U.S. Core Data for Interoperability Task Force

Transcript
October 11, 2019
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
Seth Pazinski	Office of the National Coordinator	Designated Federal Officer
Adam Wong	Office of the National Coordinator	Back up/ Support
Al Taylor	Office of the National Coordinator	Staff Lead

Operator
Thank you. All lines are now bridged.

Seth Pazinski – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
All right. Thank you. Good afternoon and happy Friday everyone and welcome to the U.S. Core Data for Interoperability Task Force Meeting. My name is Seth Pazinski. I'll be serving as the Designated Federal Officer in place of Lauren Richie for today's task force meeting. So, I'll officially call the meeting to order and I will start with a roll call. Please state here. Christina Caraballo?

Christina Caraballo – Audacious Inquiry – Co-Chair
Here.

Seth Pazinski – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Terry O'Malley?

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

Seth Pazinski – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Tina Esposito?

Tina Esposito – Advocate Aurora Health – Member
Here.

Seth Pazinski – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Valerie Grey? Ken Kawamoto? Steven Lane?

Steven Lane – Sutter Health – Member
Here.

Seth Pazinski – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Les Lenert? Clem McDonald? Brett Oliver?

Brett Oliver – Baptist Health – Member
Here.

Seth Pazinski – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Steve Ready? Sasha TerMaat?

Sasha TerMaat – Epic – Member
Here.

Seth Pazinski – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
And Sheryl Turney. Okay, any other participants that need to announce themselves? All right. I think that completes our roll call. I'll now turn it over to Christina and Terry to begin today's agenda.

Christina Caraballo – Audacious Inquiry – Co-Chair
I think I hear Clem. So, today we are – thank you guys -- going through hopefully our final edits before we present our final recommendations to the HITAC meeting next week on Wednesday. Terry and I have gone through and made edits to this that everybody hopefully has seen them over the course of the last couple of days. But let's go ahead and get started. Are we pulling up the Google doc – Google slides?

Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead
That was the plan. This is Al. That was the plan. I'm not sure that we provided the link as someone else is driving.

Christina Caraballo – Audacious Inquiry – Co-Chair
Okay. Do we need – I can try to share my screen. Okay, I'll do it. Okay, now I can't see the meeting because I'm sharing my screen. I'm not open in two browsers. So, can you guys see my screen?

Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead
Slides are coming in.

Christina Caraballo – Audacious Inquiry – Co-Chair
Our Google slides?

Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead
Yeah. We can see them.

Christina Caraballo – Audacious Inquiry – Co-Chair
Okay, perfect. So, jumping right in. We actually set this up so that it will be our actual slides for the HITAC meeting so I will breeze through some of the stuff that we've seen multiple times. All of the comments in red throughout this presentation are going to be new things that were added over the last couple of days in the Google Doc or Google slides and we have some headings at the top of the slides that are new that are marked new or draft. So, I think that on this overarching goals, this is not stuff that is anything new that – this is stuff that we've seen multiple times. So, I'm just going to move through this. If anybody wants to interject on anything that I'm moving too quickly, feel free to interrupt me. But I want to get to kind of the meat of this. Terry, did you have any more – any opening remarks before we just dive in?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
No. Let's go.

Christina Caraballo – Audacious Inquiry – Co-Chair

Cool. Sorry, I'm going right to it. So, first thing we will discuss is the key components. I think that this is pretty much the same but just going through it really quickly. We have our four classifications at level one, level two, USCDI. The initial data elements submission to the comments section is public facing workspace is open to everyone. Subsequent and ongoing submissions for specific data elements go to the same workspace to enable and encourage the contribution of additional information as it becomes available to help advance data elements.

Promotion is based on meeting specific benchmarks. So, we are going not from an annual, but as soon as a data element is ready, it is promoted as it is ready. So, a new line item from our last HITAC call. Ongoing review by ONC to determine the appropriate classification occurs. There are frequent notifications of classification changes and opportunities for feedback. And final evaluation is done by ONC with recommendations from the HITAC. Any comments or thoughts on our key components of this process?

Steven Lane – Sutter Health – Member
Do we like the word benchmarks as opposed to milestones? Bullet four. I think milestones makes more sense.

Unknown Female Speaker
I would agree with that.

Christina Caraballo – Audacious Inquiry – Co-Chair
Terry? Is milestones okay?

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

Christina Caraballo – Audacious Inquiry – Co-Chair
I'm going to edit in real time if you all are in agreement. Okay. Anything else on this slide?

Steven Lane – Sutter Health – Member
Real time is the best time.

Christina Caraballo – Audacious Inquiry – Co-Chair
Great. So, this is a new recommendation. The task force realized that data elements that have neither advanced nor received additional submissions for an extended period of time should be removed from level one and/or level two and recommends the following process of ONC. First, to provide a warning to the submitter or sponsors indicating that a data element that have not advanced to the next level and have not received additional submissions during the expected advancement times are at risk for reassignment a stalled category. Place data elements that have neither advanced nor received additional submissions in twice the average advancement time into the stalled data element category and reintroduce the data element following submission of new information that indicates that the element is more likely to advance. This is really for anything that is stagnant.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I will take the blame or credit for the stalled category and picking a very arbitrary criteria to decide what's advancing and what's not. That means figuring out how everything else is going through the

system and then if it takes you twice as long and then you are stalled. So, happy to have any other formulation. And hearing none, then we'll keep it.

Steven Lane – Sutter Health – Member
I suggested the change in the word average because half of things would be less than the average. So –

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

Christina Caraballo – Audacious Inquiry – Co-Chair
Yeah, I like that as well.

Clem McDonald – National Library of Medicine – Member
Be careful that half will be less than the median, not necessarily the average.

Steven Lane – Sutter Health – Member
I love you, Clem.

Clem McDonald – National Library of Medicine – Member
I know. I know.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Keep them in line. Don't let them get out while you're there.

Christina Caraballo – Audacious Inquiry – Co-Chair
So, then our next topic is public submitter feedback in the promotion process. There was concern that there was not an explicit process and timeline for obtaining public and data elements submitter feedback on the readiness, applicability or prioritization of a proposed data element or data classes. So, the recommendation is to solicit public feedback quarterly to coincide with updating the status of each data element in the process; specifically seek comments on the maturity, adequacy, and adoption levels of a proposed data element and specifically seek comments on the maturity and applicability of use cases, workflows, and value proposition which may be more broadly applicable for a particular data class or element.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Christina, if I can comment in this too. This really came out of the request to make the process go more quickly and to do that, there was going to need to be more feedback. So, the choice of quarterly comments was an attempt to really speed the process up and give people more timely feedback about their submissions. It is an added workload for ONC, clearly. That was sort of the trade-off.

Christina Caraballo – Audacious Inquiry – Co-Chair
Any thoughts on this? Recommendations?

Sasha TerMaat – Epic – Member
I think it's helpful to have a clear process for soliciting feedback and incorporating it, and I like the details of what would be sought in the commentary. I don't imagine everyone will have comments on

every submitted data element each quarter. But if ONC is able to maintain that frequency, it would be nice to have the feedback incorporated in a timely fashion.

Christina Caraballo – Audacious Inquiry – Co-Chair
Thanks, Sasha. Okay. The next topic is proposal to shorten the process. There was a lot of concern at our HITAC meeting that this is really a very slow process. And how can we move it along and shorten it. So, our recommendations are as follows to address this. Promotion occurs solely based on – solely on the basis of meeting the required benchmarks, changing the milestones without a minimum required promotion cycle time. We will go through the promotion model and the milestones in a little bit. But decouple the promotion process from the standards advancement process and publish the status of all data elements in the data element promotion process quarterly in conjunction with the public comment period.

Clem McDonald – National Library of Medicine – Member
Are you worried at all about maybe overloading the whole system or at least make people aware that everything can't be absorbed if there was a flood?

Christina Caraballo – Audacious Inquiry – Co-Chair
That's come up multiple times. And that's kind of where we put in the recommendation of removing the stalled data elements. And also looking at this in one year to evaluate because we just don't know how much is going to come in. So, Clem, the comment you just made. I think there's a lot of still unknowns, but these are our attempts to try to address that concern.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And so, Clem, we added sort of an annual review process for ONC based on all the comments and including the one you just made. To really be the parking lot where we can put all of the things we really weren't not quite sure were going to happen and we were worried; put them into the annual review process just to see if they happen and, if so, address them at that point.

Clem McDonald – National Library of Medicine – Member
Okay, good approach. Thank you.

Steven Lane – Sutter Health – Member
It seems that it would make sense for them to somehow link the annual review USCDI to the annual review of ISA, that they should be in some sort of synchrony.

Clem McDonald – National Library of Medicine – Member
I support that because it's all –

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
That's a good point. So, we don't want to decouple it entirely. So, maybe we want to – so we'll rephrase the bullet – the second bullet. Something like that. After we decouple, we'll align it.

Christina Caraballo – Audacious Inquiry – Co-Chair
Okay, I'll come back to that. Anything else here? Sorry I'm hopping around. I forgot I'm sharing my slides. Great. Terry, do you want to take us through the benchmarks?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Sure. We are trying to – and what did we decide benchmarks? We wanted milestones.

Christina Caraballo – Audacious Inquiry – Co-Chair
Milestones. I'll change it as you are writing.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
There are now milestones. Just a high overview with the milestones. We sort of broke it into these four pieces. And what we expected the submitters so those are called, we call them administrative requirements, but pick another name, and then going from each level to the next level. Which is what we did before. This is just an orientation slide more than anything else. So, the next slide is what's in the administrative milestone, and it's really just some basic rules of the road for submitters, complete the form, use the ISA and accepted standards, provide the information that's needed by ONC to do leveling and re-leveling.

And then once you get feedback, respond to it. This is not earth-shaking stuff. And anyone has other things that submitters should do and I'm happy to add to the list. Okay. I didn't think this was going to be highly controversial. Okay, so we'll go into the next slide. Next slide which is how you get from the comment to level one. The first eight bullets are the same as they have always been, and it's the last bullet that has been changed a little bit. We were going around about how many settings you need to have the testing in, and we thought it was two but not four – several. So, we went back to, at Dave McCallie's suggestion, we went back to Dixie Baker standards committee report of 2012 that outlines the maturity model and sort of lifted a component from that report.

And they basically said you know when you've gotten to this level when the pieces of the technology, you're putting into place support multiple platforms, but require additional expertise. Meaning, I think in this case, that this takes additional effort, it's not something that just happens by putting all the pieces together. And I'm not sure if this is specific enough, but really love to hear everyone's thoughts about how we tie a level of maturity that's really actionable by the submitters.

Sasha TerMaat – Epic – Member
So, just as a question. Are there like three or four examples, some of which would be meeting this requirement and some of which would not? I worried that it's not specific enough that we would all have the same understanding of what that requirement meant for promotion.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, that's a good point. The standards on the next slide – I'll just read from the next slide. We'll come back – we won't leave this one. The committee suggested the following criteria or breadth of support which we got through the comments and the advancement through testing, the stability of the system and the adoption of technology on which the system is based, the support for the platform and the maturity. Those are the criteria that Dixie Baker used. But going back here. I think Sasha, your suggestion to actually give examples I think will be really helpful. So, maybe we will put examples into the submission form as well as here. And do you have any suggested drafts? Sorry to put you on the spot. But you are always – you always have something.

Sasha TerMaat – Epic – Member
The domain of social determinants of health is one that probably has elements that are in various

stages of them all I would think, right? Some social determinants are probably more mature in their definition against all these criteria, others are probably less mature in their definition against these criteria. That's one that comes to my mind that if we pick different social determinants. And then if we all had a common understanding that when we think about the readiness housing insecurity as a social determinant, and we all come to the same assessment, that would give me a high confidence in the way that the criteria are working. But if we each looked at housing insecurity as an example and then came to a different assessment of where it fell based on the same information, our criteria probably are not specific enough.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. The definition of the data element has got to be specific, widely understood/accepted. Is that a fair?

Sasha TerMaat – Epic – Member
I guess if I felt like implementing housing insecurity had core technology components that were supported on multiple platforms, but it still requires additional expertise and Christina felt differently, then that criteria is not really helping us determine if it's ready, right?

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

Sasha TerMaat – Epic – Member
We would have to be commonly understanding that phrase from Dixie Baker to make sure it works.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
For USCDI I think the key is that the data element itself is clearly defined, tied to a standard that's gone through a public balloting process and therefore has some credibility and maturity of the data standards. Does that make sense to call out that piece?

Sasha TerMaat – Epic – Member
I think that does make sense. I'm still not seeing – maybe I'm missing something, but I'm still not seeing how that would relate to either – I see how that related to the old criteria of testing a certain number of appropriate settings. I'm having trouble translating that goal of the standard has reached a sufficient level of advancement and includes this data element to the sort of core technology components metric and maybe I might not have wrapped my head around it yet. So, if it's working for other people, go for it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
The other thing is we don't have to cross out the cross-out phrase. We can go back to it. Substituting Dixie Baker's language may not be the way to go, so don't get hung up on that. Where people comfortable with the previous line that is crossed out?

Steven Lane – Sutter Health – Member
With all due respect to Dixie who's an amazing person, I think using the language that we came up with as opposed to trying to shoehorn her language in probably makes more sense.

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

Are we happy with several or more than two or two to four or?

Steven Lane – Sutter Health – Member
I think several is a good word.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Several is a good word. All right. Thank you, Steven. Other thoughts? Does that make sense to everyone?

Sasha TerMaat – Epic – Member
I think the testing is appropriate and expected and then using a word like several allows for a judgment to be applied as to the particular standard in question and what appropriate testing would be.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Good. Because that was one of the issues. Different standards and different use cases need a different level of testing, I'm not sure that two to four cut it. Are we happy with this?

Steven Lane – Sutter Health – Member
I am.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Is anyone terribly unhappy? The other question – sub question was should we continue with this as required to go from comment to level one or do we think it's something to be done when you are in level two? The breakpoint would be –

Steven Lane – Sutter Health – Member
I think connectathon testing seems like it's more moving from level one to level two than coming to level one.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I think specifically moving the red text to level one to level two but leaving the connectathon as part of comment to level one. You've got to achieve a certain community of interest that is pushing this along.

Steven Lane – Sutter Health – Member
Okay, I'm following you.

Sasha TerMaat – Epic – Member
I guess I read the blue bullet, "Pilot connectathon, testing and production use," as a lesser degree of the testing expected in the currently red bullet. So, it seems reasonable to split those between some sort of initial testing, comment to level one and then sufficient testing in applicable settings for one to two.

Steven Lane – Sutter Health – Member
I like it. You don't need that capital M in move.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, right. That was a note – leftover. Note to the author, right? Move it.

Steven Lane – Sutter Health – Member
Oh, got it. Sorry.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I had nothing to do with. That text is going to disappear. Okay. Good, so we are going to pull that to the next slide, which would be Slide 14.

Christina Caraballo – Audacious Inquiry – Co-Chair
All of a sudden, I can't edit. Here we go.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Here is the stuff about Dixie Baker. We can eliminate the first red bullet if we want to keep what we were doing before. I'm happy to do that. Because not all of those really apply to USCDI. Anyone sad if we lost the first bullet?

Steven Lane – Sutter Health – Member
Not I.

Sasha TerMaat – Epic – Member
The one thing I like about that bullet that we don't have below is stability and if a data element of USCDI is being modified every other week, I wouldn't call it stable and that's probably a reasonable factor to assess.

Steven Lane – Sutter Health – Member
I agree. That's a good word.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Do you think the stability is taken care of before when it is linked to the standards and linked to an IG and linked to – isn't it pretty well nailed down by the time it gets to a connectathon.

Steven Lane – Sutter Health – Member
I don't think so.

Sasha TerMaat – Epic – Member
That sounded quite preliminary actually. I would expect that by the time you have like an implementation guide there is a degree of stability achieved because the implementation guide often provides that stability. It defines this is what this means. It's probably covered by other criteria, I guess. But it's a word to evaluate, and so I would not mind adding it in if we wanted to emphasize.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Christina, we will figure out how to put stability in the mix to really call that out as an important criteria.

Christina Caraballo – Audacious Inquiry – Co-Chair
Should we – I like Sasha's point about the implementation guide. So, maybe it's to demonstrate stability there is an associated implementation guide or there isn't?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Will that go back to comment level one or be on the level one/level two –

Christina Caraballo – Audacious Inquiry – Co-Chair
That's what I was trying to remember, I don't think we have the implementation guide actually on level one.

Sasha TerMaat – Epic – Member
It's on the comments to level one.

Christina Caraballo – Audacious Inquiry – Co-Chair
Was it in the and though – or –

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Maybe in and –

Christina Caraballo – Audacious Inquiry – Co-Chair
Not requirement. It wasn't a requirement.

Sasha TerMaat – Epic – Member
Or is it the second class one? I don't remember. I guess reading these bullets it's like it is expected.

Christina Caraballo – Audacious Inquiry – Co-Chair
An implementation guide exists that contains the data elements.

Sasha TerMaat – Epic – Member
It might be appropriate – and I think it gets into the red text that we're looking at and this third bullet on the slide that the implementation guide is similar to or for the right use case, but yes.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So now my screen is jammed. All right, so we are going to do stability and my apologies, folks. I'm having technical difficulties.

Christina Caraballo – Audacious Inquiry – Co-Chair
Do you need me to read something to you? Can you see where we are?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, I can't see right this minute. I see where we are. But unfortunately, my WebEx doesn't want to work, and now the Google Doc wants to act up. Maybe I'll just reboot the Google Doc and keep my fingers crossed.

Christina Caraballo – Audacious Inquiry – Co-Chair
So, these – the extra language we put in from the Dixie Baker stuff that Terry so kindly went through today. What are we thinking about that in these slides? In this slide?

Sasha TerMaat – Epic – Member

I like it in the third bullet. I guess the fourth bullet seems weird to me.

Christina Caraballo – Audacious Inquiry – Co-Chair
Got it. This is the same thing that we took out – that core technology component in the last one. So, it aligns with our previous discussion. Just delete it. Any objections?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
No? Good. I'm back. We'll get rid of it. The next bullet is the use to meet the requirements of the proposed use cases. So, this is – so we used several before on the last page. Actually, I'm sorry – we pulled that from the last page to here. I was going to say, "I've seen that before." Okay. Right. So, this is where it belongs.

Sasha TerMaat – Epic – Member
Does the addition of new four bullet point where we could cut the move level from one to two because we did that? Does that make the current three irrelevant?

Steven Lane – Sutter Health – Member
I think we can shorten three by just saying proposed use cases in applicable settings. Because use cases define the setting.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, in the most – right, the most applicable slide, rather than the majority. Okay.

Steven Lane – Sutter Health – Member
I mean if there's a use case that defines the setting, that should be part of the testing, right?

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

Clem McDonald – National Library of Medicine – Member
So, this is Clem. I was worried about having a flood. These are pretty tight. So, if you have to have to all the applicable settings tested, we would not have ICD 9. Just beware.

Steven Lane – Sutter Health – Member
Well, again, I think in bullet three having the applicable settings for the use cases. So, that's not, that's open to some flexibility. And then in the current bullet 4, we say several applicable settings. So, we make sure we do what's necessary in three and make sure that it's sufficiently diverse in four.

Clem McDonald – National Library of Medicine – Member
Okay. I'm no longer worried that we are going to have too many flowing in anyways. I think it's pretty strict.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
We are trying to ease your concerns, Clem. No one is going to get through USCDI.

Clem McDonald – National Library of Medicine – Member
Thank you. You are so kind.

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

Christina Caraballo – Audacious Inquiry – Co-Chair
So, we need to combine bullets three and four probably.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes. Or at least the way Steven broke it out makes sense so we're making sure that the use cases that we are implementing for the ones that are under evaluation seems kind of straightforward.

Steven Lane – Sutter Health – Member
Put back in the word, "in" there; in applicable settings.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Good. All right. And then we've met the requirements in several settings.

Steven Lane – Sutter Health – Member
Somebody needs to wordsmith the first bullet, right? Turn that back into a complete sentence.

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

Christina Caraballo – Audacious Inquiry – Co-Chair
Those are my notes.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah. On the stability we may move it to the previous slide where we talk about IG. Something like – is part of an IG with stability of definition. Okay.

Christina Caraballo – Audacious Inquiry – Co-Chair
Okay. That's not what we are going to say. But I just wanted to make notes of that. And then we are going to take it from here. Perfect.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
In the next slide we are saying, "What does it take to get from level two to USCDI." This is really a couple of things. It's really that you demonstrated technical maturity and you have been tested at scale. So, the question is what is an acceptable level of being tested at scale? And Steven wondered how do we define most? Do we put a number on it? Do we say 80% of the market is here? It's sort of an ISA definition of adoption.

Steven Lane – Sutter Health – Member
Well, even most – most implies more than 50%. Is that really what we want. Again, I keep going back to social determinants. I mean if we waited until most of the market was doing that, what's the point of putting it in USCDI? Once you have most the market doing something, it's already happening using market forces and USCDI becomes – seems superfluous almost.

Clem McDonald – National Library of Medicine – Member
That was kind of my point on the last one. I think you're right on.

Steven Lane – Sutter Health – Member
Also remembering that USCDI gives us a two+ year window before people are forced to do it. So, my thought is that things get into USCDI before most of the market is already doing it.

Sasha TerMaat – Epic – Member
Steven, remember we talked last time we met that, that is not actually accurate. That there will be two years once it is in USCDI. We looked at the TEFCA draft which said 18 months for example. So, we do need to be cognizant of that timeline.

Steven Lane – Sutter Health – Member
Okay, but still – go ahead.

Sasha TerMaat – Epic – Member
We could cut most here because we already have a quantification that it should be sufficient to establish feasibility for the majority of anticipated users.

Steven Lane – Sutter Health – Member
That I like. Feasibility for use by the majority is different than saying it's already being used by the majority.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
But I think it's two things we want to have. Because this is really about technical maturity. So, is it sufficiently mature that you can anticipate that most of the platforms out there would be able to handle this without special effort? As opposed to are they currently handling it. I think there is a distinction to be made between the two. It's a level of technical maturity that would allow us to say this is really ready to go because we are satisfied that sufficient number of these platforms can handle it now without special effort.

Steven Lane – Sutter Health – Member
Well, is it can handle it now or have the technical foundation to be able to handle it now? Because again, I anticipate that things being moved to USCDI should trigger a wave of development and implementation, and it shouldn't be after the fact.

Christina Caraballo – Audacious Inquiry – Co-Chair
So, to that point, the way I read this is we are testing it. So, it's been tested in multiple systems as like a proof of concept, but that does not necessarily mean it's been scaled to all the systems deployments across the country. So, demonstrating that it works. We've tested the data elements and we're confident that the technical maturity is a good. That still doesn't mean it's been adopted.

Steven Lane – Sutter Health – Member
It's already been in level two for a year. The writing has been on the wall, nobody should be surprised by it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
It may not be a year. Remember we are shortening – we are speeding this up. One hopes. But your point is once you get into level two, people should not be surprised you're going to get into USCDI.

Sasha TerMaat – Epic – Member
One difference between this metric and the previous ones is that initially we had several applicable settings and here we are saying the majority of anticipated users. In some cases, those might be quite similar, but in other cases the majority of anticipated users might be much broader than several applicable settings. And so I think this is I think this is appropriate to gauge if the difference between we have done this successfully in 10 settings and we need to be able to do this successfully in 200 settings to go live with USCDI across the country, if that difference is significant, that's what should be measured with this promotion criterion, right?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, I think what's our level of – I'm blanking on the word – confidence that this data element is again sufficiently mature to be exchanged at the national level? We got to have enough sites that are able to do it, enough different platforms that are able to do it to be able to say that the majority are able to do it, it's ready to go in the majority. The minority that cannot do it, FYI, it is on its way. That's really -- the question is getting back do we need a numerical level or is it –

Sasha TerMaat – Epic – Member
I think the numerical level of feasible for the majority of anticipated users gives clarity.

Steven Lane – Sutter Health – Member
I'm comfortable with that.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
All right. Clem?

Clem McDonald – National Library of Medicine – Member
Yes, I was on mute.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Excellent. And is everyone else okay with that? Okay, great. Thank you. That's great. So, now we are in milestones, right. So, getting from level two to USCDI is a complicated process. We just got the first of two slides. This is the title national applicability. The one was technical maturity we just handled, and then the question is what are we going to use for criteria that really ought to be applied nationally? So, cost and quality might be one and a huge number of stakeholders. Those are sort of positives. So, let's focus on the first two bullets first. Trying to soften this a little bit. Steven, you said two things. Addressed should not mean solved, and we will get to that later on. But you also said is cost the right issue or sufficient because there's some things that will not really have a cost.

Steven Lane – Sutter Health – Member
Well, what I was saying is cost necessary, not sufficient. Not everything is going to impact cost. Except perhaps indirectly, one can argue that when you improve quality you lower cost. But you should not have to prove that, right? So, it could be cost, it could be quality. It could convenience. It could be access, could be any number of things. So, when you guys had cost on there as the one criterion it

concerned me.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. We tried to soften it with if applicable. But maybe we want to just enumerate the things you just went through. Such as cost, quality, access. So, basically –

Steven Lane – Sutter Health – Member
User experience. Safety.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
All right. So, let's – we will enumerate a bunch of reasons why this data element is good for the country.

Steven Lane – Sutter Health – Member
You can start with the quadruple aim, right?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right. So, maybe we can just say that. Maybe we just say provide evidence that this data element advances the tripling or quadrupling.

Christina Caraballo – Audacious Inquiry – Co-Chair
I like that. Others?

Steven Lane – Sutter Health – Member
Yeah. Enough thought has been put has been put into on over enough years that we know that is the direction we want to go.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And we don't have to add anything to that.

Clem McDonald – National Library of Medicine – Member
The only thing that I worry about, but I think it's covered in the last bullet, is that a lot of the stuff that people want are those that don't have to do it. So, if the clinician has to add 10 more variables or 20 more variables that should be at least a red flag.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah. The implementation of this is something different. But you are right, Clem. Who knows what's going to happen?

Clem McDonald – National Library of Medicine – Member
You asked bullets. Something covers it. So, I'm not too worried.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
All right. We got the first bullet better, the number of stakeholders again, Steven,
thank you. We had clinicians or providers or something in there. So, are a bunch of people going to use this? Is the data element helpful? Are a lot of people going to use it? Those are pretty straightforward, I think. And then we get – the next three bullets are really about things that might make you want to

think twice about making it a national standard. One is that somebody owns the code sets and will charge everyone to use it. And Steven, are you – so your comment about addressed does not mean solved. Is addressed sufficient presumably because if it's been addressed and found to be wanting, someone would hope that there is a response.

Steven Lane – Sutter Health – Member

Again, I did not say the word had to come out. I just wanted to – I don't know if it warrants parenthetical addressed not necessarily solved. We're talking about going to USCDI – I guess I like it. If it's going to USCDI, they really have to have pretty well solved. So, maybe it's okay. All known restrictions potentially limiting the use. So again, does addressing licensing and fees mean there are no licensing and fees? This came up in ISPTF of course, all the discussion about using ICD 10. Have those issues been addressed even though people currently have to pay to use ICD 10?

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

I guess we are saying ONC has to figure that one out.

Steven Lane – Sutter Health – Member

Maybe addressed is fine. Maybe I'm being overly sensitive.

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

Okay. And then finally the overall burden to implement. So, these are the these are the hurdles that ONC and HITAC are going to put on the data element. Having made it through all the other hurdles, this is the last one – last ones. Okay? Thank you all. This is great. Are we okay with that? Hearing nothing more, we'll move on to 17 which is – Sasha, I think this is – Sasha and Clem. This is all flowing together. This is trying to summarize the comments that said – I think it was Sasha. That it's not so much the size – and Clem's comments as long as it's well-structured and based on sets of standards. It's the multiple complex use cases. I'll ask Sasha and Clem. Does this sort of address your core concerns?

Clem McDonald – National Library of Medicine – Member

I'm not sure. I guess the goal – is this intended to be a restriction or to open the gates. I think it's a pretty high restriction. Let me rephrase it – if the burden of implementation is really important, but I don't know that multiple complex use cases add to that. If humans have to enter, it's going to be a burden. If they can pull from a machine, it will not be such a burden.

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

I think Sasha – I think your point was more around implementation, around multiple complex use cases for a shared data set. Is that –

Sasha TerMaat – Epic – Member

I think just for context we were calling this large data classes. And or bulk data classes. And I was struggling with that because there are simplistic but extremely large classes of data or at least large classes. I was using preferred language as an example. And if there are 20 choices for preferred language or 20,000 choices for preferred language that actually it does not change the complexity overly much, it does somewhat because you'd probably want to have some guidance to get through all 20,000 choices. But that's different than if there are 20 ways in which the information is used versus 200 ways in which the information is used even if the set of information is only 20 things.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Because the information is more nuanced or more complex itself?

Sasha TerMaat – Epic – Member
Or because it has a larger proportion of metadata around it or different interactions and actions that are taken on it. I think I use medications as an example. So, within medications even you have of course a lot of metadata. But then also you have orders, you have prescriptions, you have administrations, you have dispense records, you have pharmacy receipts. And all the different things that the ISP task force has been talking about and that's a very complicated data class, much more complicated than preferred language if you even consider preferred language a data class. It might just be an element.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Great. So, I think the point of this was in considering the burdens of implementation just adding this to a criteria because this has not been previously addressed. I think that's the point. It's a small point, but is this important for the implementers, the vendors, to have a note that this may add to their burden of implementation?

Sasha TerMaat – Epic – Member
I would remove the large data classes language because that is confusing to me. But I do think it's important to note that supporting multiple complex use cases is more of a challenge to implementers.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
All right. The amendment then is just to address complex use cases rather than size of data and just remove everything that has to do with –

Sasha TerMaat – Epic – Member
You could maybe just copy the sentence that says supporting multiple use cases may present more significant challenges to implementers and put it as a sub bullet on the previous slide where they're estimating the burden to implement.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. I like that solution.

Sasha TerMaat – Epic – Member
Do you want me to do that in the doc while we move on?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Sure. That's great. Wonderful. Thank you. Anyone else can make any changes they want. Okay. We are getting there. Then the issue of harmonization. And it was raised – I think Steven you said it's an important issue to address. And I must admit Christina and I struggled with this a bit. I don't know if we framed it the right way, but I think you like parsimony on the one hand, but you need granularity on the other and sometimes the two cannot be reconciled or harmonized? So –

Clem McDonald – National Library of Medicine – Member
The problem is no one wants to give up their own way of saying it. And I think it's going to defeat standards. And it's the opposite and harmonization really hardly ever works. So, you really want to

say it's important to agree on one.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
How about the last bullet –

Clem McDonald – National Library of Medicine – Member
You can't say that.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Clem, the last bullet here. Let ONC decide whether data classes need to be collapsed or new ones born out of –

Clem McDonald – National Library of Medicine – Member
I think that would be good. The way it is written now it's a little vague – reconfigure. What you just said they should come to an agreement and reduce the number for a given purpose or for a given field is how I would say it. There's ways to do it – if you have a question you can have five answers and you can get different information by the set of answers. So, it's complicated.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Do you think removing – I'm just trying to clean up this slide. If we remove the top paragraph and left the last three bullets with a rephrasing of the third – taking out reconfigure. Just saying whether or not we need groupings or ungrouping of data elements. That was one question and actually this last bullet has two pieces.

Clem McDonald – National Library of Medicine – Member
Yeah, I'm not sure that grouping or ungrouping gets the point you're trying to make – get agreement on the one approach or not. That's the grouping or ungrouping.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So, phrase it differently – so, chief consensus.

Clem McDonald – National Library of Medicine – Member
What it should be when there are multiple proposals similar or set up. I know Steve often has a good balanced view of things like this. He's not speaking now. I'm not sure.

Steven Lane – Sutter Health – Member
Yeah, I think that captures it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And perhaps that's enough. You **[inaudible] [00:59:00]** and you consolidate it, or you don't –

Clem McDonald – National Library of Medicine – Member
Okay. I can go with that.

Christina Caraballo – Audacious Inquiry – Co-Chair
So, we are taking out this whole top part?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Take out the top part and take out the red bullets. Take out the red ones. Much nicer slide, okay.

Clem McDonald – National Library of Medicine – Member
It's clean.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
It is clean. All right. So, hopefully people know what we mean. Okay. And then the last slide I'm going to do this is an easy one. Just delete the slide. It does not have anything on it that's not on the other slide. All right, Christina. This is you. Final review.

Christina Caraballo – Audacious Inquiry – Co-Chair
Thank you, guys. Now we have our recommendations for the final review of the data elements. We talked about process for the final review. And I'm going to edit in real time at the same time. So, meeting all the milestones for advancement. So, here are our recommendations – dark circle. Review data elements for the technical maturity industry, readiness, and alignment with identified national priorities and barriers to implementation, adoption, and use.

Steven Lane – Sutter Health – Member
Christina. I'd separate out readiness and alignment as two different sub bullets. Those are pretty different.

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

Christina Caraballo – Audacious Inquiry – Co-Chair
Terry and I are editing together. Okay, I'll let you edit then. Thank you, Steven. So, our process here is that the ONC would provide HITAC with proposed draft of the data elements that meet the criteria for promotion into USCDI based upon the things under review. We can delete that part, sorry. And then HITAC would provide ONC with recommendations regarding the proposed draft and ONC publishes any final decisions taking into consideration for public comments and HITAC recommendations. So, it becomes a cycle. ONC provides -- does this make sense? Because I'm reading and things are changing at the same time, so sorry about that.

Steven Lane – Sutter Health – Member
It's been that kind of day, Christina.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
We're trying to make it as confusing as possible.

Christina Caraballo – Audacious Inquiry – Co-Chair
It really has.

Steven Lane – Sutter Health – Member
Looking up at that top section. Not that it necessarily matters, but alignment with priorities does that come first, last? Does not feel like it comes in the middle.

Christina Caraballo – Audacious Inquiry – Co-Chair
These aren't really ordered I don't think.

Steven Lane – Sutter Health – Member
No, no but –

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Maybe put industry readiness after barriers to implement. Maybe put alignment with priorities number two.

Steven Lane – Sutter Health – Member
Again, it's a little separate. The others seem to fall into the chronology a little bit. I mean the industry cannot be ready if it's not technically mature. Looking at barriers comes after technical maturity. So, I think that's – I would tend to do technical barriers industry alignment. But again, I don't know that it matters much.

Christina Caraballo – Audacious Inquiry – Co-Chair
Well, that makes sense. Because then you've got the more technical piece and then the industry pieces.

Steven Lane – Sutter Health – Member
It's just that I don't think ONC is going to be evaluating alignment early on in the process. That's fine too.

Christina Caraballo – Audacious Inquiry – Co-Chair
I was just looking because it says technical maturity and national priority are our two main buckets to get into USCDI. So, just order – facility.

Steven Lane – Sutter Health – Member
And barriers too. I like that. Leave it as it is. I'm happy with that.

Christina Caraballo – Audacious Inquiry – Co-Chair
Cool. Are we okay with this review process?

Clem McDonald – National Library of Medicine – Member
We got to be. Our clock is running low.

Christina Caraballo – Audacious Inquiry – Co-Chair
We have a proposal for an actual annual review of the promotion model. But there were concerns raised and this was – Sasha brought this to our attention that there's a lot of uncertainty around the process now. And we really need to reevaluate and make necessary adjustments. So, to address this concern, we have the following recommendations. We are recommending that ONC conduct an annual review of the promotion model and report the results with request for public comments.

And specific issues include but are not limited to the following – so, volume of submissions, advancement by level and failures to advance, time to advance to the next life level, aggregate time from submission to USCDI harmonization of the data elements, high priority data elements found to be

missing, high priority data element submitting, volume submission and advancement by level and failures to advance and the need to prioritize promotion of qualified data elements to USCDI versus excess volume. Any thoughts on this? Comments? Additions?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I'd rephrase the last bullet. I don't understand what versus excessive volume means.

Christina Caraballo – Audacious Inquiry – Co-Chair
Is this – and I was thinking the same thing as I was reading it. Is it the complexity? So, the slide we were just editing a few back?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
It's in the face of high-volume the need to prioritize promotion. I think high volume leads to the need for prioritization or may lead to.

Sasha TerMaat – Epic – Member
Right. We didn't want to accidentally promote a billion things at once.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right. That was Clem's challenge to the system.

Christina Caraballo – Audacious Inquiry – Co-Chair
Okay. So, how do you want to –

Clem McDonald – National Library of Medicine – Member
Well stated.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
In the event of instead of versus. So, in the event of high volume.

Christina Caraballo – Audacious Inquiry – Co-Chair
Okay. That's what we are looking for. Are we ready to move on to the next slide or any other thoughts or comments here? Okay. Pretty straightforward. The annual review – and if we have a better title for this, I think I sat on this title for a while and then moved on. Who will do that front work? But that's what we got. Start being creative.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right. That's why it's still a draft, right? So, I think the issue is if we need a prioritization step, how is that prioritization going to be done? So, we call out the need for prioritization in the previous slide or potential needs. So, this slide, I took this as meaning okay, if you need to prioritize, how are you going to do it? Do we provide ONC with guidance of what things might be important in prioritization or should we just leave that to ONC to figure it out if they need a prioritization process?

Sasha TerMaat – Epic – Member
Wait, Terry. Are you talking about Slide 21 or the ambiguous prioritization Slide 22?

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

Oh, I'm on 22. I'm sorry. I may be ahead of myself.

Sasha TerMaat – Epic – Member
Okay. I was like I'm not seeing the connection. Okay, thanks.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
This is a concern that Ken raised of the business model is let somebody else do the work and adopt it when it's all done. It's a lot lower cost. So, this is essentially asking ONC to on their annual review see if indeed that's the case. And if so, figure out a way to address it. That okay? It's pretty vanilla. Hearing none. Thank you, Sasha. Now I am on Slide 22. I guess the question I was asking on this slide again, if there needs to be a prioritization step, does the task force need to suggest what that might look like or should we just eliminate the slide and –

Steven Lane – Sutter Health – Member
No, I like it. I think we should keep it.

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

Steven Lane – Sutter Health – Member
And I wouldn't say – in that first bullet, rather than large maybe even say excessively large or –

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Oops. I'm sorry. I think we might be on different slides again.

Steven Lane – Sutter Health – Member
No, no.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Which slide are you?

Steven Lane – Sutter Health – Member
Yeah, the one you are showing. Yeah, that word right there. Large. I mean large is – I don't think it's sufficiently clear. And there may be a large number to go through simultaneously, but they might all be fine. Maybe the gravity people have done all their homework and there's a big number, but boom, they can go all go – but it's like if there are too many. If ONC judges that there are just more than is appropriate, so excessively large might be the way to do it.

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

Steven Lane – Sutter Health – Member
Too many. There you go. It is relative to the capacity of the industry.

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

Extent of applicability. That means how widely applicable is the data. So, it's not the extent of applicability. Is everyone okay with the extent of applicability? Seems a little tortured to me. All right. Are we happy?

Steven Lane – Sutter Health – Member
Then you have to get rid of the – perfect, okay. I hate bulleted lists. Do you
capitalize, do they get punctuation at the end. Oh, my god.

Christina Caraballo – Audacious Inquiry – Co-Chair
Okay, next slide. Moving?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I think it's ready to be done. Is it you or me or somebody? This is another one as part of the annual review. And what Christina and I will do is we will put these in all the slides that are related to the annual review process and group them together in a way and an order that seems to make sense to us. But just to let you know again these are parking lots for concerns that we raised in our discussions and that the HITAC raised for which we have no answer. So, we are just saying review it and address it appropriately.

Steven Lane – Sutter Health – Member
That seems fine.

Christina Caraballo – Audacious Inquiry – Co-Chair
And this is a teaser because we are not done yet. We wanted to – one of our charges was the actual feedback on the data elements submission info. So, this is the form that we have all seen multiple times. But it came back, and we want to add it to our recommendations, so you got it up with this section. And if we want to go through it, what time do we have to go to public comments? We are good. Okay.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Next couple minutes.

Christina Caraballo – Audacious Inquiry – Co-Chair
Yeah. Sometime.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
The submission form we will revise in accordance with our discussion today. We will make it look the same and match it to the detail of the promotion model.

Christina Caraballo – Audacious Inquiry – Co-Chair
So, I don't know if we need to go through this. We probably need to, but we kind of realized that the submission form information has gotten lost as you're doing the discussion, and we needed to pull it back in. I'm looking to see – I don't think we had any red sections. Did we want to go through this, Terry? I guess we have time.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah. I think it may change a little bit based on our discussions today, so I don't know.

Christina Caraballo – Audacious Inquiry – Co-Chair
Why don't we work on it and then I think everything else will look like mostly what we went through and discussed. But I will have everyone give special attention to the submission form once we revise it. Via email. Sound good?

Steven Lane – Sutter Health – Member
Sounds awesome.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Or the alternative, you can spend the next 11 minutes going over the submission form. So, that's the choice. Seth, can we cut to public comments and –

Seth Pazinski – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Yeah. Why don't we do the public comment and we'll see if there's any time left after that. Can we open the line for public comments please?

Operator
If you'd 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'd like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star key. There seems to be no comments at this time.

Seth Pazinski – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Okay, thank you. That will conclude our public comment for this call. Christina and Terry, do you want to go back to the forum or any closing remarks?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
How about some closing remarks? Thank you all for all of the work you have done over the last two years on this. It has been a pleasure learning from all some very smart people, and it's been a delight, and both of us really appreciate all the hard work you guys have put in and we will see it how flies with HITAC.

Steven Lane – Sutter Health – Member
Well, can we throwback a thank you to Christina and Terry. You guys have done a fabulous job steering this ship, making it both fun and productive. And I hope we all have – or some of us at least, have another turn at USCDI round 3 because there's clearly more work to be done. But you have done a great job to date.

Clem McDonald – National Library of Medicine – Member
I'd like to second that and emphasize that Steve's comments are especially meaningful because he's carried the labor – one of the carriers of the labor on another team which is pretty heavy.

Steven Lane – Sutter Health – Member

This has been a great group effort.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And Steven, we call out everyone. But Steven has really been the associate cochair who's probably done more editing than Christina or I together. So, really appreciate it.

Clem McDonald – National Library of Medicine – Member
He's a **[inaudible] [01:19:59]**.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah. I think we'll just set up task forces with Steven, and then we'll all call in from time to time.

Steven Lane – Sutter Health – Member
It's interesting to see what's coming next. I mean these two taskforces are both finishing their work and presenting them next week. And there is the annual report which needs to keep on rolling, but I wonder if this means we are ready for the final rule.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Let's have a taskforce about the final rule.

Steven Lane – Sutter Health – Member
I suspect we might, right?

Seth Pazinski – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
All right. One last reminder for the public. The full HITAC – the next full HITAC meeting is going to be on Wednesday, October 16th for the public as well. All the materials as a reminder are all available on the HITAC calendar on healthit.gov and any last remarks before we adjourn for the day? Thank you everyone, and I look forward to the meeting next week and we can adjourn for the day.

Christina Caraballo – Audacious Inquiry – Co-Chair
Thanks, everyone. Have a great weekend.