U.S. Core Data for Interoperability Task Force

Transcript
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Virtual Meeting

Speakers

Name	Organization	Title
Christina Caraballo	Audacious Inquiry	Co-Chair
Terrence O'Malley	Massachusetts General Hospital	Co-Chair
Tina Esposito	Advocate Aurora Health	Member
Valerie Grey	New York eHealth Collaborative	Member
Ken Kawamoto	University of Utah Health	Member
Steven Lane	Sutter Health	Member
Leslie Lenert	Medical University of South Carolina	Member
Clem McDonald	National Library of Medicine	Member
Brett Oliver	Baptist Health	Member
Steve Ready	Norton Healthcare	Member
Sheryl Turney	Anthem Blue Cross Blue Shield	Member
Sasha TerMaat	Epic	Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Adam Wong	Office of the National Coordinator	Back up/ Support
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Operator
Thank you. All lines are now bridged.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Good afternoon, everyone. Happy Friday. Welcome to the USCDI Taskforce. Of the members, we have our two Co-Chairs, Christina Caraballo and Terry O'Malley. We also have Steven Lane, Valerie Grey, and Sasha TerMaat. Are there any other taskforce members on the phone that have joined? Okay. I will circle back as others will probably join a little bit later. Terry and Christina, I'll hand it over to you for today's agenda.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Great. Christina, do you have any opening remarks? Otherwise I'll make some.

Christina Caraballo – Audacious Inquiry – Co-Chair
Go ahead and kick us off.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Thanks again, everybody, on the phone for all the help in moving this along. This is our anti-penultimate meeting, to take off what Steven says for the ISP taskforce. So, we have one more meeting after this before we have to present on the 16th. So, today, we've got a pretty packed list of issues to go over. The first couple of slides in the deck – we'll go through the agenda pretty quickly. It's going to be a quick overview. Then we're basically going to discuss issues that were raised either at HITAC or since that meeting. Next slide, please.

So, we all kind of know what the overarching goals are. Again, it's the tension between a public process, making it easy to submit data elements, and a highly technical process for specification and maturing the data elements so they're ready for national exchange. Next slide, please.

We kind of know what we've done, but we've agreed with ONC's proposed advancement promotion model. Now, we're making tweaks to that model and to the process that we think might work for ONC. Next slide, please. So, this is just a quick rundown of the process at a very high level. I won't read it to everybody. Finally, the next slide, please.

So, this is sort of the meat of our discussion today. It's these ten or nine issues that have been raised. Some of them have been raised with some proposed additional language, which will make it easy for us to discuss and we can discuss the language. Some are broader and we're going to need some more discussion.

So, this is the list, the issues that were raised for what we do with non-advancing data elements. How are data elements prioritized and who knows what that is? Is the technical maturity assessment rigorous enough? Do we need to manage that? How do the submitters and the stewards and the interested parties provide feedback throughout the process? A question that Ken has raised is who's going to do all the standards work and testing and specifying that are needed.

And then the issues around the timeline just being too long and whether or not there's better certainty that we can provide to industry around data elements that have made it to level two and their likelihood of advancing to USCDI, harmonizing data elements that are similar when they are proposed, and then sort of a general issue of what we do with really big data classes that that have lots of data elements in them. Do we need to think about a different or special process for those?

And then let me pause here and just ask the group if there's anything else we've got to add to this list that strikes one?

Steven Lane – Sutter Health – Member
Well, I think the question about large data classes is a good one. We've been interacting with a number of folks who clearly have large data classes to propose, the whole discussion with the AMA around referral content, social determinants of health – there are a lot of data classes there. We met with the group talking about transplant. So, we really probably are talking about having large groups or large numbers of elements being brought forward together. I think it does behoove us to think about how those will be managed.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right. Thanks, Steven. Any other nominees for this list?

Steven Lane – Sutter Health – Member
Well, I guess the other thing that's come up, Terry and Christina – we've shared some emails about it, but we haven't really talked about it here – is this acknowledgement that there's a very broad space between USCDI version one as proposed and "all electronic health information" and the idea of whether this group and/or ONC should be considering some intermediate milestone or data set definition that could be referenced in rulemaking.

Perhaps in some of those situations where as much as we'd like to be able to exchange or unblock all EHI, that might not be technically feasible. I'm still kind of waiting to hear from Steve and Elise about the proposal that I forwarded them, but I think that's something we should just keep in mind in our discussions.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Great. We'll add that to the list and hopefully we'll have a chance to have everyone weigh in on it. Christina, would you like to add stuff?

Christina Caraballo – Audacious Inquiry – Co-Chair
No, I agree with Steven. We've discussed that quite a bit. I would like to add it to the list. We can move right in now. We've got a lot to get through today.

Steven Lane – Sutter Health – Member
Okay. All right. Any other comments?

Sasha TerMaat – Epic – Member
This is Sasha. One thing I know we've discussed – I don't know if we need to discuss it again because I'm not sure we're the right people to answer it – but repeatedly it's come up – clarifying the confusion around the role of USCDI? So, we've talked about its incorporation in certification means that certified products would capture these data elements.

But as we think of data elements that would go outside the realm of certification, what's the role of USCDI there? And then also, reconciling the challenge that not all data elements are equally applicable to all the domains that we might start to exchange in and how do we deal with the ambiguity of what types of systems need to support capture?

What types of systems need to support receipt and display but maybe wouldn't capture natively? Certain things might be barcoded in a surgical setting and need to be viewable in inpatient or post-acute care settings but would never be captured in the same way in a long-term care facility as they might be in the OR. That's the complexity that has come up in our conversation, but I don't know that that's fully resolved either.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay.

Steven Lane – Sutter Health – Member
I'll just echo that. I think you make a really good point, Sasha. The notion that we've identified elements or discussed elements, where we've said if you capture it, you should send it as opposed to you must capture it and send it. I think the notion of domain specific or use case specific elements that are different than things that we would purely expect everyone to do.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. We are definitely going to need next week's meeting. But great comment and good stuff. Thank you, Sasha and Steven. Okay. Let's jump in. Sasha is the author of the first four of these items, I believe. So, do we have the next slide, please? So, Sasha, do you want to take us through this?

Sasha TerMaat – Epic – Member
Yeah. So, some of this, I think, was discussed in the sort of time out of elements that haven't progressed fully through the process. When I shared our draft materials with some of my colleagues to make sure I was recruiting other stakeholder expert opinions to reflect here, they weren't clear on exactly how that was going to work and worried that if there was a buildup of material in level one or level two, it would make it harder for everyone to use, harder to find if your idea has already been submitted, harder to provide feedback on the ideas that have already been submitted, harder to provide input on, "Oh, I've been piloting this. I'd like this suggestion," or whatever those pieces are.

So, their suggestion was just to make sure that it's clear what the pruning process is. Time-based was one of the ones we had talked about previously, like after three cycles, if it hasn't progressed, we would take it out and just make sure that was clear and there, of course, don't want it to be

inappropriately removing things that should still be considered, but we want to keep the list manageable for all the stakeholders.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So, you added a bunch of bullet points that we should probably discussed around this issue. It's really two kinds of evaluation – one is time-based – I guess they're related. It's really going to be time-based because if you're not advancing in technical maturity, you're going to run the clock out on your cycles.

We talked about three cycles being adequate or a reasonable length of time to give elements to advance and if they fail to advance to the next level within three cycles, they kind of go back to the beginning. They don't disappear, but they go into a new space. We'll probably have to label that. Any other thoughts about the process? Sasha, were you concerned that wasn't specific enough? They weren't going to be kicked out of the process, but they were going to be put into a waiting room.

Sasha TerMaat – Epic – Member
I think this three cycles proposal is fine. I think my colleagues didn't see that in some of the materials I shared with them for review. Maybe we want to make sure that it's clear as part of our recommendation. I don't know if we're making a report, like the ISP taskforce or if our format is different. What's going to be the end format we come up with?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I think we're going to make a series of recommendations and we will probably have a HITAC vote on one or grouped recommendations that seem to be linked. I think it's going to be a formal process again.

Sasha TerMaat – Epic – Member
Three cycles seem reasonable to me, I guess, with the caveat that it will depend somewhat on how many classes are participating in the process. If two years into this, we realize that there are several thousand data classes lingering for years at a time and it's muddying the waters, it might be prudent to revisit and say, "Look, two cycles are sufficient to advance. We have to keep this clearer."

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay.

Clem McDonald – National Library of Medicine – Member
This is Clem. I couldn't get on before. The other challenge is that if people break the submissions into teeny little pieces, it's going to drown the system. If they said they just want device categories or they want something and could reference some source, it wouldn't be as hard to work it through, but I think it's going to be really hard if you get millions of them and they're little bitty things that have to be discussed separately.

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

It's a good point, Clem. We really have the two extremes. One is a lot of teeny little discreet data elements, millions of them, versus several really huge data sets, data classes. What does it do to the system and what does it do the vendors, to the people that have to implement?

Clem McDonald – National Library of Medicine – Member
Well, the size won't necessarily determine their difficulty, but it certainly could. So, for example, what if we didn't have things like we have now and someone said, "What if we want to add ICD 11 as an option for diagnoses?" That's conceivable. It would be relevant. Well, it's not going to be a matter of inspecting every single code. So, the bigger ones, if they're systematic and come from a source, a well-defined source, may or may not be hard. That's all.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
But they'll have to be systematic and come from a well-defined source.

Clem McDonald – National Library of Medicine – Member
Yeah. We hope a lot of them have some reference for it, where you don't have to guess what they really mean. But yeah, that's just to put it on the table. I don't know that there's any action we can take with that.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. All right. That's great. Group, any further thoughts on this? Are we okay going back and adding a little more clarity to this declaration? Then we'll put it in a new bullet for review next week.

Clem McDonald – National Library of Medicine – Member
I don't think this is easily automatable. You need some wise organization to kind of make decisions. If the flow is too fast and too big, people won't be able to keep up, including ONC, who has to review them.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right. Then the flip side is it's too slow. No one is going to be happy.

Clem McDonald – National Library of Medicine – Member
Yeah.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
We're in the middle. Okay. Let's move on with this. We will make the edits for our discussion. Can we have the next slide, please? Okay. Sasha, you're back up again.

Sasha TerMaat – Epic – Member
All right. So, again, this is a little bit – I think my colleagues and I were uncertain how many data elements were going to end up in each level. We could anticipate, given some of the examples we've talked about in the work group so far, that there could be a really large quantity of data classes or elements that are ready to go into USCDI but that we need to prioritize into an industry so that we don't overwhelm health IT developers or providers with too large of a bullous all at once.

It seems like there could be an element of a promotion pass that says if there's only a small number that need to promote, then no need for this prioritization, but then if there is at one given time a large bullous, how would we divide them up to say, "Okay, these ones first, these ones second, these ones third, etc."

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Any further thoughts or comments, folks? Then we can go through the bullets. The issue of prioritization certainly is an important one. Sasha, as you reference here, some of the elements in the USCDI/HITAC end of this process at least hint at a way of prioritizing but aren't, perhaps explicit enough.

Sasha TerMaat – Epic – Member
Yeah. We thought some of the strategic considerations, scope of applicability, the quality of the use cases and workflows in terms of their relevance to that element – all those could definitely be factors that would influence the prioritization. It wasn't totally clear to us which group would do that, if that's something that the HITAC would do or that ONC would do or how…

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
It's probably going to be one or the other of those two. Any thoughts as a group on where that can be best –

Clem McDonald – National Library of Medicine – Member
Again, you've got to be Solomon for some of these things. I think I would throw it to ONC to have it be reasonable judgement. When you write a law, you end up with the judgement. You have the judicial system decide the difficult things. We kind of have to throw that – we can't program it, I don't think.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Maybe the question is do we throw it to HITAC, or do we throw it to ONC to do the first prioritization cut?

Christina Caraballo – Audacious Inquiry – Co-Chair
So, we had in our recommendations so far thought that the HITAC would review as a first step and then make recommendations to ONC and then ONC would make the decisions. So, all the data elements that are ready, the HITAC would evaluate, make recommendations to ONC, and ONC would make the final recommendations. That's what's in our current draft of things right now.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So, which of the two choices do we have that we think would be more appropriately placed to make that prioritization decision, HITAC or ONC? I'm hearing none.

Sasha TerMaat – Epic – Member
So, I guess just thinking it through, HITAC is good when you need breadth of stakeholder representation, right? That's a quality of HITAC that ONC is not necessarily able to offer to the same

degree. So, if that is an important factor to prioritization, then I could see it being an important role for HITAC. If the prioritization process, the factors we think are important, are more quantifiable and about the readiness of the standard and its degree to which it's met the qualifying metrics, then that seems like something that ONC could do without necessarily relying on the breadth of stakeholder representation that HITAC would represent.

That would be how I would think about it. My sense is that we could come up with quantifiable metrics to prioritize. But if it's hard to do that at this point or we think the stakeholder representation is important, then that would tip me towards thinking HITAC was the place to do it.

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

I think we had a discussion a while back about whose priorities and is there a body either within or related to ONC that has the breadth of overview of the data needs to promote the quadruple aim across government, across industry, where high-value data classes could be identified and prioritized, as an example. Pregnancy status, because we now have a Zika epidemic, it's that sort of use case-specific types of prioritization.

Steven Lane – Sutter Health – Member

I personally think that HITAC is a good forum for this sort of thing. I could see this becoming kind of a standing agenda item at HITAC. Now, we're going to do our USCDI work. We are the HIT Advisory Committee after all. If they wanted to keep a taskforce alive to do that or a working group, that would be fine, but it doesn't seem like a misuse of HITAC's time and energy.

Clem McDonald – National Library of Medicine – Member

Let me take a slightly counter view. It's not a misuse, for sure. But then there's the capacity – how many hours a week can people spend on this? It seems like HITAC would be better off reviewing the process that an operational organization decided. I think it would be better off reversing it so that ONC would make some suggestions and we could change them, so we didn't have to do so much groundwork. We're not an operational unit.

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

That's an interesting way to look at it, Clem. You're saying as ONC to come up with a draft prioritization and HITAC react to that draft.

Clem McDonald – National Library of Medicine – Member

We can still get the same amount of influence control, but it wouldn't be as much total hours.

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

Okay. What do folks think of that approach? So, flipping it – instead of HITAC to ONC, do ONC to HITAC back to ONC.

Christina Caraballo – Audacious Inquiry – Co-Chair

I have a question on that. Are we talking about the prioritization model or actually reviewing the recommendations for moving forward?

Clem McDonald – National Library of Medicine – Member

I think we're talking about the actual operational recommendations, how we do it in real life. If it wasn't that, then my suggestion is not relevant.

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

It's all of those data elements that have met all the criteria for USCDI but need the final review by HITAC/ONC to be officially designated. So, it's that sort of step in the process. So, what we're asking is in that final step, what's the best way to prioritize the current candidate data element so that we, on the hand, so that we avoid overwhelming industry by having a bullous that can't be digested?

Valerie Grey – New York eHealth Collaborative – Member

Terry, this is Val. I just want to make sure I understand. By the time you get sort of ready for the USCDI, it's sort of like a funnel, right? There's a whole bunch of stuff that comes in in the beginning and it keeps getting whittled down. Wouldn't this be a relatively small set of data for us to sort of prioritize or maybe I'm misunderstanding.

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

No, that's a good point. I think no one knows. The original ONC estimates were that there would be thousands of comments submitted. There would be hundreds of data elements in level one. There might be a couple of dozen that made it to level two and of those, half are going to get through for final consideration to USCDI at any one time, rough estimates. But I don't think anyone knows how this system is going to work or what the volume is going to be.

Sasha TerMaat – Epic – Member

It might also vary over time too, right? I think right now, we're hearing a lot of interest in getting more stuff into USCDI, which might lead to a large initial bullous, which then would even out over time after we've addressed backlog, for example.

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

Good point. So, Val, does that help with where we are in the process?

Valerie Grey – New York eHealth Collaborative – Member

It does. Thank you.

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

So, what do we think? HITAC reviews an ONC list or ONC reviews a HITAC list?

Sasha TerMaat – Epic – Member

Are we voting?

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

More or less. Clem's point about HITAC workload, but with the benefit of a really broad stakeholder base – where do you want to put that broad stakeholder base, upfront or second place? Who wants to do HITAC to ONC? Any groundswell for that approach?

Clem McDonald – National Library of Medicine – Member
Again, I'd argue no because we don't have enough workers to prepare that stuff for us.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So, Clem, you're the advocate for the next one, which is ONC to HITAC for review. How about comments on ONC to HITAC as the proposed path? Are we okay with that?

Valerie Grey – New York eHealth Collaborative – Member
I think my suggestion is we're recommending a prioritization model and then ONC is executing on it. So, what you're asking is that we participate in the execution. That's what I was trying to clarify before. I don't think I would say we should participate in the execution. I see us as potentially something that's going to slow the process down.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So, your preference is – do you have a preference for the process?

Valerie Grey – New York eHealth Collaborative – Member
Yeah. My preference for the process is that we create the criteria by which the things that come in can go through the model more quickly versus being the stop gap to get those items into approved standards. That's what I hear you saying. Again, that's what I was trying to clarify. Maybe I heard you wrong, but that's what I heard you saying, that we would look at the list of elements that are looking to be promoted. I don't know if that's really the role we should have. This is a standards making organization and I think we're supposed to be recommending what the standards and sub-models should be that all of those executors should follow rather than be in the execution process itself.

Christina Caraballo – Audacious Inquiry – Co-Chair
This sounds like, I feel like, an ongoing circle because we've got the – it's going to be, I believe, published annually. So, what if ONC publishes a draft, puts it up for public comment, and then HITAC reviews that draft as well and makes recommendations?

Valerie Grey – New York eHealth Collaborative – Member
Exactly. I think that's the process we followed today and that's what we should be recommending.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Does that address people's concerns?

Sasha TerMaat – Epic – Member
Can you restate that option? Was it the same as option two, Clem's choice, or slightly different?

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

I'll leave that for Christina.

Christina Caraballo – Audacious Inquiry – Co-Chair
Yeah. So, taking into consideration Clem's concerns, it would be that ONC publishes the draft of USCDI on annual basis or the data elements that are ready and under consideration because they've made it through the whole process.

Maybe that's a whole list of everything that's ready and then puts it out for public comment and then the HITAC reviews that same document that's out for public comment and makes recommendations to give back to ONC. Then the way I was thinking about it, ONC would publish the final updated USCDI based on public comment and HITAC recommendations. That seems to follow a similar process that we do now.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
That sounds like a variant of process number two, just a little clearer.

Valerie Grey – New York eHealth Collaborative – Member
If Sheryl can sign on to that, I would agree to that.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Anyone else with an allergy to that approach?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
No, I think it makes sense.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Good. As it is written, so it shall be. Okay. Great. Next slide, please. Okay. We're all done with Sasha's really clear questions and proposed answers. This came about as a potential solution to the long-time lag between being submitted as a comment before you get to USCDI? One of the proposals was you could shorten that time if it was clear that data elements that made it to level two had a high probability of getting into USCDI. Presumably, the industry would be more willing to pick those up on spec given the fact that they're likely to go forward.

So, that's sort of the subtext. I guess a bunch of questions come up around that. Is that a realistic expectation that industry would do something that had a potential of not making it to USCDI because of data elements that might not or is it more likely to wait until everything gets to USCDI and that this approach is not going to significantly shorten cycle time. I'd be interested in the vendor community about whether that's an approach that's worth pursuing.

Sasha TerMaat – Epic – Member
Yeah. So, this is Sasha. I discussed with some coworkers and we talked about some past examples of programs where there's foreshadowing of requirements. It's a challenging thing. There's kind of a tradeoff between the certainty of foreshadowing. For example, if there are ten things and routinely nine or ten of them become required later, then it's rewarding to act based on that foreshadowing. If

there are routinely ten things and two or three of them become required later, it's not a good investment to act on that degree of foreshadowing. There are also going to be questions of sheer volume and prioritization.

If there are ten things that someone as a developer knows are required and they have only time to do ten things right now, they're probably going to focus on the ten they know are required before they would get to the foreshadowed ones. So, depending on the balance of work in the certain bucket versus the balance of work in the foreshadowed bucket, if the certain bucket is large enough, no one will get to the foreshadowed bucket regardless because you're still working on the highest countenance of certain work in that other category.

There are other factors that will, of course, influence it, such as feedback from users, the utility of that particular data element or class to the product or service being offered by the person. Obviously, many types of HIT systems include many data classes and elements that are not in USCDI today, which they've done based on user feedback and other reasons. So, those would continue to be factors as people looked at the foreshadowing piece.

So, I think if the quantity that's required are manageable and people have time to go beyond the bare minimum of the requirements into things that are coming in the future and the things coming in the future are predicted with high enough countenance over time that people can trust, that if it's in that bucket, it's really going to happen, I would wisely invest now by looking ahead, then people will do it.

In the past, a lot of times when we see foreshadowing things, I'm thinking of CMS publishes a future of quality measures under consideration list, for example, or other tools like that where they show, "Hey, here's what we're thinking about."

A lot of those are tools that people look at and monitor closely, but they don't necessarily represent the degree of countenance that everyone wants to move ahead with development because they have historically shown a degree of flux on either the eventual requirement of those items or the timing on which those end up being required that mean that people prioritize otherwise. Does that make sense?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
It makes sense to me. Any further thoughts from folks? That's a very nice summary, Sasha. Thank you. Unless someone has a strong contrary opinion, I think this one we can probably just put in the parking lot and come back to it when and if we have a better sense of the volume through the final step of USCDI is. It doesn't sound like it should be our principal or one of several strategies to shorten the cycle time. Are people okay with that?

Steven Lane – Sutter Health – Member
Terry, I didn't understand what you said. It doesn't seem what?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Based on what Sasha said, it's not clear that this is going to be a terribly effective way to shorten the cycle time, like giving industry greater confidence it's going to move forward. That's not the only issue

they're looking at. Maybe we put it in the parking lot and come back to it if and when we have a better sense of what the total volume is and at that point, maybe if the equation is right, then the foreshadowed list and the to do list are somewhat better aligned and might pick it up again. I'm just saying let's drop this. Anyone else? Okay. Let's drop it. Next slide, please.

This really goes to some of the submission process and what ONC – what are the things that ONC is going to have to do to make this process work well? I think this is one of the things that might be important to do in the process and maybe get a sense of what people think about the idea of paying attention to harmonizing data elements that are similar or seem to express similar concepts or are somehow related.

So, the pros and cons of trying to have a parsimonious list of as few data elements as we can because they are more broadly applicable versus the need for sort of subtle granularity in some of the data sets and whether a harmonization process would help. Clem had to sign off, but I have a feeling he'd be weighing in on this.

Steven Lane – Sutter Health – Member
I think this is really important. The last thing we want is a lot of close to the same thing that end up leading to duplicative parallel processing. I think that once something gets into the process, the things that are close enough or closely related would be merged together and lead to some expansion within a given domain. In that way, people who come with novel ideas or amendments, addenda to something that's already started, they don't have to start from the beginning.

They can also benefit from the work that's already been done on a data class or an element by sort of extending it a bit as opposed to starting over.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Steven, I'm trying to think of what sort of recommendations we could make to ONC about what that process might look like. Any thoughts?

Steven Lane – Sutter Health – Member
I don't know what the process would – there clearly needs to be that intake process. I think we've mentioned this before, that when something is brought forward, be it an element or a class, that it be evaluated by someone, presumably someone at ONC, to see how close it is to other things that are already in the process. I think we just need to highlight the importance of that evaluation.

Then I think there are going to be those where I think it's kind of like this but not quite like this. And I guess there's going to need to be some criteria, specified or otherwise, that would be used to say this is close enough to cram them together and try to move them through as a bundle as opposed to this is different enough to warrant a separate process.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So, in our submission process, we ask the submitter to review what's already in the public-facing –

Steven Lane – Sutter Health – Member
Right. But I don't think we can count on them to do that thoroughly. We want to ask them, for sure.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
You're suggesting that on top of that, there should be –

Steven Lane – Sutter Health – Member
There be a secondary process, yeah.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
That ONC uses to continually review the submissions and provide a grouping function.

Steven Lane – Sutter Health – Member
Right.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Or harmonization.

Steven Lane – Sutter Health – Member
Grouping/differentiating, right.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right.

Steven Lane – Sutter Health – Member
One of these things is not like the other.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
You listened to that too, huh? Thoughts on that? Does the way Steven has formulated make sense? It makes sense. Does everyone agree with it? Does anyone disagree with it or would like to change it? Okay. We're going to propose then that ONC explicitly assumes the role of grouping and differentiating data elements submitted to this process.

Christina Caraballo – Audacious Inquiry – Co-Chair
Yes. That makes sense.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
It probably is going to have to be an ongoing process. The data elements may sort of coalesce into a data class and that's likely to accrete over time. Who knows what's going to happen? It's either going to accrete or it's going to split and then two separate data classes will accrete. There's going to be an active process of grouping and differentiating data elements that probably is going to extend through level one. I would expect by the time you get to level two, you're pretty tight. So, let's explicitly call out this function, say it's going to be at least through level one, and just make it an ONC function. Okay. Great. Excellent. Next slide, please.

So, this is the bulk data, the large data sets. Steven, you already raised that in the first part of the talk of our session. So, I guess there are a couple of questions about this. So, Clem was suggesting there are big data classes that if they are from a standardized source, a reliable standardized source, that they may not be that difficult for industry to absorb.

Sasha TerMaat – Epic – Member
Can I ask a clarifying question about this?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah. I was going to ask you, Sasha.

Sasha TerMaat – Epic – Member
So, when we say large data classes, do we – I'm trying to think about this. So, preferred language is a data class, right?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah.

Sasha TerMaat – Epic – Member
The current standard – I don't remember what it's called – it has hundreds of thousands of language choices. Would we consider that because there are thousands of potential data elements a large data class? The reason I give that example is that there are many hundreds of thousands of choices of language, but yet, the values are all structurally similar, right? It's a word and a code.

And then the workflow is very standardized for what you're doing with it. Preferred language is snot varied that dramatically based on what the value that is put into the field is. So, even though there are thousands of choices or elements, I don't think of that as a large class. I just wanted to make sure I understood what a large data class was.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah. That's really important. Clem was suggesting the same thing. The size may not be the issue. The issue may be how standard it is, how unambiguous it is. There may be other criteria besides size that are more important, although size will just multiply the difficulty.

Sasha TerMaat – Epic – Member
Well, I think there are other factors too that have to do with the expectation. If the expectation is simply captured preferred language, the number of values that are being chosen from is irrelevant. If the expectation is providing educational materials in the preferred language, then the number of potential languages becomes critical to evaluating the feasibility.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So, instead of focusing on size, should we use other –

Sasha TerMaat – Epic – Member

I think really complex data elements, like thinking about medications, as one example, where a single medication might have dozens or hundreds of metadata associated with it and across the whole span of different types of medications, you have the complexity of administrations, defenses, orders, history, over the counter, all of that complexity means that medication is highly varied if you compare it to an example like preferred language.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I think that's getting more at what we're trying to say. So, from an industry standpoint, it's really the complexity of the data class rather than the size. Can we be explicit or provide more examples for what makes it complex? You already said metadata.

Sasha TerMaat – Epic – Member
Yeah. Metadata would be one factor. I think the quantity and diversity of associated use cases – so, medications are complicated partly because the use cases of ordering of administering in a hospital, dispensing in a pharmacy, determining the patient's payment, as we've been talking about recently, all those are very varied and there are a lot of them.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Got it. So, maybe we amend this to complex data elements, sight, metadata, and the quantity and diversity of associated use cases. So, then I guess the question is once we cite that, is there a special process for these or do they just sort of go into the mill and churn their way through the process.

Sasha TerMaat – Epic – Member
I would like to flag them for the prioritization that we talked about because it would be different if ONC proposes prioritizing ten really complicated data classes versus ten very simply data classes. So, part of their prioritization will probably be to choose a parsimonious amount of complicated data classes and maybe a complementary amount of simple data classes for each promotion cycle.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So, to use this, then, in the prioritization process.

Sasha TerMaat – Epic – Member
Right.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So, gang, I think Sasha gave us a great clarification.

Sasha TerMaat – Epic – Member
Hello?

Clem McDonald – National Library of Medicine – Member
I'm here.

Sasha TerMaat – Epic – Member

Did Terry get disconnected?

Christina Caraballo – Audacious Inquiry – Co-Chair
Terry, are you on? Terry might have dropped. So, I'm wondering with what you're saying, Sasha, the complementary between the harder to implement and the easier, if there aren't – I don't know how I feel about this myself – if everything that's ready gets into USCDI but then we have like different tags for how long you have to actually have it implemented in your system – maybe Adam can help me here – I can't remember the lag time once it makes it into USCDI, how much time developers have. I think it was two years.

Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead
That's what's being proposed. This is Al.

Christina Caraballo – Audacious Inquiry – Co-Chair
Thanks, Al.

Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead
That is what's being proposed once it becomes a new standard version.

Christina Caraballo – Audacious Inquiry – Co-Chair
I don't know if we want to mess with that. I hear one of the issues is that lack of certainty that something is actually going to make it into USCDI. If it's in there but it's too much to handle at once, we do incrementally give timelines to implement?

Sasha TerMaat – Epic – Member
I think if we were proposing a really – medication is already in USCDI, but let's say that was the proposal and it seemed that it would take more than the usual amount of time. It would be helpful to give a degree of certainty about its inclusion in USCDI with a longer timeframe.

I think then we'd have to be mindful in future cycles that we still had that preexisting commitment out there and didn't overload it later. Does that make sense? I'm thinking about the timing. The next year, if you put a bunch more stuff in that hit at the same deadline and it's a big thing you already committed, it would defeat the purpose.

Christina Caraballo – Audacious Inquiry – Co-Chair
What do others thing? Does this make it overcomplicated or helpful?

Steven Lane – Sutter Health – Member
Can you restate the proposal or suggestion?

Christina Caraballo – Audacious Inquiry – Co-Chair
Yeah. So, one of the issues that we've identified or that there is a major concern is that there will be a massive amount of data classes that are ready. They're ready. They've gone through the process, but

as Sasha was just saying, some of them are really complicated to implement and some of them are easier.

Steven Lane – Sutter Health – Member
From the vendor perspective.

Christina Caraballo – Audacious Inquiry – Co-Chair
From the vendor perspective.

Sasha TerMaat – Epic – Member
Or from the provider perspective.

Steven Lane – Sutter Health – Member
Okay.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Hi, gang. Sorry.

Christina Caraballo – Audacious Inquiry – Co-Chair
But there's also just that – hey, Terry.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Back again.

Christina Caraballo – Audacious Inquiry – Co-Chair
Let me back up and fill you in. We were just discussing the problem that we want – first of all, the industry wants reassurance that if they're going to start working on implementing a data class or data element that it's actually going to be in USCDI. So, that's one identified issue. Another issue is that we've got two sides, like really complex data classes to implement and then the easier ones and trying to find a balance when things are brought into USCDI so that there's not overload on implementation.

But what we were just discussing is should we potentially put the data classes that are ready despite the complexity into USCDI but then think about how long it's going to take for the industry to actually implement them. Right now, once it gets into USCDI, it's two years until it's required by regulation to be used. Do we consider tagging certain data classes as having a little bit longer of a timeline but still put them in USCDI, just increasing for the more complicated ones the commitment that is there but enabling industry to adopt it?

Steven Lane – Sutter Health – Member
It's an interesting question. When we talked to Steve about this, the idea was we push things along into USCDI and there are versions. So, presumably, it's like this annual-type process, where now, it's USCDI 3 and now, it's USCDI 4, and then the rulemaking follows behind that a year or two or whatever and says now you're required to be up to version two or version three. I think the point is that the

delta between versions can only be so big or the delta between required versions, versions that are required by rule can only be so big so that the industry can absorb the change.

So, I don't know that our job is to throttle things from getting into USCDI. I think we want that process to move along a pace and if a constituency gets excited and puts a lot of time and energy into it and moves something along, they should have the credit of getting that into USCDI. Getting into USCDI is a flag to the developers that they're going to have to develop it.

Then the question is when they are going to have to deliver it and how is that going to be rationally incorporated into everyone's development and delivery timelines. I'm thinking out loud a bit because I don't think the throttling should be in getting it into USCDI. I think the throttling should be in getting it required by rules and regs, which is not a USCDI problem so much as a rulemaking problem. I don't know if I'm making sense. I feel like I'm rambling a little, but I'm struggling with this.

Sasha TerMaat – Epic – Member
That's a fair point, Steven. I thought some of the requirement pointed straight to USCDI like TEFCA.

Steven Lane – Sutter Health – Member
I didn't get that, Sasha.

Sasha TerMaat – Epic – Member
Sorry.

Steven Lane – Sutter Health – Member
Say that again.

Sasha TerMaat – Epic – Member
So, if there is rulemaking that times the requirement of implementing USCDI, then I agree there's another step that could function to say, "Oh, this version difference, this version increment of USCDI is larger in terms of the change required and will allow an appropriate amount of time for that." I was under the impression that other structures, like the Trusted Exchange Framework, had a built-in required timeframe for USCDI updates that didn't include an additional step for evaluating their size or readjusting the timeline.

Steven Lane – Sutter Health – Member
Al, do you have a perspective on that?

Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead
So, I was going to support what you said, Steven, about the requirement. When it becomes a rule, that's when the collective burden evaluation is done formally. It's a legal requirement for us to evaluate regulatory impact for the next time. So, it's not version two, but version three when we come out with a new rule, supposedly. That's when the formal burden evaluation of a new rule comes out happens.

I've got to go back and look at the details of the dependencies between USCDI and, say, TEFCA, and the CCDS-dependent criteria. I have to go back and look at that and just be really clear on it. I don't want to say the wrong thing about when that requirement would have to be met versus you have the option of meeting the newer version, the version two or the version three before the new rule comes out. When the new rule comes out, you have to do the latest version. Does that make sense? I don't have an answer for you, but I'll get it.

Steven Lane – Sutter Health – Member
I haven't seen any of this written down. As far as I'm concerned, this was all a conversation we had with Steve. It would be nice to get in writing what ONC's intent is with regard to that move. There was a slide that had colored bars on it that tried to speak to it that said that the rules would lag behind, but by how much and by what criteria. So, I think that's what we're getting at is what are the criteria and how do we assure that what we're asking of clinicians and industry can be managed.

Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead
The part that I can – I need to get more clarification about that specific question. Maybe I should clarification on the question itself. But the standards version advancement process allows a vendor to adopt a newer version than in the last rule until such time as a new rule said now, you must use a certain version. When this proposed rule comes out, there will be some version of a version one of USCDI and vendors will have two years to update and then provide it to their customers from whatever date the finalization is.

In the interim, there's going to be version two and maybe version three and maybe version four before the new rules comes out. So, through the standards version advancement process, vendors would have the option of adopting this newer version than certified to. So, that could actually allow for a number of additional years until the next rule comes out for the vendors to update a more difficult version advancement, for example.

Steven Lane – Sutter Health – Member
But my understanding is that when that new rule comes out, we may have already published USCDI Version 4. The rule that comes out at that time may only call for Version 2 or Version 3. That was my understanding was that the rulemaking is not tied in time to the versions.

Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead
Well, as the rule is being written, a decision is made about which version to put in there.

Steven Lane – Sutter Health – Member
Right.

Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead
We're going to be looking as closest to the – if there's a version that hasn't been finalized yet, there's a theoretical possibility that you could put it into a rule – the lag time on the rule is so long, it's possible that we could initially write into the rule Version 3 and then Version 4 comes out and we either finalize rule Version 3 or change it to Version 4.

It's kind of a hypothetical about which version might go into the next rule. It's really impossible to say how we're going to write the next rule if we're going to write the next rule, how we're going to write the next rule, and what version it will use. It's really impossible to run that one down to answer that question with any clarity. There's no uncertainty about exactly how that would happen down the road for the next version.

Sasha TerMaat – Epic – Member
It's also not the only factor because I did look up the TEFCA reference. TEFCA says that TEF participants would be required to support the newest version 18 months after it's approved by the national coordinator. So, even if rulemaking controls what's expected in certification, as Al is describing, the participants in the trusted exchange framework would have a different timeline that isn't variable. Based on the way it's drafted, at least, it says 18 months period, no matter what the scope of it was.

Steven Lane – Sutter Health – Member
I didn't remember that. Thanks for pointing that out, Sasha.

Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead
To that specific question and to the previous CCDS-dependent criteria, let me get a really clear answer on that and get back with the taskforce.

Sasha TerMaat – Epic – Member
Sure. I put the reference in the TEF in the chat.

Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead
Thank you.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Hello again. Great discussion. I'm sorry to have missed you. So, I guess circling back to where we were, we were talking about some sort of prioritization process prior to data elements getting into USCDI. I think Steven, you made a great point that our goal ought to be to move things into USCDI as quickly as we can and let ONC figure out how best to mitigate the burden on industry with Al's discussion about that being an explicit part of rulemaking. I like that formulation.

I think we have on the table making the complexity of the data classes a standard for prioritization and part of our consideration about getting elements to USCDI. We can kind of leave it there, I think. Anymore thoughts or comments on this? Great discussion. Thank you, Al, for stepping forward. Can we go on to the next slide? I think we're getting to the end of our list. We can go back, I guess. Can we go to the next slide? Okay.

Steven, you asked in the – I'm trying to remember what you asked, if I can find my notes.

Steven Lane – Sutter Health – Member
What did I ask?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
You asked about the complexity of data uses.

Steven Lane – Sutter Health – Member
I think it was more like what's the process for reviewing and ingesting as a whole large data classes, large new data classes and social determinants. When social determinants are ready to go, is it going to come forward as a big bullous or is it going to drip through the process piece by piece? The conversation we had with the transplant folks; they've got a bunch of stuff they need. Is that going to come through as a medium-sized project or would some of it end up in version two and some of it end up in version three?

Christina Caraballo – Audacious Inquiry – Co-Chair
I think it's going to be naturally incremental. If you look at social determinants of health and you look at what's going on with the SCOs in HL7, they have their gravity project and they're starting with standards for food insecurity, housing, and transportation, and they're standardizing that. Those three elements within social determinants of health will probably go through the process more quickly and then we'll be able to go into USCDI as the data class social determinants of health with those three and then as other data elements become available, then they can be proposed to add to that data class.

Steven Lane – Sutter Health – Member
The class but potentially in another version.

Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead
Right. This is Al. What Christina describes is pretty likely. I'm aware of the readiness of those three, maybe four or five new – I would say they're probably going to end up being called data elements. Each domain may be considered a data element, but I don't know for sure how it's going to be structured. But the readiness of these three or four or five domains would likely be what is proposed for Version 2 of USCDI.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I have another question to the group – did we skip the slide on technical maturity? I think, Sasha, you had raised that but I'm not sure the slide made it to the deck unless I was away during that time.

Christina Caraballo – Audacious Inquiry – Co-Chair
Slide nine. Oh, there, you guys got it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So, can we talk about this and then, Lauren, go to public comment?

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Sure. We've got a few minutes.

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

Sasha, you're up. Thank you so much.

Sasha TerMaat – Epic – Member
So, my colleagues and I were looking at the proposals for technical maturity assessment. We wanted to make a few recommendations. The documentation requirements, to us, the standard of just being available seemed challenging. We thought that the documentation should be sourced from an SEO that was accredited and then also that the specification should have passed a consensus-based public balloting process. That was kind of our first recommendation.

Steven Lane – Sutter Health – Member
That's clearly a higher bar, right?

Sasha TerMaat – Epic – Member
Yes, it is a higher bar.

Steven Lane – Sutter Health – Member
It's not unreasonable, but it really brings a lot of additional lift with it.

Sasha TerMaat – Epic – Member
Our thinking was if we're proposing that something be rolled out nationwide in the Trusted Exchange Framework, potentially 18 months in certification, a year or two, then it would be reasonable that it be sourced from an accredited source and be balloted.

Steven Lane – Sutter Health – Member
I think it's reasonable. It's just a shift.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And that raises another slide that I think I missed and that was who's going to do this work, the upfront work. That may be our discussion next week. Sasha, can you go back one?

Sasha TerMaat – Epic – Member
Oh, yeah. You want me to do the other recommendations quick?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah. Go back one slide. There you go.

Sasha TerMaat – Epic – Member
That was our first one. The second one was depending on the systems or organizations and their size and representativeness of rolling out nationwide, we could picture cases where testing in two to four systems was not representative of what it would really mean for this to be deployed nationwide and more representative testing would be necessary. There are probably other cases where four systems or organizations might be very representative of the type of deployment we were expecting.

We were just worried that, again, if we only tested in two systems and they weren't representative of what it would really take to roll out nationwide, that could leave us in a pickle. And then we kind of fed that into our second one, which was around real-world pilots, just to make sure that was part of the technical maturity assessment.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Do you have some thoughts on what would – it sounds like you're saying some data classes are going to require less rigorous testing, but you somehow need a certain standard of technical maturity. Have we phrased what that standard is sufficiently?

Sasha TerMaat – Epic – Member
Well, I think for the testing bullet, I think we want to ensure that the testing is both comprehensive and representative. So, two to four might not be comprehensive enough or representative enough.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Should we make it elastic language and say number of systems sufficient to provide real world testing?

Sasha TerMaat – Epic – Member
Yeah. That might be appropriate.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Instead of two to four, which was pretty arbitrary.

Sasha TerMaat – Epic – Member
Right. And then depending on the use case, if there are more stakeholders involved, there might need to be more people involved in testing just to make sure it's representative of all the stakeholders, for example, whereas it could be flexed based on the need.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So, we'll come up with some more language. Again, we're going to get this out to you early, so you'll have more time to think about it rather than last minute. So, Lauren, should we go to public comment and then swing back? We have another slide to go through.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Absolutely. Operator, can we open the public line?

Operator
Absolutely. 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. From participants using speaker equipment, pick up your handset before pressing the star keys.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
And do we have any comments in the queue at this time?

Operator
There are no comments at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Okay, Terry, I'll let you know if we get any additional comments.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Great. Can we go back to the slide we left? I think with this, Sasha, we'll rewrite it to have it be enough to give confidence that it's being adequately tested. Can we go ahead another slide, please? This I think we can add in pretty easily. I think it's the importance of opportunities. We just have to be explicit about a process.

Then the next slide, I think, is one that was raised at HITAC. This is an important one. I think it sort of is beyond, in a sense, USCDI, but Ken and Arien both said – Ken said the best business model for this would be to sit back, do nothing, let somebody else do all the testing and when it's approved and ready for deployment, then pick it up and do it and you'll have no cost.

This is a system that really relies on the goodwill of the vendor community and the provider community working together. It raises the issue that if this is a public good that we're building interoperability, then is there a role for public support for developing the standards and supporting the testing? Let me throw that out to the group.

Steven Lane – Sutter Health – Member
I'm going to come down on the side of this is a public good and where the market does not provide, that's the role of government. More government potentially guiding the market, providing incentives, providing support, providing catalysis – is that a word?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I don't know.

Sasha TerMaat – Epic – Member
I guess to put out another perspective, I actually have more thoughts that it will go the opposite way and we'll actually have more things coming into the process and trying to be promoted than we anticipate. I don't know that this is as much of a worry, in my mind. I think there's going to be a lot of participation.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Sasha, you're right. This is merely anticipatory anxiety and we don't really know how the system is going to work. Maybe instead of this, we say something to the effect to just be aware that if priority

data items are not advancing, that there may be a role for government to provide incentives by convening other things as needed.

Sasha TerMaat – Epic – Member
Or we evaluate the process at periodic intervals, like set intervals to say we're speculating this might be a concern. Let's check in after a certain amount of time and see if this seems to actually be a concern and then discuss how to address it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah. I think that's a reasonable approach just to flag it as possible worry about it but not do anything about it.

Sasha TerMaat – Epic – Member
Yeah. Watch and say we'll take that into our evaluation of the success of the process when we do our one-year checkpoint or whatever.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Actually, you just raised another point that's not on any slide and that is should we propose an evaluation process for this or at least a framework or things we think ought to happen? Or is that beyond our scope?

Sasha TerMaat – Epic – Member
I don't know what our scope is, but generally, I do think it's helpful to periodically evaluate our work and determine if it's appropriately getting us to the outcomes we want, or it needs adjustment.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
All right. We'll add another slide on that for everyone to review as a mockup and evaluation process. That's great. Did we hit all the slides? Christina, do you have parting words of wisdom for us?

Christina Caraballo – Audacious Inquiry – Co-Chair
Thank you all. Great discussion.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah. Really, great job. So, we promise you a revised deck. I guess we can ask – would it help if we dropped this into a Google doc? Basically, dropped the bullets in so it's easier to make comments and suggestions and out of the Google doc build a deck – would that be helpful?

Steven Lane – Sutter Health – Member
I'm not sure it's as critical here as in some of our other taskforces just because so much of the interaction happens on the calls. Sasha obviously contributed a lot here and her colleagues. Maybe you'd be best to say.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
What would work best for our final review, which again, the premise to get to really early?

Sasha TerMaat – Epic – Member

I don't know that we have a preference as to format, but certainly, one thing where all of our stuff is centralized is convenient so that we could solicit input from a variety of experts.

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

Okay. We'll figure it out and something will be on a Google doc or Google slide or Google something. Great. Thank you all. This was really great work. We're almost there. Lauren, unless there's a public comment, I think we're done.

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

No. I don't see any comments. Thank you all again. Have a great weekend.

Steven Lane – Sutter Health – Member

Thank you.

Sasha TerMaat – Epic – Member

Bye.

Christina Caraballo – Audacious Inquiry – Co-Chair

Thanks, you too.