Health Information Technology Advisory Committee

Pharmacy Interoperability and Emerging Therapeutics Task Force 2023 Virtual Meeting

Meeting Notes | July 26, 2023, 10:30 AM – 12 PM ET

Executive Summary

The goal of the Pharmacy Interoperability and Emerging Therapeutics (PhIET) Task Force meeting on July 26 was to begin discussions to identify opportunities and recommendations to improve interoperability and bidirectional messaging between pharmacy constituents and clinical care providers. Guest speakers joined the meeting for a Q&A session on Identifying Opportunities and Recommendations to Improve Interoperability Between Pharmacy Constituents for Pharmacy-Based Clinical Services and Care Coordination. A robust discussion followed.

Agenda

10:30 AM	Call to Order/Roll Call
10:35 AM	Opening Remarks and Introduction of Task 2 – Identify Opportunities and Recommendations to Improve Interoperability Between Pharmacy Constituents for Pharmacy Based Clinical Services and Care Coordination
10:40 AM	Task 2 Guest Presentations
10:55 AM	Task 2 Discussion
11:50 AM	Public Comment
11:55 AM	Task Force Work Planning
12:00 PM	Adjourn

Call to Order

Mike Berry, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the meeting to order at 10:30 AM.

Roll Call

Members in Attendance

Hans Buitendijk, Oracle Health, Co-Chair
Shelly Spiro, Pharmacy Health Information Technology Collaborative, Co-Chair
Pooja Babbrah, Point-of-Care Partners
Chris Blackley, Prescryptive
Steven Eichner, Texas Department of State Health Services
Adi Gundlapalli, Centers for Disease Control and Prevention (CDC)
Meg Marshall, Department of Veterans Health Affairs
Ketan Mehta, Micro Merchant Systems
Justin Neal, Noble Health Services
Naresh Sundar Rajan, CyncHealth

Scott Robertson, Bear Health Tech Consulting
Alexis Synder, Individual
Christian Tadrus, Community Pharmacy Owner
Sheryl Turney, Elevance Health
Afton Wagner, Walgreens

Members Not in Attendance

Shila Blend, North Dakota Health Information Network
David Butler, Curatro, LLC
Rajesh Godavarthi, MCG Health, part of the Hearst Health Network
Jim Jirjis, HCA Healthcare
Summerpal (Summer) Kahlon, Rocket Health Care
Steven Lane, Health Gorilla
Anna McCollister, Individual
Deven McGraw, Invitae Corporation
Eliel Oliveira, Dell Medical School, University of Texas at Austin
Fillipe (Fil) Southerland, Yardi Systems

ONC Staff

Mike Berry, Designated Federal Officer, ONC
Tricia Lee Rolle, ONC

Key Points of Discussion

Opening Remarks and Introduction of Task 2 – Identify Opportunities and Recommendations to Improve Interoperability between Pharmacy Constituents and Pharmacy-Based Clinical Services and Care Coordination

PhIET Task Force Co-Chairs, Hans Buitendijk and Shelly Spiro, welcomed the Task Force, reviewed the Meeting Agenda, and recapped the Charge. PhIET Task Force shifted focus to Task 2 – Identify Opportunities and Recommendations to Improve Interoperability between Pharmacy Constituents for Pharmacy Based Clinical Services and Care Coordination.

Task 2 Guest Presentations and Discussion

Shelly Spiro introduced the subject matter experts.

- Kim Boyd, President, Boyd Consulting Group, LLC, gave a presentation on Bridging the Gap: Unveiling the Potential of NCPDP Standards for Clinical Messaging between Pharmacists and Providers. She discussed the main challenges to achieving a standardized messaging system between pharmacists and providers, the importance of prioritizing real-time data exchange, and offered recommendations for consideration.
- Stephen Mullenix, BS Pharm., R.Ph., Senior Vice President, Public Policy & Industry Relations, NCPDP, and Richard Savage, Executive Vice President, Innovation & Standards Development, NCPDP, gave a presentation on Pharmacy Standards Development & Interoperability. They discussed the NCPDP's

strategic initiatives and approach to solutions, and introduced Work Group 20; the new NCPDP Work Group focused on Coordination of Care and Innovation (CoCI). Also discussed were HL7 FHIR and APIs.

- Josh Howland, Pharm. D., MBA, SVP Clinical Strategy & Product, RedSail Technologies, gave a presentation on the lack of cross-functionality of messaging and the limits of the NCPDP messaging. He also discussed what is wanted in messaging versus what is needed, and the importance of pushing for a Universal Patient Identifier (UPI).

Discussion:

- Hans Buitendijk asked which should be the area of focus, API or messaging?
  - Josh answered both are important to achieve comprehensive messaging capabilities.
- Pooja Babbrah asked for more information on ADT notifications, brought up by Kim in the chat, as it pertains to care coordination and the new Work Group 20. She also asked to hear about UPI.
  - Kim Boyd answered that getting patient information to the pharmacist is crucial and would ensure total care and reduced rates of readmission to hospitals and acute situations. She noted that Work Group 20 would focus on this aspect and that UPI is also important.
- Shelly Spiro mentioned the importance of a UPI to pharmacists and asked Rick and Steve what some of the targets of the NCPDP's plan are, in relationship to harmonizing the HL7 standards.
  - Rick referred to the graphic in his presentation regarding HL7 and noted they are working closely with HL7 and see a path to success for the pharmacy benefits programs. They have identified standards on both sides for creating interoperability between the two.
  - Steve added that they have had more interaction with those at HL7 and that they are working to set standards and ensure they work to the maximum benefit of all users. Current systems had incomplete and/or duplicate patients at a range of eight and 18%. They will also continue to advocate for a UPI.
- Shelly asked Josh Howland for an update on the software used for the pharmacist electronic care plan and any comments received from pharmacists currently using the software now, both the pros and cons.
  - Josh answered that it has been well adopted by independent community pharmacies with over a million care plans being submitted quarterly. The adoption rate has been slow for those using FHIR. Payers, and some others, are facing the biggest challenges with receiving complete care plans instead of solely the parts that are relevant to them. Currently, FHIR is not being used to its full capacity outside of pharmacy to pharmacy or pharmacy to CPESN communications.
- Shelly followed up by asking if most users are opting for CCDA or FHIR.
  - Josh answered that most are using FHIR, including larger pharmacies. He agreed with Kim in the chat; it is still not fluid enough.
- Scott Robertson noted his concern for patient privacy and the possibility of an inappropriate exchange of patient information with UPI.
- Hans went back to the topic of HL7 and noted the time needed to develop all standards. He asked if there are any areas that should be prioritized to accelerate the process.
  - Rick answered that some of the most important projects right now are value-based care programs, working with partners to allow pharmacists to participate in these VBA programs, programs within digital therapeutics, and continuing to identify gaps in the communication flow.
- Hans asked Rick if there are any opportunities among the standards already set around messaging and data sharing to advance communication exchange.
  - Rick answered that NCPDP has a foundation that can support the driving of adoption of programs where players who are interested in accelerating the process can give specific details and examples in the utilization of the standards of the process. Ensuring there are participants who are actively seeking to move the process forward with tangible examples is

key.

- Steve Eichner said there can be challenges in looking at lists when medications are not coded into a medication list, i.e., drugs that are in clinical trials with no catalog numbers. He asked if that issue needs to be addressed to make it easier for pharmacists to reconcile potential conflicts in patient medication lists.
    - Shelly answered that NCPDP and HL7/EHR have several work groups that are assessing the medication lists. The NCPDP is also working on the standardized medication profile that will also help with the medication list. This will help overall medication reconciliation. The challenge is obtaining all the information needed within the system.
- Steve added that advances are great, but information needs to be reliable, timely, accurate, and complete for the sake of patient safety.
- Shelly agreed and added that different medication lists need to be identified. The work groups have been identifying different types of medication lists, like active medications, and discontinued medications, with the reason for discontinuation, and they have recently identified a private medication list that needs patient permission to be shared. Additional lists include over-the-counter medications and supplements taken by the patient.
- Steve reminded everyone that this is a subject that needs attention.
- Pooja asked if there was an opportunity for bidirectional certification for prescription standards on the pharmacy side. She also noted that standards for transactions exist and asked how it is ensured that these standards are being utilized and incorporated.
    - Rick agreed and mentioned that they have already begun looking at how the standard changes with the passing of information in both directions. He added that not only the patient's role in information exchange should be considered, but all participant roles.
- Afton Wagner added that while pharmacists want seamless information exchange, it is still very early in the process. Bidirectional exchange is still done manually, sometimes she noted the actual state of messaging now and added that the best course of action to get to an ideal space is to make small actionable recommendations.
- Scott added that viability for the range of participants needs to be acknowledged.
- Afton added that it is important to look at what the partners are doing and identify how everyone can work together.
- Shelly asked Rick and Steve how the NCPDP utilizes anomalies within communications in the specialty areas like pharmacy or post-acute care.
    - Steve said Rick has a better handle on it from a standards perspective and added that they do well with use cases, but the challenge comes with knowing which tasks should be prioritized.
    - Rick added that building use cases is important. Participants need to join and get involved with examples of use cases that may be more challenging so that solutions can be identified.
- Shelly noted that HL7 doesn't look at the standards the same as NCPDP, particularly with specialties, there are no separate work groups. She asked if anyone would like to address the difference.
    - Scott answered that he has been involved with both HL7 and NCPDP for some time. HL7 is more academic, and NCPDP is more use case centered. He noted that HL7 has come closer to the use case model, but there needs to be a stronger push to get providers to think in terms of use case scenarios.
- Shelly asked Kim what gaps she thinks are most important to identify.
    - Kim answered that it is between pharmacies and pharmacists with the other primary care providers. She noted that achieving fluidity and real time access to patient information is needed for the best level of patient care and coordination. She stated that they would have more information on this matter in September and would report back to the task force on the findings.
- Pooja added to Scott's previous comments on HL7 and NCPDP. Noted that something like a medication may be covered under either a pharmacy or clinical benefit, and there are standards

established on either side. Asked how it can be ensured that the standards of both systems are working together. Noted that overlap needs to be taken into consideration. Added that pharmacy and clinical data need to speak to each other.

- Hans asked if there are any activities the ONC can help with by expediting or by any other means.
    - Kim referred to Christian in the chat and his comment on pharmacist access to the patient chart. She suggested focusing on the fluidity of chart data for the pharmacist. Prioritizing applicable chart areas would be a good use of the task force's time.
    - Rick added more consistency and understanding of benefits, and creating a more common workflow would be good.
- Shelly asked what ONC can do to facilitate the adoption and use of standards for pharmacy based clinical services.
    - Josh said he thinks there is clear guidance needed on how to chart in HL7.
    - Kim referred to slide 8 in her presentation and added that there needs to be specificity around criteria, specifically on the systems and how they will operate, certification, standards, and data exchange.
    - Steve said that NDPCP has been monitoring grant proposals at the federal level and encouraging interoperability to create some level of equity in grant funding opportunities.
    - Rick added that a specific direction and more consistent implementation from ONC would be ideal.
- Shelly asked how ONC can help with medication availability transparency.
    - Steve noted that medication shortages are a major challenge and added that they have been looking at the "facilitator model." There is currently a multistate pilot taking place in relation to COVID and available lab information for pharmacists. Bidirectional communication would help in medical availability transparency.
- Steven continued that there is some level of opportunity there regarding drug shortages.
- Shelly said this is a clinical issue, not just a drug inventory issue. There needs to be a way to recommend another medication when another is in short supply. No bidirectional communication means there is no way to prescribe any alternatives.
    - Steven agreed.
- Pooja reminded everyone to keep the patient in mind while recommendations continue to be made.
- Christian added that a lack of adoption of EHR systems is the primary problem.
- Rick added that patient involvement is critical for complete patient care and medication management.
- Alexis said pharmacists are burdened to facilitate medication coordination having to make monthly calls related to medication shortages due to a lack of coordination between providers and those shortages. Pushed to keep patients informed and not burdened with fixing any communication gaps.
- Hans reviewed the tasks to be discussed in two weeks and asked everyone to watch for homework assignments and note if their name is on the recommendations list.

QUESTIONS AND COMMENTS RECEIVED DURING PUBLIC COMMENT

- No public comments were received.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT

Mike Berry (ONC): Welcome to the Pharmacy Interoperability and Emerging Therapeutics Task Force. Meeting materials can be found at https://www.healthit.gov/hitac/events/pharmacy-interoperability-and-emerging-therapeutics-task-force-2023-3.

Please remember to tag "Everyone" when using Zoom chat.

Pooja Babbrah: Welcome to all of our guest presenters. Thank you for your time this morning!

Pooja Babbrah: I'm curious how the data elements mentioned in this presentation tie to USCDI data elements. Is their overlap? May be worth looking at this for our recommendations

Hans Buitendijk: What efforts are in flight in terms of standards and/or connections to exchange data outside of the prescription focused SCRIPT transactions and what the FHIR based eCare Pan would cover? E.g., access to relevant lab results, sharing of test results, allergies only, etc.. What gaps do see that would have to be filled in terms of standards and/or connectivity?

Kim Boyd: Great question Pooja - the data elements have been reviewed to tie into the USCDI. There is additional evaluation underway through the 2nd gap analysis and comparison to USCDI v4

Pooja Babbrah: Link to the NCPDP Strategic plan: https://www.ncpdp.org/Strategic-Initiatives.aspx

Hans Buitendijk: You mentioned the variation in standards (incompatible, incomplete data structures and coding systems). What can ONC do to help align the variations in standards for the same data, at least to ensure they are fully compatible if not common? What areas are most in need of acceleration and resolution?

Pooja Babbrah: Thank you for calling out UPI - such an important topic. Also - how is TEFCA going to play into the sharing of data with pharmacies? I know we have mentioned this in past calls, but need to be thinking about how this will impact pharmacy

Kim Boyd: Analyze different use cases and data requirements to determine common elements that should be present in the standardized data format. This will also help in identifying any specific variations that are necessary for unique cases, such as Med Rec, ADTs, Standardized Immunization Data

Justin Neal: 100% agree on UPI. Even in our internal pharmacy environment where we are using multiple systems (Dispensing software, clinical/EHR, PA tracking Software.) Spread that beyond the 4 walls of the pharmacy and across multiple stakeholders this become very important to make sure we are talking about the same patient.

Kim Boyd: UPI 👍🏻

I concur both - without incentives to certain communities of care - such as LTPAC, rural providers, etc. to adopt FHIR, messaging will still be vital to support these communities which are often wrought with patients with disparities

Rick Sage: Wholeheartedly agree with UPI...

Hans Buitendijk: Agreed that it is not "just" Direct or "just" RESTful APIs, but an appropriate mix that can use the same payload format/structure support the use case and available infrastructure at hand.

Donna Doneski: Technically, ONC's hands are tied re: UPI by Section 510 of the FY24 Labor-HHS Appropriations bill that prohibits HHS from spending federal dollars to promulgate or adopt a national unique patient health identifier standard. ADVION and our colleagues at PatientIDNow have been working to remove this 20-year old rider. Learn more at https://patientidnow.org/

Josh Howland: My only problem with UPI when it's using something like Experian is that we're using probabilistic matching. If that number is issued by the government then you don't need to make an educated guess, and you don't have to pay for it. Cost is definitely a concern. As Donna mentioned, the government is currently hamstrung to overcome that problem.

Hans Buitendijk: HHS may be challenged to create one, but perhaps well connected networks using aligned record locator services has the opportunity to substantially close that gap.

Kristol Chism: As the Co-Chair for NCPDP's Work Group 20- Coordination of Care and Innovation, we are looking for case studies to improve and promote interoperability, including looking at adding a new task group to explore Admit, Discharge and Transfer (ADT) for pharmacists. Come and join us!

Pooja Babbrah: +1 Hans

Suzanne Gonzales-Webb, CPhT: Which HL7 working group is this coordination happening?

Katie Russell: +1 Kristol , &You don't need to be a member to join a task group !

Pooja Babbrah: Could there be recommendations for patient matching outside of an actual UPI

Christian Tadrus: UPI is a very important data element for PDMPs which are jurisdictionally and technically varied across the states. Legislation across the states that have created these repositories mostly cite similar data elements but rarely specifically require use of a UPI. If UPI was tied to medical orders / prescription orders / care plans / etc. and also PDMPs, clinical interpretation around use of drugs of concern becomes more informed and supports the healthcare professionals that are responsible for prescribing safely.

Pooja Babbrah: @suzanne - in the slide deck, there is a slide that shows where there is work happening across the HL7 accelerators. This work is happening across many of the HL7 workgroups

Suzanne Gonzales-Webb, CPhT: 👍

Hans Buitendijk: Ones to check in particular are Pharmacy, Patient Care, and Structured Documents. Scott Robertson probably has the full list.

Kim Boyd: What we have also heard is that when the eCarePlan is used there is not necessary a fluid way for the primary care provider to communicate back to the pharmacist the actions they took based on the recommendations.

Hans Buitendijk: @Kim: Is that ideally a push by the PCP, a query by the Pharmacist, or either/or as needed for targeted data beyond the overall plan?

Pooja Babbrah: Interesting. I wonder if we should be thinking about eCare Plan as more of a "dialogue" - similar to prior auth, realtime benefit, etc.

Christian Tadrus: Is the eCareplan something that HIEs or QHINs could facilitate transport / exchange for to help speed adoption by endpoint other than pharmacies?

Pooja Babbrah: +1 Christian

Kim Boyd: NCPDP VBA Subcommittee will continue to evaluate through the gap analysis not only the data that may still be needed in the eCare Plan as an example but additional codification recommendations.

Alexis Snyder: +1 to Scott

Kim Boyd: +Christian

Pooja Babbrah: this may also help in getting information to payers too - if pharmacists are capturing this information - it would be great to get payment too

Hans Buitendijk: @Pooja, while I can see a dialog aspect around maintaining a care plan across the care team members (work in progress, hard challenge), there are still the other dialogs outside the care plan.

Pooja Babbrah: @hans - agree

Josh Howland: I would love to see more email/chat like interactions that send components of the eCare plan to providers/payers. Everyone has their own care plan for a patient, but no way for other providers to add/append it. We've fallen into basically sending an electronic PDF of a patient's history.

Christian Tadrus: Is there a need to update the Pharmacist eCareplan Standard to align with data elements identified in newer versions of USCDI?

Pooja Babbrah: @christian - thank you! That was my question/comment

Kristol Chism: The eCarePlan currently lives within the MTM task group at NCPDP. We encourage participation in our discussions on how eCare Plan is being used currently, how it can be updated and how it can be better utilized/exchanged.

Kim Boyd: +Christian - I can go back and recheck but during the evaluation of the eCare plan data elements I believe the NCPDP standards team also evaluated against the USCDI

Pooja Babbrah: @kim - thanks! If these evaluations have been done, I think sharing that with this group will be very helpful.

Shelly Spiro: @Christain PeCP IG needs to be updated to follow HL7 USCore

Christian Tadrus: For pharmacies engaging in PGx, POCT, patient drug therapy monitoring, screenings and even research... lab interfacing would facilitate care coordination and patient care decision-making.

Hans Buitendijk: And going back to Josh's suggestion focusing on Direct as well, there seem to be opportunities to take advantage of that mechanism as well where networks, FHIR servers, etc. are not yet in place (or even where they are as a method for messaging based communication - e.g., eCase Reporting under Careqaulity with APHL/AIMS platform), while using existing standards for the payload.

Kim Boyd: @pooja - I will confirm and circle back.

Scott Robertson: Back on the ADT subject and "notifying the pharmacies". That may be problematic: knowing all of the impacted pharmacies. Better different approach would be having the pharmacies query hospitals for new patient records. This would be similar to having the pharmacies query EHRs/Practice Management Systems for recent updates on patient.

Kim Boyd: @rick agree

Hans Buitendijk: @Scott: One could argue that today pharmacies could connect under Treatment with hospitals/clinics/practices to query for that data. Currently primarily C-CDA focused, with FHIR based APIs on the way. What is the key capability/policy/investment that needs to be in place to actually make that happen as this would be based on existing capabilities that are expanding.

Pooja Babbrah: @scott - good point. I was thinking similar to how a hospital sends the ADT notification to the primary provider on file, they could send the ADT notification to the primary pharmacy on file. It's a start

Kim Boyd: @agree also about Pharmacy System certification opportunity you mentioned @pooja

Donna Doneski: Does the new functionality in NCPDP SCRIPT 2022011 that essentially allows for sharing a copy of the prescription have applicability for care coordination/ bidirectional exchange?

Hans Buitendijk: The focus of HL7 has for many years been on the foundational standard to support a wide variety of use cases without addressing the use cases specifically. That worked as most solutions were intra-organizaitons. IHE started to add the use case focus for HL7 standards, and with FHIR that was brought closer to the HL7 organization to address.

But there is still a distinction between the base standard to drive consistency across the myriad of use cases, and the use cases that need to take advantage of the standard, which is very wide and broad.

Kim Boyd: +pooja - the VBA Subcommittee is taking a look at a specialty medication focus - as this may very well be supportive of what health plans are focused on and they are the ones who are partnered in VBAs.

Christian Tadrus: With professional activities of pharmacists, the use case is that a pharmacist "must have access to the patient chart and plan of care" to perform their functions well. Pharmacists are part of the patient's care team either by decision to use a certain pharmacy or through explicit designation. Conceptually, that baseline logic should inform which interoperability use cases are most common / necessary / mandated or important for patient safety / health outcomes.

Pooja Babbrah: Thanks @kim

Good point Hans

One of the recommendations could be more alignment with ONC and the new WG 20 - care coordinationa

coordination

Justin Neal: @Pooja great example and and just bearing in mind the Specialty Pharmacy space where the pharmacy getting the referral such as a HUB may be supporting/managing the prior authorization process but ultimately sending this prescription off to a specific dispensing specialty pharmacy that may not have the same information or data access the HUB did. But they may require that additional info for an accreditation requirement or payor requirement, above and beyond good clinical practice. A more disconnected process than community pharmacy.

Hans Buitendijk: ONC certifies primarily against implementation guides (C-CDA, not v3/CDA, FHIR US Core not FHIR Core, Immunizations not v2). How much more prescriptive should we go?

From Sheryl Turney to Everyone 11:47 AM

Specifics on the standards and certification of systems for pharmacy vendors; management and EMR systems needs to be more specific. Create a roadmap to certification and data standards required to implement addressing different provider types.

Pooja Babbrah: +1 Steve's comment. We should have equity across SDOs for funding

Kim Boyd: Thank you TF members and other participants for the opportunity to engage today. I need to exit the call to facilitate the start of another call. Looking forward to being involved in how we advance data fluidity between all providers.

Donna Doneski: Not just ONC... CMS needs to weigh in on making sure pharmacists have access to the info, too.

Catherine Graeff: Should we also look at the new SCRIPT message where pharmacies communicate with hear other regarding out of stock?

Pooja Babbrah: Good point Donna. I know ONC is working more closely with CMS on regulations. One important recommendation is for ONC to work with CMS on new regulations as it relates to pharmacy. Especially as it relates to clinical coordination and clinical care

Afton Wagner: Agree with equal funding for all SDOs

Pooja Babbrah: We can come up with some specific recommendations around this. Probably related to VBC

@Cathy - yes. I think we had inventory management as one of the upcoming topics

Rick Sage: We have a Task Group focused on Product Locator to allow physicians and pharmacy to search for available product

Tricia Lee Rolle: @Rick Thanks so much we've also reached out to Phil L to share more about the WG

Afton Wagner: Agree with Christian. Getting data into EHRs is going to be key.

Hans Buitendijk: @Christian: Are there complementary certification benefits on the pharmacy side as well?

One of the challenges with current certification program is that it is mostly a one-sided program where interoperability is actually a team sport that involves two or more that both need to work in harmony.

Josh Howland: Thanks everyone. Have to drop for another meeting. Looking forward to seeing what comes from this!

Hans Buitendijk: One could argue that the primary source may be enough to be consistently supporting a standard/capability as that provides only one way for others to follow. But today not all primary HIT sources for data are supporting the same standard/capability necessary to do so. Including pharmacy management systems.

Shelly Spiro: Thank you Josh

Pooja Babbrah: I think a voluntary certification program for pharmacy - similar to pediatrics could be a way to go to start, but I think we need complimentary certification on the pharmacy side.

Sheryl Turney: great meeting everyone

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

No comments were received via email.

Resources

Pharmacy Interoperability and Emerging Therapeutics 2023 Webpage
Pharmacy Interoperability and Emerging Therapeutics 2023 – July 26, 2023 Meeting Webpage
HITAC Calendar Webpage

Adjournment

Shelly Spiro reminded Task Force members to add their recommendations into the Task Force Recommendations Planning Document. The next Task Force meeting will be on August 9.

The meeting adjourned at 12:01 PM.