



Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) U.S. CORE DATA FOR INTEROPERABILITY TASK FORCE 2021 MEETING

May 11, 2021, 10:30 a.m. – 12:00 p.m. ET

VIRTUAL



Speakers

Name	Organization	Role
Leslie Kelly Hall	Engaging Patient Strategy	Co-Chair
Steven Lane	Sutter Health	Co-Chair
Ricky Bloomfield	Apple	Member
Hans Buitendijk	Cerner	Member
Grace Cordovano	Enlightening Results	Member
Jim Jirjis	HCA Healthcare	Member
Ken Kawamoto	University of Utah Health	Member
John Kilbourne	Department of Veterans Health Affairs	Member
Leslie Lenert	Medical University of South Carolina	Member
Clement McDonald	National Library of Medicine	Member
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Member
Brett Oliver	Baptist Health	Member
Mark Savage	Savage Consulting	Member
Michelle Schreiber	Centers for Medicare and Medicaid Services	Member
Abby Sears	OCHIN	Member
Sasha TerMaat	Epic	Member
Andrew Truscott	Accenture	Member
Sheryl Turney	Anthem, Inc.	Member
Daniel Vreeman	RTI International	Member
Denise Webb	Indiana Hemophilia and Thrombosis Center	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Al Taylor	Office of the National Coordinator for Health Information Technology	Staff Lead
Michael L. Lipinski	Office of the National Coordinator for Health Information Technology	Presenter





Call to Order/Roll Call (00:00:00)

Operator

All lines are now bridged.

Mike Berry

Thank you very much, and good morning, everybody, and welcome to the USCDI Task Force. We appreciate you joining us today. I am Mike Berry with ONC, and I would like to open up today's meeting with roll call. I will start with our co-chairs. Steven Lane?

Steven Lane

Good morning.

Michael Berry

Leslie Kelly Hall?

Leslie Kelly Hall

Hey, everybody.

Michael Berry

Ricky Bloomfield?

Ricky Bloomfield

Good morning.

Michael Berry

Hans Buitendijk? Grace Cordovano?

Grace Cordovano

Good morning.

Michael Berry

Jim Jirjis? Ken Kawamoto?

Ken Kawamoto

Morning.

Michael Berry

John Kilbourne?

John Kilbourne

Good morning.

Michael Berry

Leslie Lenert? Clem McDonald? Aaron Miri?





Aaron Miri

Good morning.

Michael Berry

Brett Oliver?

Brett Oliver

Good morning.

Michael Berry

Mark Savage?

Mark Savage

Good morning.

Michael Berry

Michelle Schreiber?

Michelle Schreiber

Good morning.

Michael Berry

Abby Sears?

Abby Sears

Good morning.

Michael Berry

Sasha TerMaat?

Sasha TerMaat

Good morning.

Michael Berry

Andy Truscott? Sheryl Turney?

Sheryl Turney

Good morning.

Michael Berry

Dan Vreeman?

Daniel Vreeman

Good morning.





Michael Berry

And, Denise Webb? Great, thank you, everybody, and I will now turn it over to our co-chairs, Steven and Leslie.

Past Meeting Notes (00:01:37)

Steven Lane

Thank you so much, Mike, and thank you, everyone, for your attention this morning. This morning, we can tell you that all of our past meeting notes are now posted to the web. We even got last week's in in time before today's meeting, so we are finally on a roll now that we are going to be finishing up our work, but we are going to have some ONC folks, specifically Mike Lipinski, here from the team to talk to us a little bit about the policy behind our work and answer some key questions that especially Mark and others raised last week. We will then come back to our work on Tasks 2B and C.

I am guessing we are not going to get all the way through our work today given that we have a chance to talk to Mike and others, so I am guessing we are going to end up needing one more meeting to finish up our recommendations on 2B and C before we are going to be able to prep those for presentation to USCDI. We will do our public comment as usual five minutes before the end and wrap it up there. So, with that, let's go on to Slide 4. Mike, I am not sure everybody here knows you, so maybe you can just introduce yourself a little bit and your role here on the team at ONC, and then go through your slides, and then we will do some Q&A.

Michael L. Lipinski

Okay. Can everyone hear me clearly?

Steven Lane

Yes.

ONC Office of Policy Brief on USCDI and EHI (00:03:07)

Michael L. Lipinski

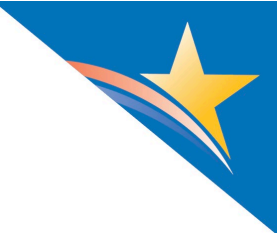
Okay. So, I am Michael Lipinski, attorney by trade, I guess. I have been with ONC since 2009, since the passage of the Recovery Act and the HITAC, and I have been working on regulatory and policy matters with ONC since that time. Now, I am the Director of the Regulatory and Policy Affairs Division, as you see on your screen, which is one of three divisions within the Office of Policy, and we have three branches that focus on regulation, focus on info blocking, particularly book guidance, and any compliance issues under the program in coordination with OIG, and then, another branch that focuses on settled policies and working with our stakeholders, primarily CMS, and leveraging the use of health IT. So, today, I am going to focus on talking to you about the relationship with USCDI and EHI under information blocking. Thanks for having me.

Steven Lane

Great. Any questions for Mike before he jumps in? All right, go ahead, then.

Michael L. Lipinski





Okay. So, on the screen now, you see the definition of information blocking that is in 45 Part 171.103. The key piece is what you see highlighted, which is in red font. What we did is considering all the comments that we received on the rule, which were over 2,000 submissions, and concerns both about the proposed EHI definition itself and the marketing actors that were covered under the rule in terms of compliance and understanding the rule. We took a few steps. I am not going to talk about the content and manner exception today, but there is some relationship there in terms of giving, for lack of a better term, a glide path for stakeholders to comply with the regulation.

So, the other thing we did, though, is what we are going to talk about, which is for that period of time that you see, since April 5th through October 6th, which is about 18 months exactly, we limited the data that had to be exchanged for purposes of compliance. The easiest way for us to do that was to identify a set of data that the market or actors were familiar with, and granted, not all are familiar with the USCDI because of how broad the definition of “actor” is, particularly the “healthcare provider” definition. So, you are talking labs, post-acute care, and skilled nursing facilities, which probably have not used certified health IT or have any reason to pay attention to some of this regarding standardization of data.

But anyhow, we thought it was the obvious set of data based on the proposed rule and what a majority of stakeholders were familiar with, so that is why we used USCDI as our basis, but there is a key part. We have issued a few FAQs on it, and I think folks who are not as close to this missed it, which is understandable. It is just the data that is represented by the USCDI, so it has nothing to do with the standardization of the data. It does not even... If it is EHI and you have that data, it does not have to be in the format identified by the USCDI standard, or it can be in a different standard. A really obvious one always is “problem.” Sometimes, it can be coded in the ICD-10, for example, compared to SNOMED CT, and that is fine. It still meets the definition and needs to be made available for any legally permissible access exchange or use.

So, I want to stop there, because I think that is the first key part, before we talk about the broader definition of EHI, so to speak. I think one other thing we talked about in the rule was that this is the definition of EHI at this time, as I think we said, and we can talk about the designated records set too, but there are certain data that we did not focus on. We obviously took comment on pricing information, and we did not specifically include that. However, if it is in the designated record set, once we get to October 6th, then that will be data that will have to be made available. I will stop there before we talk, though it is only one more slide, so we can go through the broader definition. Maybe that would help from context, and then we can talk, if that makes sense. So, let’s just move to the next slide, then.

So, here is the actual full definition of EHI that we codified in regulation, which is in 45 CFR 171.102, and again, based on comments that we received, this is alignment for a lot of stakeholders who are familiar with EHI and their concerns about having to have two different sets of data that they would have to keep and differentiate between for clients with two different rules, so, hearing that comment, we focused on essentially EPHI to the extent that it would be included in the designated record set, and obviously, there is the definition of the designated record set, and there is guidance on OCR’s website about the designated record set.

The key pieces are that it is used, essentially, to make decisions about individuals, but there are also other data that are specifically identified, like enrollment, payment, medical records, and billing, and there is a





definition of what a record is. I do not want to get too deep into that, but we can get there if we want to, but because we get a lot of questions about notes and we continue to issue guidance about the eight notes that are identified in the USCDI, the key piece to keep in mind from a context and guardrail perspective is that it is used to make decisions about individuals with notes and needs to be part of a designated record set, and therefore will be EHI. Okay, I think I have said what I need to. I think it will be formed now by your questions, so we can go there.

Steven Lane

Thank you so much, Mike. I really appreciate your making the time to join us and go through this. I actually know that our questions go off in a slightly different direction. The one thing that has really come up here is the whole question of the role of USCDI future versions with regard to information blocking, and I think it has been clear, as AI, who is with us, has reiterated, that as we make the transition next year in 2022 to the requirement to support the access, exchange, and use of all EHI that USCDI Version 1 fades into the background with regard to information blocking, and as far as we have heard, there are no specific plans for information blocking in particular to point to any future versions of USCDI.

But, the thought has been raised and we have discussed a couple times here that the industry really has yet to fully embrace any specificity around how we are going to provide access to exchange and use of all EHI. What are the technical standards? What is the format? And, of course, as you intimated, a clear definition of what belongs in the designated record set or not is going to be part of that determination, and we are really talking about less than two years away where providers are going to be held to this, and yet, the vendors are not required to have EHI export capability until the end of 2023, so there is this long period where providers are held to something that is not well defined, vendors are not yet required to support that, and I think there is some confusion.

So, one thought that has been suggested is that USCDI could provide a bit of a bridge to its future versions by at least defining those vital few data elements that are really important to the most critical use cases, and by providing clearer definitions of the technical standards and clearer requirements for their use and exchange, that could help alleviate some of this confusion and potential pain related to a lack of standardization for all EHIs, and I just wanted to open that to you for your perspective on that. Do you see value in a group like ours and HITAC making specific recommendations related to future USCDI versions with the thought that that will help to make that transition to all-EHI?

Michael L. Lipinski

A couple thoughts. I always try to talk about... Info blocking is kind of like the umbrella over all the providers and, obviously, other actors, not just providers. There are developers that have certified health IT and health information networks/exchanges. I see the certification program, particularly USCDI, which is required under the certification program, as a way to get more data interoperable and out of systems, so that is one point. The other point is that I think USCDI has a lot of value. It is a standard that has been adopted by the Secretary under Section 3004 of the Public Health Service Act, and there are other provisions that point to use of standards under 3004, such as the two HITAC provisions, 13.111 and 13.112.

So, I think it will always have value in regards to standardizing and identifying data that is important for exchange and for access to be made available. I just do not think it is ever going to be a one-to-one correlation with information blocking. Again, a lot of that has to do with how broad the definition of





“healthcare provider” is. There are so many providers that are covered that are neither incentivized to adopt certain technology that would even be able to use the USCDI, for example, or process it, so to speak, in layman’s terms, and I am not sure that is going to change any time in the near future. Like I said, just think of most of the long-term, post-acute care, as well as some of the behavioral health facilities that are covered. There are even certain ones, like ambulatory surgical centers, which are covered, but also have various exceptions under the promoting interoperability program.

So, I am not sure how you... Again, there is a lot of value, and we as an agency see a lot of value in USCDI, and we think other agencies do as well, particularly within the department, so identifying the right data elements that should be in there and standardizing the data elements that are going to have extreme value in the market in terms of making more data easily accessible for exchange and use. I just would not say it’s a one-to-one with information blocking. I think it is definitely going to help certain entities make that data available that are covered under information blocking, and obviously, that content and manner exception I mentioned earlier shows our policy focus.

We want to let the market decide how they want to exchange, which could be in a proprietary way if they agree with the actor and whoever is requesting the data, but if they do not, you can see in that exception that our focus is trying to make that data available for the use of certified health IT as agreed upon by the requester, if not in a standardized way, and ultimately, still try to get the data up in a machine-readable format with a way to interpret the data, which is, again, agreed upon with the requester. So, obviously, our policy is to use standardized approaches to exchange of data, both in the program as an agency and undertones within the information-blocking regulation, but I would not say there is any type of one-to-one correlation between USCDI and particularly the EHI definition other than, again, what I said in the outset. It would be the easiest identifiable term or set of data that we could use from a limiting perspective in this first 18 months.

Steven Lane

Great. I do not see any hands up, so I am going to keep throwing some questions your way. Oh, there is Hans, okay. Sorry, Hans, go ahead.

Hans Buitendijk

Sorry, I was waiting for you to open it up. That is why I did not raise my hand yet, but you knew that I was going to ask a question here. Thanks, Mike, for the backdrop on that. On the one hand, I clearly understand that from an information blocking perspective and the exceptions that we are starting out with after October 22nd, 2022, it is going to be EHI, and therefore, in that sense, it does not have a direct one-on-one relationship, but I think the point that you are making around the other purposes around certification, and if you want to add without special effort, if you want to add interoperability in using standards, that it is clearly creating the ability to help guide that, and as a result, it eases the path to not **[inaudible] [00:19:21]** or be trapped into information blocking, accidentally or otherwise.

So, it has an important part there, at least as we understand it, so I think that is where some of the comments are typically coming from. Is USCDI going to be the same in the end? Is it intended to cover EHI? Does it need a record set? So, I appreciate that for information blocking strictly from an EHI perspective, it need not be, but for everything else, if we do not, we are going to have a problem because at that point in time, we do not make it easier for everybody. So, that is why I am curious. From that perspective, is the intent of





USCDI as you understand it meant to grow over time, with the most critical first and the other ones second, to encompass the EHI designated record set? That is not meant to mean that everybody must support everything, particularly if certain providers or institutions or organizations do not have that electronic data, but that it is covering so that for those that do have electronic data, those are the standards according to which we want to operate, and therefore, USCDI is going to grow into that level. What is your perspective on that, looking at it through that lens?

Michael L. Lipinski

So, that is a policy perspective. I do not necessarily disagree, but it is not a stated policy of ONC. We have to be cognizant of that. My leadership has not indicated that that is our intent with USCDI. I can talk to what the regulatory intent was, and that is what I am going to continue to focus on, but I think that is true. To your point, clearly, those entities that are going to use the USCDI as it is currently identified are going to have a more likely ability to meet requests for data, particularly the products that are certified, and it does lessen the use of, say, the infeasibility exception, for example, or the need for using that. So, I think that is true; I cannot confirm to you that as a policy position of our agency, that is the goal for USCDI.

I do think it is understandable, and I do not think it goes beyond the lines of reason to assume that it will expand the USCDI, just looking back at various versions of what started out as the MU data set, which then became the common clinical data set. And then, looking at some of the other data elements that are identified in the certification program, some without standardization, but some with: For example, some that we use for recording data under demographics for sexual orientation and gender identity, but also, in transition to care, there are data elements identified, such as cognitive and functional status.

So, I am not saying that those are the ones that are going in. Please do not read too much into that. I am just pointing out that there are clearly other data elements that may or may not eventually find their way into the standard, but from a policy perspective, we have not indicated that a policy goal of ONC is to expand the USCDI to ultimately cover what would be included in the designated record set, and just to talk a little bit about some of the data that is going to be, there will be some administrative data in the designated record set, so we have not even broached that topic related to standardized data and whether it should be or not be, and for now, the USCDI has focused on it being clinical data.

Hans Buitendijk

I appreciate that. And, considering that we not only looking at EHRs, for those from HIT in general that have EHI, it is very reasonable that that data is in there from that perspective, so I do not think we are going to have too strong of an argument there, but not every system might manage it, which we need to be aware of.

Michael L. Lipinski

I definitely agree that USCDI is an enabler. Meeting and being certified to the USCDI is an enabler to providing access exchange and use of EHI under information blocking, and in electronic access as well, which is obviously what we are striving for.

Steven Lane





Thanks, Hans, for that question. Mike, I jumped ahead to a slide for later in our meeting, but we have had a key question here, and I believe that we thought you might be able to help us answer this. Can you see the slides now, Mike?

Michael L. Lipinski

Yeah, I can see the ONDEC one. I am going to look at it, but I may defer to AI because I am a guest today, and I am not quite sure of your past meetings, but I will take a look at it.

Steven Lane

AI actually missed our last meeting where this came up, so you will both be coming to this fresh. So, the question came up... We are focusing here on the black text, including the strikethrough. This slide is some potential suggestions that we might be making through HITAC, but looking at the black text, which was and is the existing leveling criteria that ONC has used in looking at submissions that come through the ONDEC, we were trying to understand the specificity in the lower right-hand corner of the words “pertains to majority of patients, providers, or events requiring its use,” and the key question here is when we say “events requiring its use,” does that mean that even if it is a rare event, the item would pertain to the majority of those rare events, or if this something that pertains to a small number of patients or providers, are we talking about something that the majority of the time that that rare event occurs, this data element would pertain, or does this mean that really, it is the majority of all healthcare events or the majority of all patients that would require this particular data class or element? I know this is a big shift from where we were just discussing, and you may, in fact, not be the subject matter expert on these words, but this was a key question, and Mark, since you raised this initially, maybe you want to add any specificity to the question before we ask Mike and AI to comment.

Mark Savage

No, I think you have summarized it. If it is not clear to Mike or AI, I can take another stab, but I think you summarized it.

Michael L. Lipinski

Is it a question of what “majority” also modifies? Are we talking about Oxford commas?

AI Taylor

I can take this.

Michael L. Lipinski

Great, AI.

AI Taylor

I discussed this with Matt earlier in the week. So, Steven, I think the way that you framed your question is the perfect way to frame it to answer the question. Is it the majority rare events or the majority of all events, “events” meaning it could be a particular care encounter, it could be something that requires the collection or use of a particular piece of data, it could be doing a pre-op appointment, it could be a preventive medicine visit, it could be a case reporting, or it could be a place where you might be preparing a case report or a program report for various programs that you are participating in?





I think in general, that majority of events or many events refers to the broader community because there are many, many cases, particularly with ONDEC submissions, where the majority of these rare events or rarer events required a particular data element, but the number of times in general per year where that is needed is quite a bit smaller than other examples. I think that is a fair way to assess that, and so, it is a balance between addressing these specific, very narrow use cases, or rare events, as you said, or looking at what the broader stakeholder community is going to need because as we add things to USCDI and as systems are updated to incorporate those new data elements, we are asking every system that does the update to add that data element, not just the ones that are going to be taken care of as specific, narrow patient populations. So, I think that is generally how we look at it. We are looking at the broad stakeholder communities as far as “events” goes.

Steven Lane

Okay. Well, I do not think that is what we wanted to hear based on the conversation we had previously because there are clearly a lot of folks who have been chiming in at these meetings who have an interest in addressing the needs of the data-underserved, of addressing the issues related to equity, and with the lens that there are communities that do not represent either the majority of patients, the majority of providers, or the majority of events writ large across the healthcare spectrum that still have very important data needs, so if that is indeed the case and we can take your word as gospel on this, I think that will end up being the focus of our next round of recommendations. Mike, do you have anything to chime in on that, or did I perhaps suggest appropriately that you are not the SME on this one?

Michael L. Lipinski

You are correct. I would defer to AI on this.

AI Taylor

And, Steven, I should say that this was our general approach for Version 2 for setting these levels, and so, the task at hand for the task force is to decide whether to sustain those or recommend changing them.

Steven Lane

Got it. Okay, Mark, your hand is up.

Mark Savage

Just to crystallize your summary, Steven, which I appreciate, in a different way, the people on the margins will always remain on the margins because they are in the minority, and that is troubling to me.

Steven Lane

Thank you. I think it is a very good point, and I think we will come back to that in crafting our recommendations. Any other questions for Mike, or specifically AI or Mike Berry? Was there anything else that your team had hoped Mike Lipinski would be sharing with our group to inform our work?

AI Taylor

The only thing that I was thinking about is the focus on ePHI versus EHI, and I think what Mike addressed is that the EHI definition for info blocking purposes is centered around the protective health information as opposed to other things like potentially administrative stuff that is not really ePHI or PHI as being part of the EHI definition. Is that right, Mike, or is that off?





Michael L. Lipinski

What do you mean by “administrative stuff”? There is administrative stuff that is ePHI. That is going to be part of your designated record set. I am not quite sure what you are trying to say, to be honest.

Al Taylor

Are there examples of things that are in the designated record set that would not be EHI, other than non-electronic?

Michael L. Lipinski

Examples of things that would be in the designated record set that are not electronic? Yeah, the designated record set is everything that you have access to under OCR. Some of it will not be ePHI. That is why we focused on ePHI. It is going to have to be the data that is electronic, so ePHI is data in electronic media. I think a lot of folks on here know this, but the designated record set is much broader than just ePHI, so you can have other records in there that are not in electronic format that a patient would have a right of access to under 164.524, and I do not think that is really relevant for this discussion. Does that make sense to others on the call?

Steven Lane

I think so. Al, it sounds like you were differentiating in your mind the EHI and ePHI, and in my mind, that is not an important differentiation that I think about when I think about this work, but was there something else in there that you were trying to get at, Al?

Al Taylor

No, I think Mike covered it. Mike, thank you for clarifying.

Michael L. Lipinski

Just so we are clear, I think folks have read the rule, though I am not saying everybody has here, but we obviously limited EHI in the beginning by just saying it is limited to ePHI in the designated record set. Our proposal was much broader than that because of the definition of health information in the Public Health Service Act is broader than that.

So, there were various limiting factors, and a lot of it is for the policy reasons we laid out in the rule, including, as I said earlier on, many of the actors covered are already covered entities under HIPAA or business associates under HIPAA, and therefore are familiar with ePHI, the designated record set, and so forth. Information blocking is a new paradigm, so I think we had to consider who was going to be covered and what made most sense at this time, but obviously, the definition of EHI was our first limiting factor. They do not necessarily have to be one and the same; it was a policy choice to limit EHI to ePHI that is in the designated record set, and then, obviously, for this first 18 months, the data identified in the USCDI.

Leslie Kelly Hall

Thanks, Mike. Abby has a question.

Abby Sears





Thanks, Leslie. My question is given this administration's focus on equity and the recent learnings from the pandemic and the public health data that needs to move, do you see the ONC revisiting their policy decision that they just made around limiting to ePHI versus EHI? Do you see a revisiting or a conversation around that? Because for me, there is a little bit of incongruency with the administration's focus and the narrowing. I am not sure how we are going to bridge that.

Michael L. Lipinski

I guess I would ask back to you what data you think is being excluded that would not be part of the ePHI.

Abby Sears

Well, let me put this out there, though I might sound like a fool because you may have a different interpretation of it: Things like transportation, food insecurity, and housing. I am not sure if you consider that ePHI or EHI. I would have thought it was EHI and not ePHI.

Michael L. Lipinski

I think that was helpful. Obviously, for the ePHI, I wish I had my definition up right now, but again, if it is used for making decisions or included in the designated record set, then it is going to be in there, just like price information, if they put it in the designated record set. So, I assume that data is important to you, and I think it is important to make decisions to improve health outcomes when you start talking about social determinants of health, so I think it can find its way into the definition of ePHI just as easily as it could into EHI definitions.

Steven Lane

Mike, would you say that it makes its way into ePHI when it is specific to an individual, such as their housing and their transportation?

Michael L. Lipinski

Right, it has to be individually identifiable information. I am not a HIPAA expert, though I have been around them enough to remember some of the stuff, but I would need to pull up the ePA-side definition, honestly, so that we are all talking from the same thing.

Steven Lane

Abby, I get the sense from your question that you are concerned that some of that SDOH data might be left out in the cold and not be considered under the auspices of either info blocking or USCDI. Can you say any more about what you are trying to avoid here?

Abby Sears

Well, I am just trying to learn and to understand what conversations have been had strategically at the ONC around closing that divide around equity, and I am not an expert in these definitions are structured or ratified. I think I am just coming from a place of curiosity, and maybe this is more of a strategic question related to social determinants of health. How do we make sure that that is as pertinent and relevant information when it is such a narrow set of data? Going back to how you narrow... Having to track the whole population is part of it as well, so I think it is both of these things. Is it really going to be considered ePHI, and how do we make sure it is ePHI? Is it a good thing to make it ePHI? I am not entirely sure it is, so I am kind of batting that around in my head. Also, this patient population, which accounts for a significant component of the cost





and the impacts to a lot of what is going on... I am just trying to figure out how that would fit into the thinking with the ONC and how we bridge that gap. I think that is just what I am trying to understand.

Michael L. Lipinski

I have the definitions up just so you understand how that works. The way it starts out under HIPAA is you have individually identifiable health information, so that is a subset of health information, including demographic information, collected from an individual, and it is created or received by a healthcare provider, health plan employer, or healthcare clearinghouse and relates to the past, present, or future physical or mental health or condition of an individual, provision of healthcare to an individual, or the past, present, or future payment for the provision of healthcare to an individual, and that identifies an individual or with respect to which there is a reasonable basis to believe the information can be used to identify an individual.

So, you start with that individually identifiable information. Then, you go to protected health information, and that essentially means individually identifiable health information, which is the definition I just gave you, that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium, and then, there are certain data that are not included in protected health information, like a person who has been deceased for more than 50 years, and there are other provisions, but nonetheless, "protected" is how it is transmitted, and then, electronic protected health information is just that data that is transmitted by electronic media or maintained in electronic media, and so, that is what we then say is EHI, and it is only the ePHI that is in the designated record set. I know that is a lot.

Leslie Kelly Hall

This is Leslie. So, if we go back to that anchoring statement, it is things that are used to be making decisions, and so, then you go into that definition, and it talks about helping to identify a person, and towards the end, it was somewhat alluded to demographic information, and SDOH comes into demographics; it is also part of the actual patient's identity, such as who I am, what I feel, and what my situation is. And so, perhaps, then, to clarify this, a recommendation could be made that encourages that SDOH is underneath the banner of clinical decision-making, and then it starts to flow across definitions, rather than without that, it is not expressly excluded or included because I guess it could be defined differently by the user. This is partly when you see it. So, I think in these areas, it might be worthwhile for us to consider recommendations that allow SDOH to be included in the decision-making definitions. Is that...?

Steven Lane

Not that it would have been excluded, but just making sure that it is explicitly included.

Leslie Kelly Hall

Right.

Michael L. Lipinski

I do not have your charge in front of me, but that sounds reasonable to me, and I think you all know this, but I would just want to point out that ONC has always had a vested interest in this space, like we have one criterion about recording psychological behavior and social data that is standardized. We constantly look at this issue. Obviously, as you have all pointed out as well, there are executive orders focusing on health equity. This is my position because from a regulatory perspective, studies are always very important in terms of pointing to evidence-based decision-making for us in that studies show that if certain data points





were included in the decision-making process for a patient, they could have improved health outcomes. I think that is always relevant and important for consideration. And then, what can ONC do in that space, then, to further that improvement of health outcomes?

Steven Lane

Great. Any other questions for Mike in particular, or can we let him go and move on to the next part of our presentation? Seeing no more hands, Mike, thank you again for taking the time to join us. We really appreciate you sharing your expertise. We may come back to you in the future with more questions.

Michael L. Lipinski

I am always open to those questions, am happy to engage, and thanks for letting me join today. Good luck with the rest of today's meeting. See you all. Bye.

Tasks 2b and 2c (00:46:18)

Steven Lane

Thanks so much. All right, let's go on to Slide 8 just to reorient us to where we are in our process, focusing on Tasks 2B and C at this point, but we have invited people to be thinking about Task 2A at the same time. We did a lot of work early on in our process thinking about Task 3, and we will be coming back to that, but right now, the focus really is on Task 2, and particularly B and C, which is to say, looking at the evaluation criteria to assign levels to submitted data classes and elements, as well as the prioritization process used to select data elements for inclusion in the next draft version.

So, AI, I think you were going to take us through the next few slides. Do I have that right? You will be talking about the ONDEC process, which is really more specific to Task 2A to make sure that people have a shared understanding of ONDEC. We have invited people to review the questions that are represented in the prep sheet, which is posted on the public web, but unless you have gone through and actually made a submission yourself, which some of us have and some of us have not, you may not have seen the internal workings of ONDEC, so I think AI was just going to walk us through that so people have the inside experience of what that looks like.

AI Taylor

Sure. You just want me to go through the slides, right? You do not want me to do a live demo, do you?

Steven Lane

I do not think that is necessary. The screenshots do the trick. But, if somebody has questions, please bring them up.

AI Taylor

So, this is the entrance portal to the ONDEC submission system, and I wanted to point out that I included in the public chat box the link to the prep sheet, and the reason I did that is the prep sheet has additional supporting or instructive language within the answer fields to help guide the kinds of information that we are looking for.

Steven Lane





AI, just so that nobody is confused, I actually posted it in the public chat. You posted it in the private chat. If you are looking for it in the public chat, it is under my name.

AI Taylor

Okay, thanks, Steven. I realized it was in the other chat, thank you. So, that is our current version of the prep sheet, which provides some instruction and supporting information for preparing a submission. I should note that it is not the submission itself. We are not accepting copies of a completed prep sheet. It really is just so that people who need to do offline work, sometimes with committees or their entire organization, can formulate their submissions. So, that is a good guide, and the information that is in the prep sheet is also fair game for the task force to weigh in on when we talk about whether it is considered a 2A task or a 2B task. We are looking for input on and improvement to that.

So, in order to do a submission, which is the second button under “How It Works,” you have to be a registered, logged-in user for our platform, which hosts both interoperability standards advisory and ONDEC. So, once you log in, you can click on “Start My Submissions,” and then, the additional information on this page is to show generally what we are doing with the information that you submitted, and so, we will make changes to this. I think we are going to end up changing the submission due date to sometime in September. I do not know the exact date yet, but we will change this page as needed. Next slide, please.

So, this is the first page of the submission system, and it actually requires you to put your name in your email, but the email address will not be public. Your organization and name will be published, along with the submission, but not your email. We need the email to notify submitters of any action on the submission, including our publication review and need for additional information on it. We do have the feature to save a draft, so if you come back to the ONDEC system and click “Start Your Submission” again, you will come to the last page that you completed in your last submission, so the “save draft” feature is also available. Next slide.

This is where we begin to collect information about the data element itself, such as the name. If you look at the bottom, you can do multiple data elements for each data class, but if you want to submit multiple data elements across multiple data classes, you have to come back and start a new submission for the next data class. Some of this is pretty self-explanatory, and we want for you to be just as clear as you can be as far as the data element description. The data element description is what will end up being the data element definition.

It is an important piece for us to do, and we have gotten some submissions. Maybe it was not clear to us what the description was, so we would just get back with you, and Steven has been a participant in this process, where there was some clarity that we needed to get, and so, we ended up going back and changing the data element description or data element definition just to make it better or clearer in public. So, if multiple data elements are requested, you can add that, and as far as I know, there is no limit to the number of additional data elements in a single class you can submit. The prep sheet has six fields for additional data elements, but that is just as an example. Next slide.

This is the information that we ask about the particular use case for how this data element will be used, at least from the perspective of the submitter. It could be that there are multiple use cases, and it could be that those other use cases are outside that knowledge of the submitter, but that is okay. We want you to





describe the reasons why this is needed, and particular situations in which the data is collected, accessed, or exchanged. And, any additional information, including links and attachments, can be added to this. The last question is about the quadruple aim. We want you to at least take a stab at this. So far, we have not done a lot of data collection on the breakdown for the quadruple aim, but the task force felt like it was important to collect it. Perhaps that is something that we could revisit as far as if it... That information should be captured within the use case description, but [inaudible] [00:54:09] something that is currently required. Next slide.

Just as a note, one of the things that could be helpful is if you have completed a prep sheet, including text, the prep sheet has fillable fields that can just be copied and pasted so you do not have to retype everything, and if you store it, you fill it out and save it in electronic format. You can simply copy and paste from these large fields in the prep sheet to the large fields in the ONDEC system. This page is related to the maturity, so we are looking for several aspects of data maturity: The data element or the vocabulary maturity. Is the term already using standardized text? Various different vocabulary standards could be used. It is also possible that a data element is otherwise represented in an implementation guide such as U.S. Core implementation guide or the CCDA templates, and where that is appropriate, just make that indication about where it is used. It is not a requirement that is used in FHIR U.S. Core or in CCDA 2.1.

That is something that is pretty important for people to understand. There are situations. The SDOHCC/IG is not the FHIR U.S. Core, but it is an implementation guide, and that can be used as a reference. Public health implementation guides were also identified as implementation guidance, both FHIR- and CCDA-based, and those are where that additional information would be. Now, we want to describe the use of the data element, so it is fine to standardize the use of it and have a published implementation guide, but if nobody or almost nobody is using it, it is less feasible for inclusion in USCDI, and so, we ask about how extensively it is used, whether it is in a test or production environment.

And then, the third part of maturity is the exchange. So, USCDI is the capture and exchange of health information and this core data set, so we ask about whether or not it is exchanged with external organizations and to what extent it is captured. Now, these questions expand for additional information if you say yes to them, and so, the appropriate information about the extent of the exchange can also be included. Next slide.

The last part of this is... These are challenges. Just to be clear, the challenges that might be listed here are not going to go into the determination about leveling in general. So, these are... The first one could potentially affect the level because there are some situations in which there is not broad consensus on how to use a particular data element or how to represent a data element, and my favorite example is smoking because depending on your perspective for evaluating smoking, how to represent it is different. So, if you are trying to prevent – if you are trying to provide smoking cessation education, the standardized terminology is different than if you are trying to calculate lung cancer risk. Cardiac risk is also different. So, if you are not smoking in the last 30 days, your cardiac risk goes down, but not so much the lung cancer, for example. So, if there are problems with consensus, that is a potential challenge to making it either a part of USCDI or having a specific applicable standard or value set to represent the data.

And then, the other challenge areas are involving any restrictions or fees associated with the use of the data element, which, again, is not a dealbreaker, but is important to understand. Any specific privacy and





security concern that is different than HIPAA data... The next one is a best guess as far as implementation burden, and that could be if it is going to take a lot of development, if it is going to require a lot of standards work, implementation guide work, or if it is going to affect the workflow so significantly that it is difficult to implement at the provider level. So, these are some thoughts about that. And then, any other thoughts that you might provide that could be helpful. When we do the review, we sometimes go in and make edits and changes to these fields just to help guide ourselves better when we make our decisions about coming up with the next draft of USCDI. Next. Can you go back one slide, please?

The only thing I think I want to do is once you click... There is an opportunity to review and edit your submissions before you submit, but there is also a requirement that you acknowledge that this is going to be a public submission. Your name and your organization will be published and out there, and we may contact you for additional information, and then, you will also get an email that says the submission has been completed, and you can go back to that submission and at least review it. You cannot edit it once you have submitted it, but you can get with us and make changes to it as needed, and we can get with you and look for additional information from you, the submitter. Next slide. Back to you, Steven.

Steven Lane

Thanks so much, AI. I made a point in the chat which I will just put voice to, which is... You made a comment that the identified challenges are not used to determine the level, and I must say, as I was going through this process and I got to that stage in the work, I did have a sense that if I called out too many challenges, that might negatively impact my submission, and your statement just now was the first time I had ever heard that, and if that is indeed the case, that should be stated explicitly, probably at the top of that page on the website as well as in the prep sheet, and maybe we will capture that as a formal recommendation.

AI Taylor

Okay.

Steven Lane

Grace, you have your hand up.

Grace Cordovano

Yes. So, I have a number of pieces of feedback on this process. So, even if I took the time to complete the prep sheet, which I have tried, as a Board-certified patient advocate who can speak English, who has a PhD in biochemistry, I cannot complete it. I do not have the technical expertise and all the knowledge to appropriately answer all of the different fields that are marked as required, so I see that as a barrier. I will give you examples: Questions like use cases, number of stakeholders who capture support, access/use, maturity. Those are things which are more tangible to me now after working with the task force, but I am still not able to answer a lot of these questions without reaching out to someone for help. Making mandatory fields like technical specifications... Again, I understand both sides of the coin and why these are essential pieces of information.

I am wondering if we are really going to make this inclusive and allow patients, their care partners, and the general public to really participate in this process. Would it be possible to add some things like a dropdown at the very beginning which identifies by stakeholder, and if someone self-identifies as a patient, general consumer, or lay public, if we can simplify the form, and perhaps, instead of all the different technical pieces





of information, if we would allow for the use case to be captured as a patient experience or a story where you can very briefly highlight the benefit or the harms associated with why you would want something in for consideration.

There is always this discussion about things being very self-explanatory, and sometimes, when we take a step back and realize the intricacy of the work that we do and the privilege of the work we do, maybe it is self-explanatory to us, but not to people outside of this realm, and we may be excluding really important pieces of information that could really enhance the work that we are doing.

I wanted to ask one other thing, and again, going from my experience and learning still about all the different nuances of the work that we do, is there a way that, when you submit something, if something has been previously submitted, could you be pointed in the direction of that? Is there a way? Is there a search function? Or, when you add your email, let's say I submitted something, but it has already been previously submitted. I have spent a few hours looking for different things, I have reached out to task force members, and sure enough, something that I thought was not included really was, deep in there. So, that is another note. I am just wondering how we can help connect the dots for someone who may not be super fluent in the long history of the work that the USCDI task force has done. That is the end of my feedback.

Al Taylor

Can I respond to that, Steven? There are two big things that I heard, Grace, and one of them is the need for more plain-language descriptions of the questions, and I think that is a fairly straightforward fix, and I am a huge advocate of plain language, and I try my best, but of course, I am more on the technical side, but certainly sensitive to that. The other part about being able to see if anything has been submitted already... We are working an improved search function in the USCDI, and I think we are going to go live with it any minute now, any day now. We are working on that.

So, you can search. The platform that hosts the USCDI is also the same platform that hosts the interoperability standards advisory and/or standards version advancement process, and so, the search function will work across all three of those platforms, but you can refine it to look for a data element that is in USCDI, and I think that that could begin to address...and, I think I heard you say that you volunteered to test the search function for the new platform as soon as it is up and running, and I have you on the list now. So, those are two good points, and then, your other point is about dropdown menus, dropdown things, and all that. That could really be helpful and really help make it easier to use. I will double-check this, but you can search existing data elements and data classes by name in the ONDEC, at least data class, but I believe data elements are also searchable, but I do not think we have a dropdown menu for that.

Steven Lane

And, one other suggestion that Grace made, which Hans also chimed in on in the public chat, was this notion that depending on the submitter stakeholder group, the requirements of the form might change, and I am not sure that I would personally support removing questions or adding questions based on the identified stakeholder group, but one might consider whether or not all the same fields would be required. What I hear you saying, Grace, is that you have a sense that the requirements of completing the field might be so daunting for some stakeholders that they would abort their submission rather than trying to work through those. I think the idea is that if someone self-identifies as a patient or patient advocate, that perhaps we





lower the bar, if you will, and provide additional support from ONC or whoever is doing the analysis to step him and help fill in those blanks that might otherwise be more difficult to complete.

Grace Cordovano

Steven, if I may, I am not sure it necessarily has to be to lower the bar. I do agree with you about not necessarily removing all the fields, but the asterisks for the required fields, but it is another level... When we talk about use cases, there are technical use cases for the exchange, but then, there are the real-world use cases, which technical people may not have any insight to in the way that a person living and experience healthcare at the point of care may be able to shed light on. So, I think it is just an additional level of perspective that may not be in here. However, maybe that becomes an added field or question, in this case. I am sure there are people on this task force that have had significant experiences within healthcare personally and professionally, and when we think about use cases, capturing the harm and benefit that can happen as a result of having a data element or class is important to also capture it with respect to what is in the real world.

Steven Lane

Great point. Mark, your... Actually, Mark, can I put you on hold? We have some commenters that hardly ever comment, and I want to make sure we give them some air time.

Mark Savage

Absolutely.

Steven Lane

Ken, it is so nice to see your hand up.

Ken Kawamoto

Thanks. So, I think this conversation reminds me of the purpose of this process and the purpose of USCDI. This is something I have thought about and commented on off and on. It strikes me that the current process is really about what the things are that are pretty much ready to move to USCDI, where all the analysis has been done, the technical hurdles have been all overcome, the standards have been developed, and we are ready to almost rubber-stamp what the industry already knows is ready or pretty much ready, and if that is the explicit purpose of this process, I think it is okay, but if the preferred purpose is to identify not what is ready to move forward in USCDI, but what we need to move forward in USCDI and what we need for interoperability that might not be there yet for improving patient care and that kind of thing, I think this process has some issues because it is geared toward people who can say, "Hey, I have already analyzed all the different standards, I have already analyzed the 20 vendors that have implemented this, and I have done surveys of the EHR vendors, and these are the outcomes that it currently states, and I have been engaged in this project."

My sense increasingly is that is, in fact, the purpose of USCDI and the ONDEC process, and it is just trying to formalize that, saying, "Hey, tell us what is ready to move, and we will move it forward." If that is the idea, to not just rubber-stamp the status quo, but to identify things that we need to move this country forward, then I think we need to review things like asking submitters, even sophisticated folks like people on this committee, how we know what every EHR vendor's implementations of these data elements are. That is





just not a pretty reasonable thing to ask, nor is it reasonable to say that if you want to suggest something for us to consider, you have to do that.

So, I would just bring this up as an opportunity to look at what the purpose is, and if the initial state is that we do not have bandwidth to do anything other than rubber-stamp things that are ready, maybe we should just explicitly state that that is the purpose of ONDEC. Maybe at a later phase, we will be open to suggestions of things we can move forward, but I think that is worth thinking about because maybe that is all we can do because there is so much to do at this point, but I would think ONC, as a coordinating body, would ideally be suited to do things like getting folks' input on what would be highly used, even if you do not know what the standards are, even if you do not know what the EHR vendors have implemented, and we will now take it to the EHR vendors' associations to see how they do it and we will take it to HL7 for the things that get a lot of thoughts where this would be important to say, "Hey, do you guys have standards?" That is my comment.

Leslie Kelly Hall

Ken, when Steven and I met with Micky and the leadership team at ONC, we talked about this idea of the chicken and egg and the nest that we can incubate new information, and they were quite encouraging for using ONDEC not just for ready-for-primetime areas, but more aspirational ones, and our recommendations as we look to how to make it more user-friendly, how to offer up things that are not mature, but high-priority, I think they were quite open to those considerations. I interrupted, and I see there are more comments, so forgive me for that.

Steven Lane

Let's go to Ricky.

Ricky Bloomfield

Thanks. My comment was somewhat similar to Ken's, and it gets to some of Grace's comments, in that it may be helpful if there is a desire to expand the diversity of those who are commenting, then thinking outside the box of other approaches might be useful in collecting that type of feedback, and obviously, the feedback that we are collecting right now does require a certain amount of not just technical expertise, but understanding of how the regulatory process works and what type of feedback you can provide, and by its very nature, that does limit the type of individual who will even attempt to provide feedback, but I could see some value in making something as easy as opening a Change.org petition or other form of crowdsourcing where you can really appeal to patients themselves to try to hear what they might be interested in in terms of what might need to come.

And, if you do that, obviously, a lot of the things you will get are things that might be available already, such as clinical notes, and of course, those are things that we are quite familiar with, and others are going to say, "Well, I want my imaging data," for example. But, I think that trying to think of ways that we could engage a broader set of stakeholders that may not be represented as well on this committee or that might be hard to accurately channel could be beneficial. I think it would require a very different process than what we currently have with very different submission forms than we currently have, but might be something that we could just think about as a way to expand the nets of feedback and crowdsource in a more unique way.

Steven Lane





Great comment, Ricky. So, I want to let Mark and Hans get a word in. We are going to be going to public comment fairly soon. We have spent a lot more time on ONDEC and what I was thinking of as Task 2A work than we might have planned. We have a number of slides regarding the material that has already been discussed, which I think may end up waiting until our subsequent meeting, but Mark, do you want to go ahead?

Mark Savage

Sure, thanks. I will try to keep this short. So, I really appreciate Grace's, Ken's, and Ricky's comments. The thought occurred to me that we could even set up something where, instead of having to fill out a form for some who are less technically adept, you have an interview process or actually a conversation with somebody at ONC. I understand that might be more intensive, but is the kind of thing in other areas where you actually are able to elicit the kind of information needed to complete a form for people for whom that is not their primary desire to complete the form.

In addition, I want to give an appreciation and an observation. When I did this back in October, I ran into some of the observations and questions that Grace commented on. Some of the ways I solved them was actually knowing who to reach out to at ONC, and the appreciation is that staff there were really good about trying to help me get the form completed, but I happened to know how to reach out to somebody ahead of time. That was critical to my success, and I think we need to keep that kind of piece in mind. If it is critical for others' success, do we make it explicit, or do we solve the problems so that is not needed? I am not sure. It is definitely appreciation and an observation.

And, I have two final observations. One, the comment that the timeline might be moved up to September 2021... If that is the case, I would strongly encourage getting that out to the public as soon as possible. I understand you cannot rush decisions, but the amount of time that it may take somebody to do the prep work to have something ready by whatever criteria...a difference of a month to two months could be big, so just think about when we get that information out to the public. Lastly, some of the criteria that we are considering recommending would necessitate some changes to the kinds of questions or the number of questions that are asked in the forums, so we should be aware of that. That is a more complicated version of the point that an asterisk saying it is required might not be an asterisk saying it is required anymore. Thank you.

Steven Lane

Thank you, Mark. I think we are going to be pulling together these various suggestions about how to make this more accessible and inclusive and including those in our HITAC comments. Hans, do you want to go ahead?

Hans Buitendijk

Sure. My brief comment is that I completely agree there needs to be different ways in which different stakeholders can provide input depending on their focus area of expertise. In one of those where the submitter is indicating that there are standards in the maturity level, there are two questions around that that are yes/no/unknown at this point in time, but if the answer is yes, I think we need to ask for what that standard is, what that implementation guide is, whether it is part of U.S. Core or not, whether it is under development or not. That is going to be very helpful information to start to help understand its maturity, where it is on path, if it is already there, might it be eligible for the next regulatory round, but not for SFAB





because it is a different standard, it is not yet referenced. That information is going to be very important for everybody that needs to develop against that to have a good understanding of it. So, I really would encourage that we ask not just yes or no, but what is it if you think it is **[inaudible] [01:19:54]**?

Steven Lane

Hans, we do. If you answer yes, it expands and asks for additional information.

Hans Buitendijk

Okay, sorry. On the slide, it looked like it was just yes/no, but that is great, particularly beyond vocabulary.

Steven Lane

Let's take this pause in the hand-raising and go over to public comment if that is acceptable, and then, if we have the time, I would like to at least have Leslie run through the rest of the slides so people might have a sense of the work that we have done and where we are going to come back next time.

Public Comment (01:20:34)

Michael Berry

That is great. Operator, can we open up the line for public comment?

Operator

Yes. If you would like to make a comment, please press *1 on your telephone keypad. A confirmation tone will indicate the line is in the queue. You may press *2 if you would like to remove your line from the queue, and for participants using speaker equipment, it may be necessary to pick up your handset before pressing *. One moment while we poll for comments.

Steven Lane

And, while we are waiting for public comment, I will also encourage any task force members who have anything they want to add to the discussion to go ahead and get their hands up so we can do that before we adjourn.

Operator

There are no comments at this time.

Steven Lane

Excellent. Thank you so much. And, there are no hands up, so, Leslie, do you want to take us through Slides 16-20 quickly just to describe the work that you and others have done to get us here and set us up for next week?

Leslie Kelly Hall

Sure. So, what I did was attempt to take all the comments from these groups, and I edited where I heard comments and made recommendations, so I am going to go through these quickly because we would love to see specific things added. We do have some specific recommendations from Mark that we will discuss next week, but in the meantime, we did request not only clarification in this stakeholders impact, as we got from Mike, but also to add the language that Abby indicated so that those on the margins could stay on the margins, to Mark's point. Next slide, please. We also then defined on the data supporting unregistered





stakeholder groups under our draft priorities a prioritization process that these things could be medically underserved, data-underserved, or population-underserved so that we were a little broader in that definition. Next slide, please.

Steven Lane

Leslie, I think we want that to say “underserved,” and not “undeserved.”

Leslie Kelly Hall

Good plan! I am dyslexic, I will just tell you right off the bat. That is funny. Next slide, please. Nice catch. We also looked at the priority maturity ideas. We thought and discussed a semiannual review by ONC of ONDEC and the current leveling for validation or modification, and note the date of the review within the website so people can see how current these things are. The specific recommendation is that the ONDEC process and definitions in leveling are constantly reviewed for accuracy, and at the Version X for annual review, the USCDI also takes a task-to-task look at current leveling for validation and modification or making changes in recommendations to HITAC, that we provide guidance on the evolution from USCDI to EHI, that we ask ONC to provide that guidance.

We heard that again today, and about the role of the USCDI Task Force in those efforts. And, ONC is to provide guidance for the EHI release about standards reuse, repurpose, creation, and the use of free text or narrative approaches to signal the industry as it prepares to meet EHI release. And, this gets to where the low-hanging fruit is and if it can be used because getting this all done in 18 months is a challenge, so providing ONC’s guidance or biases toward reuse, repurpose, and creation could be important. We are trying to gather Clem’s ideas here, as well as others, and then we talked about adopting both priority and maturity. Next slide, please.

Also, looking at a way to do some sort of visual recommendation or visual representation of these recommendations, go to the next slide please. This is certainly not a rocket science approach, but some way that we could say, “Wait a minute, these are current standards that are really at Level 1, but we have a high-priority area where they all meet Level 2. How could we use this to depict the leveling?” This is just a very basic example, and we would love examples for visual representation. Next slide. I think that is it. So, we got through those on time. I would love to hear your comments, and in the notes, I will also incorporate for next week some of the recommendations I heard today. Thank you.

Steven Lane

Thank you. And, just to be clear, we are at time now, but we did want to at least get all of you a chance to see how we have been capturing this. As Leslie said, Mark did suggest some additional comments that came in last night that we will perhaps incorporate in the red lines for discussion next week. At this point, we are going to continue on a weekly cycle. We have really just a couple more weeks to finalize the recommendations that we are going to bring back next month to the HITAC, so we are going to try to stay focused on turning these into really concrete recommendations. Leslie and I will work together to wordsmith these so that we can go through them and capture specific recommendations next time to refine them. I guess we are at time, so we will leave it there unless somebody has a brief comment to help close us out.

Hans Buitendijk





Just a quick question. Do you want to have us forward feedback at you directly, or to AI, or how would you like to do that?

Steven Lane

Include Leslie, AI, Mike, and myself, and we will be happy to take that. Thank you.

Hans Buitendijk

Great, thank you.

Steven Lane

Everyone have a wonderful day. Stay safe, get vaccinated if you have not yet, and we will see you next week.

Michael Berry

Thanks so much.

Leslie Kelly Hall

Bye, all.

Adjourn (01:27:07)

