say we need, use cases. We may not have use cases that support everything because we just said, "Well, we need it." But, we probably could come up with them. But, do we need to take the time to do it? I get that point as well. Maybe not.

But, if you look at our process, we have a lot of implications saying that a use case is bringing us things. I agree with the point that we probably need to consider both points of view when it comes to the use case application. But, to get back to where we were on that slide, I think we need to be very careful about saying that there is a limit. We need to word it in a way that we do not need a line drawn. We just need to be careful to not overburden places unnecessarily.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yeah, I think the thought, if there was one behind that, was the limit would be – someone would have to decide and take the temperature of industry and say they are frazzled and not going to do another thing right now. So, it may not be less – the gate might not be getting into USCDI. It might be moving within USCDI the full deployment. That along that pathway, there is going to be some gates based on bandwidth and industry pushback. I don't know if that is consistent with what you're saying?

Laura Heermann Langford – Indiana University – Public Member

Yeah, I can see that in agree to it. With that bullet point in mind, we probably need to look at our stages and understand at what point is that considered. If the industry is unable to absorb anymore – it may be that we've accommodated that enough and it would be around Stage Five, I think. Again, as far as a recommendation, I would hate to see that we state there should be a limit and then a body after us comes by and says, "Well, it was recommended we have a limit so let's set a number." That's not our intent. Our intent is about what is useful to people and to be judicious about it, to not overdo it. I think you're right, that it will be natural as we go through the stages. But, let's look at our stages again and say, "Have we carefully articulated this in a way that is understood?"

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yeah, that's a good idea. There needs to be another bullet in there that clarifies. Thank you. Point well taken. We will do something.

Christina Caraballo – Get Real Health – Co-Chair

Yeah. As a reminder, as we talk about the use cases – and, Eric, you brought up that it's not just to build technology for the sake of it, but to actually serve a purpose. And, the very first step that we put together as a task force, as a reminder, is that it has to be important to someone to get into Stage One, which is our proposed status, to even start the evaluation process. I think that we have built that in at the very beginning. And, we've even put it in that it's down to the data element level the you can propose for a use case, in order to capture that. I wanted to throw that in as well. I think we have organically wrapped in the fact that we need to serve a purpose, or a greater good, throughout our recommendations, and should continue to do that in each area.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Well put. Steven.

Steven Lane – Sutter Health – HITAC Committee Member

I think I'm caught up. Sorry, my hand was still up.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Okay. Nancy.

Nancy Beavin – Humana – Public Member

I just wanted to say that I am supportive of the conversation around not having limits. I don't think that meets our purpose, to say we're going to limit a number of entries to the USCDI. From a business perspective, though, or an implementor perspective, for me it's more about priorities. I'm not sure how that would ever happen. But, if we do not have limits, and there are lots of opportunities to implement new data classes, when you get right down to it, the implementers are going to have to look at priorities. I'm just wondering if that something we should have some kind of discussion around.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Good question. And, who is going to set the priorities and orchestrate industry?

Nancy Beavin – Humana – Public Member

Yeah, and I do not know who that is. But, I think it comes back to the conversation we were having much earlier around how does this get – what is the structure around implementation of the USCDI.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Okay. This has been a fascinating discussion. Eric?

Eric Heflin – Sequoia Project – Public Member

A couple of thoughts that might help on bullet one. First of all, I'm not sure how to measure the word overburdened. How do we ascertain that we are "overburdening" the industry or segments of the industry? I'm a little bit uncomfortable with that word for that reason. It is a little unmeasurable.

The second thing, in referencing bullet one here, under preliminary task force recommendations, is there is some methodologies that perhaps we could employ to help solve this. What we are really talking about here is capacity. And that capacity has a couple groups. The USCDI group, for example – we have a certain product capacity of how much we could assess in a given activation of the task force. There is an amount of capacity that various market segments could adopt, various standard bodies could curate, and so on.

So, there are methodologies for handling that, one of which we used, for example, for IHE workgroups, where we face this issue every year. We simply evaluate the potential every year. We then assess them based on criteria that we talked about very nicely in our prior two phone calls. And then, a force ranked list as the output of that evaluation process, which will include things such as difficulty in implementation, value to industry, maturity, and things like that.

And the output of that is a force ranked list of those candidates for the cycle. And then, at some point, an appropriate body, perhaps the USCDI, internally does this for ourselves. Our capacity for this cycle is to look at 10, 50, or five data classes and then the line is simply drawn by the prioritization, and then by the capacity of the worker that's actually curating that.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Okay. That is great. I think that is a better set of criteria to use on the point that was trying to be made. It really is about capacity. Would you mind articulating on paper what you just said, so we can look at it and try to plug it in? I think that would be an important addition to the slide.

Eric Heflin – Sequoia Project – Public Member

Yeah, I'll be glad to try it. Perhaps say something along the lines of the amount of data class recommendations added to each cycle should be a function of priorities and capacity of the various stakeholders, including the evaluation workgroups. Or, something to that affect, if that sounds about right.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yeah. And, perhaps even some detail about what would go into those rankings, the prioritization --

Eric Heflin – Sequoia Project – Public Member

Okay, sure. I'll go ahead and take a stab at that for the workgroup to consider.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Wonderful. Thank you. Robert.

Rob Havasy – HIMSS – Public Member

Good timing, actually, because I was going to build on what you and Eric just said. I am wondering if we've actually created the feedback mechanism that we need for this kind of throttling with our addition of Stage Six. So, if we look at the ratio of anything that's made it from the USCDI into widespread deployment, at some point, if only 10 percent of the USCDI is in widespread deployment, that's a signal that something is wrong. We've put too much into the pipe and industry can't handle it, or our criteria are off and we're suggesting things that are not working.

Perhaps a simple throttling mechanism is to look at that ratio and if it ever gets over some threshold. If the USCDI has 100 elements in it, and only 30 of them are in widespread deployment, so 70 percent are not making it, that triggers a process of re-prioritization or going back to look at the criteria or something. I'm just wondering if structurally we have not already created a signal that we're either pushing too much through or pushing the wrong things through.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Maybe so. That is interesting. Okay, thank you.

Rob Havasy – HIMSS – Public Member

I mean, unless we think that the intent of stages one through four to identify things that are so forward-thinking that we know we are going to put a lot of out that's going to take a long time to reach widespread deployment. Maybe there is something there.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

I think the gates at each stage seem very logical. The last gate getting in the USCDI – you're only going to get there if most of the standards work and the technical work and the testing has already been done. So, it's not an issue that you have to go out and develop everything to make this useful and usable. It is that everything is in place, and it's a question now of how do you implement on what all the work that's been done to get into the USCDI? At least, that is my take on that level. So then, the capacity issue is really one that's implementation capacity. Can I take this body of work and now make it work in my system? Is that close to reality?

Rob Havasy – HIMSS – Public Member

It certainly sounds right to me.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Okay. And Leslie.

Leslie Kelly Hall – Healthwise – Public Member

I'm struck with the idea that capacity changes when technology is useful. For instance, who knew I would actually like to watch on my Delta app that my bags are about to come down the luggage rack. So, the capacity does change. For instance, as a patient becomes more involved in data exchange, they can bring huge efficiency to organizations.

So, for an example, in the 300-bed hospital, there might be as many as 15 people in preadmission and testing. Of those people involved in preadmission and testing, let's say 60 percent of the data is actually gathered directly from the patient in verbal interviews, that could be supplanted by patient generated health data. Perhaps that's then a drop in FTEs in preadmission and testing for the administrative burden of half, or even 30 percent. This would be a dramatic shift.

Although the capacity for implementation might say this is going to be tough to implement data exchange for pre-visit preparation information and from patient generated health data, the long-term effect of reducing the administrative burden for collecting that data would be absolutely dramatic. So, capacity in this case, has shifted. So, the capacity for implementation is offset by a shift in capacity from the preadmission testing staff to the actual patients doing the patient generated health data.

So, let's make sure, as we weigh these things and look at these things, that capacity is reflected not just in singular burden of implementation but capacity shifting.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Interesting. This is going to find its way into a use case somewhere, no doubt. Eric. And then Rich.

Eric Heflin – Sequoia Project – Public Member

I just wanted to mention that I put my comments, as per your request, Terry, into the chat window.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Oh, fantastic. Thank you very much. That is great. You don't get a pass on this week's homework, but you have an extra credit check somewhere. Rich.

Rich Elmore – Allscripts – Public Member

There may not be optionality for developers, but I think there should be optionality for the production users of USCDI at a minimum, if it's not a pertinent use case. This is one way to try to make sure that we have something that's – it's not like a broad-spectrum antibiotic trying to solve a problem, and we're not sure exactly what it is. It could be much more targeted to where we need to implement and who has to be involved in that implementation. I am riffing off of the point that Leslie just made, that capacity and shifting and labor is something to take a look at. I would think further, there should be some

dimension of USCDI that's speaking to which developers or which users need to actually do this, which gets back to the use case conversation that Eric introduced and got up on the wall for us.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

That is a great point. That actually might be another way through the gate into Stage Six. It's not that everybody has put this into use, it's that the people who need it have put it into use. Steven.

Steven Lane – Sutter Health – HITAC Committee Member

I have largely a process question. I appreciated the Eric put his thoughts down in the comments window. This came up on the HITAC meeting this morning, about the relative merits of using the comments window. As the members of the committee or, in the case, the task force, we don't need to belabor the point here. But, it would be nice if Lauren and the various co-chairs could get together and come up with clear guidance for all of us for how best to use the chat in public comments window during both the HITAC and the task force meetings.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Okay, this is Lauren. We can send some additional guidance out. But, just as a quick note, we do consider -- any comments that are submitted from the public to that chat window, they will be considered public comments. They will be a part of the official transcript and summary of the meeting, as well as any information or note that the committee members put in there. So, they are captured. But, we will clarify moving forward

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Great. And, Lauren, another question for you. How are we doing on our time and public comment period and so on?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Yes. So, we are just about there now. So, if you are at a good breaking point, why don't we go ahead and break for public comment now and then, Terry or Christina, I will let you wrap up with any final action items or next steps. Is that okay?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Great.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Operator, can you please open the line for public comments?

Operator

If you would like to make a public comment, please press star-one on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press star-two if you would like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star key.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Thank you. We will remind everyone to please keep their comments to no more than three minutes. Operator, do we have any comments in the queue at this time?

Operator

There are no comments in the queue at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Okay, we will circle back to see if there are any other comments. Terry, did you want to continue the discussion or after public comments should we just go ahead and wrap up?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Well, we need every minute we got. Sorry, gang.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Operator, just to confirm, any other additional comments within the queue?

Operator

No comments in the queue at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Okay, then why don't we resume. Terry, I will give you back five minutes.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Okay, is there a way we can pull the homework, the pending slide that did not get included in everyone's deck? That one. Yes. Thanks.

Here are some thoughts about some other issues that we might want to begin thinking about So, part of the homework is, when do we think about these, and can we do it in our committee calls in homework? Or, as someone had previously suggested, what about subcommittees taking on a particular issue, not necessarily these, but any of the ones we raised today? Maybe some discussion on that. Eric?

Eric Heflin – Sequoia Project – Public Member

Yes, this is something I have done for a prior task force I've had the honor of sitting on as well. What I have often done is, rather than just responding based on my knowledge or my organization's knowledge, I would love to be able to share this slide in particular with some of the communities Sequoia helps facilitate, like eHealth Exchange and Carequality and others, and ask them. And then, I'd take the results back and aggregate those and share them with this task force, if that makes sense?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

And, Lauren, there is no limit on the sharing of these slides? They're public domain?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

No. This is all public information.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Wonderful. Then, please pass it around to whomever you can find.

Eric Heflin – Sequoia Project – Public Member

Okay. Very good. I will do that and try to bring the results of that back to this workgroup for their consideration.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Great. And Steven.

Steven Lane – Sutter Health – HITAC Committee Member

I think that my preference, personally, would be to err on the side of doing more homework rather than trying to schedule additional subcommittees, just because of the challenges of making the time. I was impressed this morning that the work of our task force, while it engendered a lot of discussion, there really was not ample time to consider modifications in the larger committee. So, I fear that, if we push things down to a subcommittee, something similar could happen, that the members of the subcommittee would end up developing the near final product and it would be harder for people who weren't participating to have much of an impact. If we can commit to doing a little bit more homework, and then working through the issues together, that will improve the representation in the final product.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Okay. That's fine. We are trying to strike the balance between being respectful of your time and already imposing on it with the homework – and I think your point about subcommittees is well taken. Unless there is somebody who really wants to run a subcommittee, and you can certainly speak up now, we are taking volunteers, then we will continue to pile on the homework and plow through it during the meetings. Christina? What about that?

Christina Caraballo – Get Real Health – Co-Chair

Sounds great.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Is it still snowing in DC?

Christina Caraballo – Get Real Health – Co-Chair

It is. It is supposed to snow until 11:00. All of our snow on this March day.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

It just started in Boston. Okay, thank you, everyone. This has been a fantastic discussion. I think my brain hurts after all of this. It will take a while to pull this together. But, thank you all. Although, it doesn't seem like we achieved any specific target today, I think we made great strides towards many of them. Thank you all.

Eric Heflin – Sequoia Project – Public Member

Terry, if I can make one parting comment. This is Eric Heflin.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yes, please.

Eric Heflin – Sequoia Project – Public Member

I just want to mention that I am not really in agreement with the next to the last bullet, or last major bullet, where it says regulatory body oversight required. I think we could probably break that down into oversight versus actual implementation work. I see that being a joint effort, where a regulatory body oversees this, but actually has a convening organization or subcommittees that work very broadly to help implement and oversee this in detail.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Great. Please send this in. I think we made great slides on redoing this slide. The only two bullets that didn't get touched were the two in the middle, which are pretty vanilla. So, great.

I think we will end up with a much better charge. Maybe we did accomplish something today. Good work. Again, thank you all. And, Lauren, I think we will give them back three seconds. No, we won't.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Thanks, everyone, for your time today.

[Event concluded]