Conditions and Maintenance of Certification Requirements Task Force

Transcript
March 12, 2019
Virtual Meeting

Members/Speakers

Name	Organization	Role
Denise Webb	Individual	Chair
Raj Ratwani	MedStar Health	Chair
Carolyn Petersen	Individual	Member
Ken Kawamoto	University of Utah Health	Member
Sasha Termaat	Epic	Member
Leslie Lenert	Medical University of South Carolina	Member
John Travis	Cerner	SME
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Cassandra Hadley	Office of the National Coordinator	HITAC Back Up/Support
Mike Lipinski	Office of the National Coordinator	Staff Lead
Kate Tipping	Office of the National Coordinator	Staff Lead
Christopher Monk	Office of the National Coordinator	SME

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

Thank you. Good morning, everyone. Happy Tuesday. Welcome to the Conditions and Maintenance of Certification Task Force. We will get started here with the official roll call. Denise Webb?

Denise Webb – Individual - Chair

Present.

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

Raj Ratwani?

Raj Ratwani – MedStar Health - Chair

Here.

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

Carolyn Petersen?

Carolyn Petersen – Individual - Member

Here, good morning.

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

Ken Kawamoto, I believe, is still on vacation. Lucky Ken. Sasha TerMaat?

Sasha TerMaat – Epic - Member

Here.

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

Les Lenert? I believe he's absent so far. Maybe he'll join us later. And John Travis?

John Travis – Cerner - SME

Here.

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

Thank you. Okay. Let's see, do we have Kate on the line yet? All right. Can we go to the next slide? So, this is just a review of the task force charge for this particular task force. I know we just kind of keep showing this, but we want to, as a reminder for both the public and our task force members because we have so many concurrent task forces just as a refresher that this

group is providing recommendations on the API, real work testing and attestations, conditions and maintenance of certification, updates to mostly the 2015 edition, health IT certification criteria, and changes to the certification program, and deregulatory actions in which we are going to spend a little bit of time talking about today. So, with that, I'm going to turn it over to Raj Ratwani, one of our co-chairs to kick us off on that topic. Raj?

Raj Ratwani – MedStar Health - Chair

Thank you, Lauren. Lots of good progress it seems like over these meetings. So, thank you all for putting so much time towards this. I know it's hard to do this for the second or third week or whatever week we're in, so I appreciate it. We're getting towards the end of things, so that's good news. I think lots of good recommendations coming from all of us. So, if we can jump to the next slide, we got into some of this yesterday. And just kind of the quick summary, I'm going to jump down to the bottom in regards to the kind of deregulation decertification.

1) The removal of randomized surveillance requirements; 2) removal of the 2014 edition from the Federal Code of Federal Regulations; 3) removal of the ONC approved accreditor from the ONC Health Recertification Program; 4) removal of certain 2015 edition certification criteria and standards; 5) removal of certain program requirements; and 6) is recognition of FDA. And then, I think in the subsequent slides, we can start going through each one of these. And I know we made it through the first couple of these yesterday. So, if we can jump to the next slide, I do want to start by revisiting the removal of randomized surveillance requirements. We had made the request for some data from the ONC. And those data were provided. Lauren, I'm assuming we can speak about those data publicly.

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

I'm sorry, what data is that, again, Raj?

Raj Ratwani – MedStar Health - Chair

The data that was sent out about the surveillance numbers. Can we speak about those data publicly?

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

Oh, yeah. That's all information that can be found in the chapel.

Raj Ratwani – MedStar Health - Chair

Okay. So, and did this go to everybody?

Kate Tipping – Office of the National Coordinator – Staff Lead

Hey, Raj, I'm sorry, this is Kate. I had some computer issues. I just sent it to you and Denise.

Raj Ratwani – MedStar Health - Chair

Oh, okay. So, to share this with folks, it sounds like, between August 2016 and present, there

were 55 unique randomized surveillance activities. And each surveillance activity could assess multiple criteria. So, across those 55 surveillance activities, there were 276 criteria assessments. And then, it further states that the two percent requirement was only enforced in 2016. So, I think that the overall number of 55 is lower than it would be if 2 percent enforcement had been continued through the years. And this is where it gets a little bit tricky here. Of those randomized surveillance activities, it says that there were 261 criteria, so 261 of the 276, that resulted in no non-conformity, and 15 criteria assessments that resulted in nonconformity. And then, it further breaks those down.

So, depending on how you look at these data, it kind of tells a different story. If you look at the total of 55 unique randomized surveillance activities, of those 55, 11 resulted in the identification of a nonconformity, which is approximately 20 to 25 percent, if that gives people any information. I don't know what a reasonable number is there, but 20 percent to me seems kind of high.

John Travis – Cerner - SME

Raj, could you repeat that last couple of statements? I'm just trying to reconcile the numbers of the volume of 15 or 16 nonconformities out of 270 some odd criteria tested.

Raj Ratwani – MedStar Health - Chair

Yeah. So, let's separate it. So, let's first talk about just the 55 unique randomized surveillance activities. If you look at just those 55, 11 of the 55 activities resulted in the identification of a nonconformity. So, that's one way to look at the data.

John Travis – Cerner - SME

Okay. I got it. I follow you.

Raj Ratwani – MedStar Health - Chair

Did you get it? And then, because each unique randomized surveillance activity can assess multiple criteria, that's where that number of 276 comes.

John Travis – Cerner - SME

Okay. That makes sense. Yeah. And I don't know if this is only a way of establishing relatively, and I don't know that it's necessary to do, I'd be curious how much nonconformity was identified through randomized surveillance versus through complaint driven enforcement. I would imagine the number is much higher in the complaint driven enforcement. And that is as it should be because that's going to be a more comprehensive input source because that involves the entire user base and third parties and other interested stakeholders who might find issue with the use of certified products and the capabilities and production. And it's probably more of a barometer geared to something closing in on production. And I just wonder if that's the value statement.

I think I mentioned yesterday that I suspect ONC is substituting randomized surveillance in a way for real world testing to draw closer to an evaluation. So, obviously, the randomized surveillance was not without its worth because then ACBs affirmed finding nonconformities.

So, it wasn't strictly a matter of people not quite understanding and responding to the surveys or responding to observed witness walkthroughs of the use of the application. There were actual findings. But I just wonder if ONC is relying on a strategy to emphasize more connection to production use as a primary means of achieving the similar end, which is to have assurance that the products are living up to their certifications as used.

Raj Ratwani – MedStar Health - Chair
Yeah.

Denise Webb – Individual - Chair
If everybody would like to know, I was just looking at this table. And it shows that for reactive surveillance activities, there were a total of 694. And 608 resulted in nonconformity. These are unique reactive surveillance activities, not certifications criteria. So, it is a lot larger.

John Travis – Cerner - SME
Yeah. And that's kind of where I was going is that looking at the whole manner of the surveillance program, the far greatest weight of due diligence and value and effort, I think, was in that in terms of actual investigation and actual activity. I recall from the randomized surveillance that there was significant effort on the part of our certifying bodies to conduct it for what I would say was a lower yield. So, in terms of the value of the activity –

Denise Webb – Individual - Chair
And while roughly 20 percent of those unique randomized surveillance opportunities or activities resulted in nonconformity, the actual assessed criteria only resulted in nonconformity of 5.43 percent of the time. So, the actual –

John Travis – Cerner - SME
Yeah.

Denise Webb – Individual - Chair
It's very low.

John Travis – Cerner - SME
I was just going to say given a scarce resource and, obviously, at least it seems obvious to me, taking the tactic of emphasizing production based assessment and proof points, 1) ONC and the ACBs are, in a manner of speaking, shifting a level of the effort to the vendors by requiring real world testing. And that's the point of its value. They still have complaint driven enforcement. They still have the language we saw yesterday about the discretion to engage in randomized surveillance. Although, if we're arguing for its removal all together, that takes away the may.

But just in terms of where the investment and the return are, given the level of effort, I feel like between real world testing and complaint-driven enforcement and the authorities ONC has for enhanced surveillance, I'm not sure what value is derived from randomized surveillance.

Denise Webb – Individual - Chair

I think it's appropriate to leave the discretion as proposed.

John Travis – Cerner - SME

Yeah. It leaves it available. And that may be in a case where there is evidence that more effort – it winds up being a complementary tool where more emphasis is placed in that method when it's called for but maybe not so much as a routine, ongoing, required activity.

Denise Webb – Individual - Chair

And I do think the proposal that Sasha suggested about the one requirement that they were going to remove remain related to the randomized and the 12 month period for assessing the same health IT.

John Travis – Cerner - SME

Yeah.

Raj Ratwani – MedStar Health - Chair

Yeah. I think that makes sense. So, any other thoughts on the two percent? Does anyone have a different thought on that? Okay. I think we can move on then. So, no real recommendations around that but keeping Sasha's recommendation on clarification of language there. And then, did we make it through all of No. 2 yesterday?

Denise Webb – Individual - Chair

Yes.

Raj Ratwani – MedStar Health - Chair

We did?

Denise Webb – Individual - Chair

Yes, we made it all the way to No. 4.

Raj Ratwani – MedStar Health - Chair

Let's jump over there.

Denise Webb – Individual - Chair

Nos. 2 and 3 were pretty straight forward.

Raj Ratwani – MedStar Health - Chair

Okay. Can we go to the next slide, please? Thank you. So, jumping to No. 4 here, the 2015 edition certification criteria and standards. You can see on the slide on the lower right the proposed criteria to be removed. Thoughts on this?

Sasha TerMaat – Epic - Member

This is Sasha. ONC gave I think three reasons that they proposed to remove these criteria. And they said that they thought that, in some cases, the criteria didn't necessarily represent the latest standards or methods that are represented in the interoperability criteria. Overall, these are not interoperability related criteria. Whereas other criteria incorporate many of these data capture elements, for example, but are more focused on the program goal of interoperability. And they say that they believe all of these features are widely adopted in electronic health records and will continue to be included in electronic health records, even if not certified. I guess, my assessment is that I would agree. These are not interoperability centric criteria. They are widely adopted in electronic health records.

And they're not going to be removed from the electronic health records, even if they aren't included in certification. So, I found ONC's presentation of reasons convincing.

Denise Webb – Individual - Chair

Yes. And also, I think because of the USCDI and interoperability and the requiring of certain data elements to be available for exchange that would indirectly necessitate that a number of these data elements have to be continued to be captured or collected in the EHR. So, I think their justification is pretty solid.

Raj Ratwani – MedStar Health - Chair

John, any thoughts from your side?

John Travis – Cerner - SME

I don't have any. I think they're reasonable. They're kind of in the realm of similar if we were talking quality measures or being, so to speak, a little bit topped out. There are other things that motivate the data collection to occur on a lot of these to support other requirements for interoperability. So, I don't feel like they're really gone. They are preserved in a manner that's meaningful.

Denise Webb – Individual - Chair

Did anyone think there was – sorry, John?

John Travis – Cerner - SME

No, I didn't have any further thoughts. Please go ahead.

Denise Webb – Individual - Chair

Did anyone think there were other areas that should be included that weren't? Nothing came to top of mind for me but I thought we should ask that.

John Travis – Cerner - SME

I can't say for what we've been through so far in some pretty deep reads that anything else struck us as though that shouldn't be retained – I'm sorry, or that should be removed of the things that carry over from the original 2015 edition.

Sasha TerMaat – Epic - Member

Are there other criteria? I guess I'm just looking at the list now that would not be as necessary? So, demographics, for example, which came to me to fall into the same type of criteria as problem list or patient list.

John Travis – Cerner - SME

Yeah. If the requirement remains in the USCDI required data classes, that's an opportunity to still –

Sasha TerMaat – Epic - Member

Demographics is criteria in A5 if I'm looking at the right row here. I might have a similar question about family health history. I assume that, at some point that will be incorporated into USCDI. It seems a little bit strange to have a data capture requirement that isn't required by CMS's programs in certification separate from what's in USCDI.

John Travis – Cerner - SME

That actually might be a principle to adopt, Sasha, or at least raise it as if we want to make a recommendation, I'd be okay with it. But that if you have the requirement for the interoperability side, including the standard for any code set or nomenclature, you, in essence, are still requiring the EHR to be able to collect that data in the form that interoperability demands. And you really don't need a separate requirement to prove that you can add, modify, do the fairly basic things that are basic EHR operations.

The other thing I'd consider not even so much as devil advocacy but to think through is one of the things that is a goal for the data capturing or rendering is to prove that there is an ability to and erase this in the EHR burden reduction report from ONC the reliability of local mapping through the reliability of mapping within the EHR to move from either vendor specific or local adoption of code sets to the normalized standards for vocabulary or code sets. And I don't know that that's something that's really very – the certification testing confirmed that you had that ability but that doesn't really do much to improve the quality of local mapping if there is a problem. That's the problem of the implementation not of the capability. So, I think you're right. I don't know that there's a ton of value in retaining a collection requirement that's also a data exchange requirement where the standards and the code sets are really also enforced.

Denise Webb – Individual - Chair

Do we want to recommend demographics and family history to also be renewed?

John Travis – Cerner - SME

I'm okay with recommending the principle of removing criteria that are already found in the interoperability criteria as a principle and then, demographics would qualify for that. I think family health history is – I don't think we'll see the form the USCDI in the future as we saw it as initially proposed. I imagine, at some point, we'll get a publication of a roadmap of the required data classes where they will simply be proposed in future rule making, and we'll see

family health history show up or something similar. Do we want to preserve it until that time comes and adopt the principle of removing data captured criteria that are repeated in required data for interoperability and then, just apply it as it comes?

Denise Webb – Individual - Chair

I think that would be an appropriate recommendation because then, ONC can take that principle and decide where additionally they should apply it before publishing the final rule.

John Travis – Cerner - SME

Yeah. And it may prevent them from proposing criteria for things that are already going to be required in the interoperability criteria for data.

Denise Webb – Individual - Chair

Yeah, I kind of like that. That makes sense to me.

Sasha TerMaat – Epic - Member

I agree. And I'm trying to capture that proposal in the deregulatory actions notes on the Google Doc. So, if folks have any suggestions on the wording or anything after I've captured, you can comment there.

Denise Webb – Individual - Chair

Thanks, Sasha.

Raj Ratwani – MedStar Health - Chair

All right. Any other thoughts on this one? Okay. Go to the next slide. No. 5, removal of certain ONC health IT certification program requirements. Does anyone know the page numbers on this one for the –

Denise Webb – Individual - Chair

Page 54 of the preamble, 54 or 55, and then, FDA is 56 and 57.

Raj Ratwani – MedStar Health - Chair

Okay. Thoughts on this one?

John Travis – Cerner - SME

I had one, and I was trying to make sure I read it correctly. There's a statement, I'm trying to digest the text quickly, about for what is being removed that the information is already available on vendor websites. And I kind of didn't fully understand the way the comment was characterized as if that was apart from the current transparency disclosure statements that are on the websites because if you remove them, where do they think they reside.

Sasha TerMaat – Epic - Member

John, I think the way this works, and it is super confusing, I agree, but vendors are required to provide cost and limitations information currently on their websites. They're also required to

make a specific attestation to their ACB that they provide this to any party. And so, ONC is saying it's stupid to provide an attestation to your ACB that you provide this if it's already required to be on your website because, obviously, it's provided. It's on the website, which can be checked by anyone. So, I think what they're proposing is the website piece would stay subject to the other provisions about removing the limitations portions but that the attestation of signing a form for the ACB that says yes, we provide this would go away. And I agree with ONC's assessment that that has minimal value.

John Travis – Cerner - SME

Yeah. So, I think the way the two work together is that only some of the information is being removed, but the transparency and disclosure requirements remain available as they are now.

Denise Webb – Individual - Chair

And it's also saying that because of the conditions of certification and information blocking provision now, there are certain limitations that vendors are not going to be permitted to have on their health IT if they limit use, exchange, and portability of any data. So, it's sort of a catch 22. I think they are saying, too, in combination with the new regulatory aspects that that's another reason that this doesn't make sense to have them attest to their ACB because they're going to have to do an attestation that they don't information block, which would mean that they don't have any of those types of limitations on their products.

John Travis – Cerner - SME

Right. And other states still stand, yeah.

Denise Webb – Individual - Chair

I thought it was a little complicated to read, but I finally figured it out. It wasn't the most straight forward.

John Travis – Cerner - SME

Yeah, that makes sense. I don't know that I have any issue with it as proposed.

Denise Webb – Individual - Chair

Carolyn, did you have anything?

Carolyn Petersen – Individual - Member

No. I agree it was not the most straight forward piece of text. But I think I concur with what you said, Denise.

Raj Ratwani – MedStar Health - Chair

Okay. Then, I think we can move on. So, going to No. 6, which is discussion around an agreement to recognize the Food and Drug Administration processes and specifically calling out some of the software precertification that the FDA announced back in 2017. I found this section a little bit difficult to understand what they were actually kind of driving towards. But

do people have thoughts on this one?

John Travis – Cerner – SME

Maybe I'm not fully getting exactly what they're trying to propose but a couple of reactions. Just taking it on the precertification process from the FDA, are they speaking of the risk framework that was part of the work of the – well, those were at least guidance developments that came out of the FDA not long ago that kind of served to identify different categories of software, the FDASIA work. Is the act being referred to here? I'm sorry if I'm being a little dense. Because if it is, it makes more sense than outright pre-market types of activities that are done for regulated medical devices that may be software because I think that's a completely different aim. And, honestly, for both of them, there's only kind of, I don't mean to sound flippant, but there's only kind of a serendipitous overlap between the FDA constructions and ONC certification. Software may happen to fall – go ahead.

Denise Webb – Individual - Chair

I think they're specifically looking at certification criteria that are in the ONC health IT certification program where there is some potential overlap or redundancy related to quality management systems criteria and the 2015 edition safety enhanced design criterion. I think what ONC is suggesting here is that if the process that a vendor goes through with the FDA recertification program that they would provide some exemptions to this criterion in the health IT certification program, which to me makes sense. And they did say here it depends on the final framework of the FDA software pre-certification because if the final recommendations don't align, then it may not be appropriate. And it seems to make sense.

Anyplace where the ONC can look at other regulatory programs that may overlap with them and take advantage of the opportunity to reduce the regulatory burden then, I'm all for that.

Raj Ratwani – MedStar Health - Chair

Yeah, I agree. Denise, it was the last part of your statement that sort of confused me a little bit because the way that I read it, and I did read it very quickly, it sort of sounded like the FDA is doing some stuff around pre-cert. And there's the Fedasia report. And we're not quite sure where they're settling. But if they settle in a place that we like, we may want to align these.

John Travis – Cerner - SME

Yeah.

Raj Ratwani – MedStar Health - Chair

And I agree with that. But the key part is we don't know exactly what that's going to look like yet. So, that's why I was just kind of wondering about the timing of this and what the actual action is here.

John Travis – Cerner - SME

Yeah, it's hard to judge a benefit to something like this yet.

Denise Webb – Individual - Chair

Yeah. They do say despite these proffered benefits, there may be reasons not to adopt such a recognition program. So, for example, stakeholders may not agree that the FDA software pre-certification program sufficiently aligns with our program. And then, there is an RFI around this. I don't think we were asked to respond to the RFI as a task force. We were just supposed to respond to this recognition as part of the deregulatory – what did you say, John?

John Travis – Cerner - SME

I said I guess it's something that is not quite ready for a proposal given the lack of knowledge here. The thing that's a little odd about it, it's kind of a prospective thing that we don't have enough information really to make it – conceptually, it sounds great. I agree. But until we really know its intersect, it's hard to react to it and say well, if it does work out that it's valuable, do it. But if it isn't, don't. That's not worth a lot of commentary until we know more to actually make a judgment about it because there's not enough known. So, it may be something to postpone and defer to future rule making when more is known.

Raj Ratwani – MedStar Health - Chair

I agree. I would have concerns committing to, and I don't know if they're asking for a commitment, but concerns about removing something like safety enhanced design without knowing exactly how the pre-certification program is going to work out and seeing data about performance of products under pre-certification because the pre-certification really puts a lot of pressure on active safety surveillance to catch any issues that could be popping up in the market place. And so, there's a whole host of other mechanisms that need to be developed to make pre-certification work. And so, the ONC would have to move in that direction as well. I think just saying we're going to recognize pre-certification and then, not also developing those other processes is problematic from a safety perspective for sure. So, I'd have a lot of concerns with that.

Denise Webb – Individual - Chair

Well, I think really all they're proposing here is that they would establish processes that would provide for a recognition program. I don't think they're actually saying what that's going to look like because they don't have enough information. I think on its face value, that's a good aspirational thing to do. But I don't think they're suggesting anything concrete beyond that. And maybe Kate can confirm this but this is how I read it.

Carolyn Petersen – Individual - Member

Yeah, that's how I read it, Denise. This is Carolyn. My sense is the recognition that FDA has announced that it's going in this other direction, and the specifics of that are still perhaps being operationalized in ways that people are trying to figure out what that means. That's not unusual with FDA guidances, actually. And it's kind of more a tribute to interagency cooperation and trying to work together to make things more seamless for users and developers and such. But I didn't read it as a promise of something particular or kind of blanket acceptance of whatever comes down the road.

Denise Webb – Individual - Chair

I'm just curious, Sasha, did you see it any differently?

Sasha TerMaat – Epic - Member

No. I guess I had a similar sort of sense of this is an intriguing idea. It's not clear how the specifics of it would work. I guess I think it merits exploration. But I didn't get a sense that there was a specific proposal of how it would be implemented here.

Denise Webb – Individual - Chair

No. It just says they would propose to develop processes to have a recognition program depending on what comes out of the FDA framework. Do we have that right, Kate?

Kate Tipping – Office of the National Coordinator – Staff Lead

Yeah. And that's part of the reason the request for information is included so nothing is set in stone yet.

Raj Ratwani – MedStar Health - Chair

I would say either no recommendation or a recommendation saying continue exploration and, importantly, seek data to show effectiveness or lack of effectiveness of the pre-cert program before making any moves on the ONC side.

Denise Webb – Individual - Chair

Well, I think we're going to have a lot of recommendations, so I'd be fine on this one just leaving it be.

Raj Ratwani – MedStar Health - Chair

Okay. What do others think?

John Travis – Cerner - SME

I agree. It's kind of a little bit of an interesting one for the very same reason not worth really even raising at this point. But we probably invested more time discussing it than it really merits. To do it, it costs nothing and does nothing for now.

Raj Ratwani – MedStar Health - Chair

Fair. Sasha, Carolyn, other thoughts from your side?

Sasha TerMaat – Epic - Member

I'm fine with no recommendation.

Carolyn Petersen – Individual - Member

Me, too.

Raj Ratwani – MedStar Health - Chair

Okay, great. Next slide. So, I think that covers all of the deregulation items.

Denise Webb – Individual - Chair

Right. And do we actually have a meeting on the schedule yet for Thursday to go over the summary of recommendations?

Kate Tipping – Office of the National Coordinator – Staff Lead

If it hasn't gone out yet, it will be going out shortly. I believe it's from 2:30 to 3:30 Eastern, I assume. Yes, I'm sorry, Eastern.

Sasha TerMaat – Epic - Member

I don't see it yet.

Denise Webb – Individual - Chair

Yeah, I don't think it's come out yet but it's going to.

Raj Ratwani – MedStar Health - Chair

So, we'll spend that meeting reviewing recommendations. And we should be set up pretty well for the initial presentation the following week.

Denise Webb – Individual - Chair

I think, in the meantime, if everyone would take a chance to review the notes in the Google Docs because that would be the source of the recommendations that are going to go into the summary that we're going to present at the HITCC. And Kate is putting that together for us.

Kate Tipping – Office of the National Coordinator – Staff Lead

Yes. And I sent folks a link to the Google Doc for the Word doc of the recommendations. Obviously, nothing is finished but I started at least where we had started discussions around real world testing and attestation. So, I'll work on getting the rest of those items in. So, if you want to take a look at that document as well and edit as you see fit.

Denise Webb – Individual - Chair

Okay. So, we welcome everyone on the task force to take a look and that would help prepare us for Thursday so we can get through it in the hour that we have scheduled. I actually think, for the ONC team and Accel that we can probably schedule that for an hour and 15 minutes. We just need to break. I have a quick debrief and then, we all have a 4:00. I know Sasha and I do and Lauren.

Raj Ratwani – MedStar Health - Chair

Okay. Can we move to public comment? Is that what's next?

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

Yeah. And I agree, Denise, we can probably set an additional 15 minutes if that works for everyone else. And so, operator, can you open the public line?

Operator

Yes. If you would like to make a public comment, please press star 1 on your telephone keypad. A confirmation tone will indicate your line is in the cue. You may press star 2 if you would like to remove your comment from the cue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys. One moment, please.

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

And do we have any comments in the cue at this time?

Operator

There are no public comments at this time.

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

Okay. Well, we'll turn it back. I know we still have about 15 minutes left if there's anything we wanted to recap. But, otherwise, I think we'll just start preparing the draft recommendations, taking what's in the Google Doc and transforming that into the slide deck to present to the full committee next week. Kate, anything else from your end?

Kate Tipping – Office of the National Coordinator – Staff Lead

No, that covers it, Lauren, thanks.

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

All right. Well, I think we got a lot accomplished over the last two meetings we've had. These back to back meetings I know have been a bit much but it helped us to get to where we are today. So, I just want to thank everyone for your time today and we will talk again on Thursday.

Denise Webb – Individual - Chair

Yeah. And thank you to all of the task force members for your commitment of time. We really appreciate it.

Carolyn Petersen – Individual - Member

Thank you for your leadership. We appreciate that.

Raj Ratwani – MedStar Health - Chair

Thanks all.

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

Thank you. Have a great day. Bye.

Denise Webb – Individual - Chair
All right. We'll dial in for debriefing.

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

[Event concluded]