



# U.S. Core Data for Interoperability Task Force

Transcript  
May 10, 2019  
Virtual Meeting

## Speakers

Name	Organization	Organization Type
Christina Caraballo	Audacious Inquiry	Co-Chair
Terrence O'Malley	Massachusetts General Hospital	Co-Chair
Tina Esposito	Advocate Aurora Health	Member
Valerie Grey	New York eHealth Collaborative	Member
Ken Kawamoto	University of Utah Health	Member
Steven Lane	Sutter Health	Member
Leslie Lenert	Medical University of South Carolina	Member
Clem McDonald	National Library of Medicine	Member
Brett Oliver	Baptist Health	Member
Steve Ready	Norton Healthcare	Member
Sheryl Turney	Anthem Blue Cross Blue Shield	Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Al Taylor	Office of the National Coordinator	Staff Lead
Adam Wong	Office of the National Coordinator	Back up/ Support
Johnny Bender	Office of the National Coordinator	SME

**Operator**

Thank you. All lines are now bridged.

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

Hi, everyone and welcome to the USCDI Task Force call. We are nearing the finish line here so I will just do a quick roll call and turn it over to our co-chairs. [Inaudible] [00:00:19]. Christina Caraballo.

**Christina Caraballo – Audacious Inquiry – Co-Chair**

Present.

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

Terry O'Malley?

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

Here.

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

Steven Lane.

**Steven Lane – Sutter Health - Member**

Here.

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

Brett Oliver.

**Brett Oliver – Baptist Health - Member**

Here.

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

Sheryl Turney.

**Sheryl Turney – Anthem Blue Cross Blue Shield - Member**

Here.

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

Les Lenert. Ken Kawamoto.

**Ken Kawamoto – University of Utah Health - Member**

Here.

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

Clem McDonald.

**Clem McDonald – National Library of Medicine - Member**

I said yes for Clem, that's me. But I'm not sure who that was a yes for.

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

Yes, thank you, Clem. Valerie Grey.

**Valerie Grey – New York eHealth Collaborative - Member**

Here.

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

Tina Esposito. Steve Ready. And Sasha TerMaat. Okay. Hopefully, the others will join but I'll turn it over to Terry and Christina to get us started.

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

Sounds good. Welcome everyone and a thousand thank yous to all of you who did ballots, were on calls, sent in emails. It was really, really great. And I think the majority of the task force members got their two cents in one way or another. I think our job today is to go through the – it would probably be easiest if we go through the transmittal letter because the slide deck just mirrors the transmittal letter with less information. And before we start on that, does anyone have any general comments, questions, concerns?

**Clem McDonald – National Library of Medicine - Member**

Yeah, this is Clem. I do. So, I just looked up the US Post Office format. And it's not an electronic format. It's saying at least 10 points type, one space between city and address. A simple type font. So, always put the address and the postage on the same side of your mail piece. I think it's wrong for this purpose. This is for a paper format. You can find it on the web.

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

You can find it on the web. And, actually, the post office won't really let you use it for anything else.

**Clem McDonald – National Library of Medicine - Member**

It's not fitting for an electronic structure. And there's one that already does that and it's HL7

both in FHIR and in V2. It's all structured in a standard way. So, this is really a distraction and a confusion, I think.

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

And so, Clem, what would you –

**Clem McDonald – National Library of Medicine - Member**

Well, I'd take it out. I think the current situation is just fine. This talks about how you put it on the envelope. No reverse type, white printing on a background. This doesn't apply to electronic content.

**Christina Caraballo – Audacious Inquiry – Co-Chair**

Clem, what was the HL7 FHIR V2. Can you point that to us? Does it have a standard that we should be referencing instead?

**Clem McDonald – National Library of Medicine - Member**

I don't think you have to insist on it because it's already there. It's done the same way in both. There's a name, first name, last name. I don't know how it goes. And they deal with the international stuff. First name and last name is not always the same in different languages. And prefix and suffix and title. It's got all of those things in it. That's the name. And they've got the address as street address and this and this. I don't know the whole details. It's what's mostly used. So, if we're going to get a different one, it should be at least an electronic one that deals with positions in sort of field positions. This is talking about how you print it on an envelope.

**Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead**

Clem, this is Al Taylor from ONC. I have just a comment and maybe we're just not framing it right or phrasing it right. But at least when I think about the US Postal Service standardized addressing, it usually is a service that's provided for when you're doing data entry into an electronic format where it then calls out to normalize or standardize the US addresses. And I don't know what that process is called but I think that's what most people think of when they think of when they think of US Postal Service standardized addresses.

**Clem McDonald – National Library of Medicine - Member**

Well, what they call it on the web is this is called the format. And it's got all of these other sorts of surface things. I think that would be good but even that's a little – so my address is Chapel Crossing, C-R-O-S-S-I-N-G, and the post office will turn it into X-I-N-G, which is fine. But I'm not sure if everybody knows that when they write it and when they record it at a hospital. I think what we should do is encourage all systems to convert it into the post office street address specifications that they can pull offline. But this doesn't say that. I agree with that idea but then, you've got to talk in terms of who has to do that. Is it the person who is putting in their address or is it the system that accepts it and then, checks it?

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

Clem, I think what we're saying is accept the format because the purpose behind this was to enforce this –

**Clem McDonald – National Library of Medicine - Member**

But, Terry, the format, if you're looking on the web, the format is talking about all of these paper structured formats, unless you got a different website. I just looked it up. It's describing how you have to record it on an envelope. It's a –

**Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead**

So, there is USPS Web Tools Application Programming User's Guide Document Version 5.3. I'm happy to share the link to this. Obviously, there are multiple specifications available. And I'm sure USPS has a written one as well. But there is also online API guidance. And the only thing with this is, as Steve Posnack previously said, they don't license it for any use outside of shipping.

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

And I think the point behind this was really it came out of the AHIMA paper on patient matching and the –

**Clem McDonald – National Library of Medicine - Member**

I'm behind all of that. Yeah.

**Christina Caraballo – Audacious Inquiry – Co-Chair**

Yeah. I just sent a link that was referenced in that paper in the chat. I was just going through them.

**Clem McDonald – National Library of Medicine - Member**

Well, the paper is on the proposal. But the problem is what you'll find when you say format is not that general statement. I would make sure you have a complete and accurate address because they won't match. I'm sorely supportive of that. I just think that if this becomes regulation, it's saying, literally, USPS format and content. And if somebody looks it up, it's not what you're meaning.

**Christina Caraballo – Audacious Inquiry – Co-Chair**

So, how about align with USPS?

**Clem McDonald – National Library of Medicine - Member**

I think what you want to accomplish is that the computer systems that receive it would verify it and convert it into the standard address. But are they allowed to if it's only allowed to be used for shipping?

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

Yeah. I don't know, Clem, if we're going a little deeper than we have to.

**Clem McDonald – National Library of Medicine - Member**

Well, I'm just looking at the words. You type it into the web and what you get is this thing for

format is the thing that you don't mean.

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

So, do we want to change the word format?

**Clem McDonald – National Library of Medicine - Member**

I think if you've got a reference to an API that gives it as a structure that would be fine. But the API then, I just heard someone say, can't be used by hospitals or other clinical care systems.

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

I think what we're recommending in the USPS format was the one that was cited in the AHIMA is we're looking for really a standardized way of entering an address, basically, because when it is not entered in a standardized fashion, data entry errors go up and patient matching suffers.

**Clem McDonald – National Library of Medicine - Member**

Well, I don't think the entry – then, Terry, what you're saying is you don't want to enter – the standardized fashion you need a computer. You need to know that they call it X-I-N-G instead of crossing. I think the intention is absolutely correct and right. But I don't think it's expressed correctly.

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

Okay. How would you like to express it?

**Clem McDonald – National Library of Medicine - Member**

Well, who knows the API and what it says? There might be a piece of that you could say. But did I hear correctly that the ideal would be that the post office would let hospital and clinical systems, when they register patients, to use their checker? That would be the perfect answer because then, no human has to do it. The computer will tell them no, this address is probably this. You must get that. You go to some place and ask for the address. Actually, other systems will let you use it. So, maybe it's not restricted just as shipping. I've seen it happen in other contexts where it corrects my address. Does anybody know? Is anybody really familiar with the API?

**Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead**

The address API documentation says important notice, address information, API. The address validation APIs can be used in conjunction with USPS shipping or mailing services only. Failure to comply with these terms and conditions can result in the termination of USPS API access without prior notice. So, it might be that people are using the APIs and are not in compliance with their terms and conditions and it hasn't been turned off.

**Clem McDonald – National Library of Medicine - Member**

Well, what about we recommend there would be a request to the postal service to allow healthcare registration systems to use it? And that would get everything right. That would be our recommendation.

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

All right. So, that's a friendly amendment. So, the rest of the group, do you want to weigh in on that? So, let me just see if I've got this right. So, our recommendation 1B where we say to encourage the use of USPS format would be ONC to convince the post office – ONC to investigate –

**Clem McDonald – National Library of Medicine - Member**

Or request access for healthcare organizations to use that system to get the addresses exactly the same or correct.

**Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead**

I think that one acceptable use of the addresses, the standardized addresses for health care organizations is for shipping. It's a mail address. So, that's an appropriate use of it. It's also used for identification but it's also used for shipping. So, that may very well be –

**Clem McDonald – National Library of Medicine - Member**

We may just say use the API, the healthcare system should use the API without asking because they probably could already.

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

I guess if they're sending letters out.

**Clem McDonald – National Library of Medicine - Member**

So, why don't we say that the healthcare organizations use the API and ONC smooths the road for it or smooths the pathway if there are any barriers?

**Christina Caraballo – Audacious Inquiry – Co-Chair**

What about ONC requests access for healthcare organizations to use USPS standardized address for capture in the clinical systems?

**Clem McDonald – National Library of Medicine - Member**

Is that the API?

**Christina Caraballo – Audacious Inquiry – Co-Chair**

Yeah. Well, I can write API in there.

**Clem McDonald – National Library of Medicine - Member**

Well, if you add API and then, we can cite it then because there's a document.

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

Yeah. We just put another footnote in.

**Clem McDonald – National Library of Medicine - Member**

Okay. So, sorry to be so disruptive.

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

No. No, no, no. Again, one of the purposes of this call is to get issues like that out on Friday afternoon rather than Monday. So, perfect, Clem. That's great. And so, we're going to vote on this on the call. So, Christina's recommendation, is that okay with everyone on the call, ayes and nays?

**Clem McDonald – National Library of Medicine - Member**

I like it.

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

Are there any nays? We're going to do fast votes. The chair recognizes that it passes. Great. All right. What's next? Everything else is perfect. That's great. So, if you want, I can go through – so, this transmittal letter came about based on the ballots that I think six or seven of you completed. It came about from a phone call, which had four people on it. And it came about from a smattering of emails that came in. This was all last week. And the resulting words in the transmittal letter really reflected recommendations that – the changes came about on recommendations that didn't have unanimous support of the task force and, essentially, were rewritten back to either a more generic, less specific format. So, some of our positions resulted in change.

For example, the address, phone number stuff was pretty straight forward. There was no real big difference there. The definition –

**Clem McDonald – National Library of Medicine - Member**

The only question I have on that is that the idea of when someone registers, you've got to then include the addresses for the last 20 years, I think, is really painful. And I'd rather say just accumulate them. That is don't require people to go backwards and enter them. They won't even have systems to do that right now. But ask if they'd continue to hold them after they change them.

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

Yeah. All we're asking for is that they include both current and previous addresses. We're not asking them to enter all of them. So, again, we have a disclaimer in the front. I don't know if anyone read the disclaimer. But, basically, it says we're just talking about data elements. We're not talking about how someone has got to implement it or what the workflow looks like or any of that stuff.

**Clem McDonald – National Library of Medicine - Member**

We just want a place to put it.

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



Yeah. Here's what you need to keep. You figure it out. We don't care.

**Clem McDonald – National Library of Medicine - Member**

Well, there you're getting sort of a guidance action. If you say here's a place you could put it versus this is what you must do, they're two different senses.

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

Yeah. This is a must. The USPS format really is a must do. It's to standardize the format. And I appreciate the improved words there, verbiage. But that is a must. That's sort of the basis for error reduction and improved patient matching. That ranks high up on important things to do, in my mind. Phone numbers. So, mobile and land lines, just say that we have a place for both of them. We didn't say one should be a priority over the other. It just should have room for both. And Recommendation 2B was really to designate whether a phone number is shared or private, which I think captures the spirit behind the recommendation. Okay.

**Steven Lane – Sutter Health - Member**

So, this is really two things. One is whether it is that of the patient or another party. And the other is whether it is shared or private.

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

Right.

**Steven Lane – Sutter Health - Member**

Okay. That's fine.

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

Did somebody else have a comment on that, too?

**Clem McDonald – National Library of Medicine - Member**

I'm just not sure what the shared or private – I don't know what that is because –

**Steven Lane – Sutter Health - Member**

A landline is shared. A mobile line that's designated to an individual person is private.

**Clem McDonald – National Library of Medicine - Member**

Well, I thought we already distinguished land lines from mobile lines.

**Christina Caraballo – Audacious Inquiry – Co-Chair**

We were combining two so this also addressed if a phone number was a parent's that was associated with a child.

**Clem McDonald – National Library of Medicine - Member**

Yeah. That's good. And I think that's there, too, isn't it? It says who is it associated with.

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

The problem is for a child is that it may not be in their name or it may be the parent's cell phone to be contacted in lieu of.

**Steven Lane – Sutter Health - Member**

I know that in our organization, we have a very manual, free text process wherein we specify that it's okay to leave a private message on a given phone number. So, whether a phone number is a mobile or a land line, it may or may not be private.

**Clem McDonald – National Library of Medicine - Member**

I think that's a better phrasing. Could you leave a private message on it? That's a better phrasing.

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

Yeah, good point.

**Steven Lane – Sutter Health - Member**

But you're right. For any number, it should say is it mobile or land line, what individual is it assigned to. Again, a home number to a home with six people living in it, that's going to be a shared line. It still may be attributed to the patient themselves, even though they're an adolescent because it is, indeed, their home number. But it would be designated as shared and/or not okay for leaving private messages or however you want to designate that.

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

And, Steven, would you ask the patient whether this is a number that they would –

**Steven Lane – Sutter Health - Member**

Yeah. That's a patient designation. Absolutely.

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

Okay. So, what if we rewrite this section to say we're going to do land line and mobile? It almost doesn't matter. But you want to know who it's associated with.

**Steven Lane – Sutter Health - Member**

Yeah. Oh, yeah.

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

And then, whether or not it can accept a private message.

**Steven Lane – Sutter Health - Member**

I like that.

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

Now, again, the patient has to designate whether it can accept a private message or whether they want to use the line for a private message.

**Sheryl Turney – Anthem Blue Cross Blue Shield - Member**

This is Sheryl. I don't want to throw a wrench into this but what about the web line? They're becoming a lot more popular as well. And they're neither land lines nor mobile.

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

Good point.

**Clem McDonald – National Library of Medicine - Member**

Do you mean IP telephones?

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

Yeah, VOIP.

**Clem McDonald – National Library of Medicine - Member**

I think you think of that as a land line, not anything different. It's ringing in your –

**Sheryl Turney – Anthem Blue Cross Blue Shield - Member**

Well then, we might just want to use a different descriptor because it's, essentially, people might not think of it as a land line.

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

Mobile other?

**Clem McDonald – National Library of Medicine - Member**

Oh, okay. We can say a home phone or something like that because it's often the same number. You just get a cheaper service.

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

Yeah. So, you want to do three designations, land line, mobile, or other.

**Clem McDonald – National Library of Medicine - Member**

No, no. I think instead of saying land line say home phone. Well, maybe that won't work. But just because that's kind of – I don't think there's a difference between the IP lines and what we used to call land lines. It's just what you happen to buy. The function is the same.

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

And think about why we're asking about a mobile number is because that's useful in patient matching. So, it's a good number to know.

**Clem McDonald – National Library of Medicine - Member**

Correct.

**Steven Lane – Sutter Health - Member**

Well, it's interesting, as Clem says, people now are subscribing to a web based number that you can access from your mobile phone. You can access it from home, from work. It's independent of the hardware. So, it is mobile in that sense but it's not what we traditionally think of as a mobile number.

**Sheryl Turney – Anthem Blue Cross Blue Shield - Member**

Yeah. That's what I was talking about.

**Steven Lane – Sutter Health - Member**

Yeah.

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

Interesting.

**Steven Lane – Sutter Health - Member**

My wife has got a Google phone number that she uses for her business.

**Clem McDonald – National Library of Medicine - Member**

So, we've got to get a good name for that.

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

So, we're trying to accomplish at least two things with this section. One is to identify the mobile number just for patient matching purposes. And then, we have a communications issue about privacy. And so, maybe we ask those separately. So, we identify the mobile number plus any other numbers. And then, we ask whether the patient would – which number the patient would prefer to use for a private message if any.

**Christina Caraballo – Audacious Inquiry – Co-Chair**

I feel like we've gone back and forth on this before. And, Terry, help me remember. But I think one of Sasha's statements was they collect in the systems all of the phone numbers but putting a – distinguishing between them might be more complicated. So, I'm trying to remember. But maybe we could do something like an in between where we put include the mobile and land lines that we have. And then, put software should support multiple phone numbers specifically identifying mobile numbers because I think the key is that mobile has come up as extremely valuable for patient matching. So, if we say support multiple phone numbers and we don't qualify what they are but put a mobile number associated with the patient and put a little star next to it or some other field. That's the key one that we need.

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

Okay. Do we have a –

**Christina Caraballo – Audacious Inquiry – Co-Chair**

I think silence is everybody liking that.

**Terrence O’Malley – Massachusetts General Hospital – Co-Chair**

Do you want to write the recommendation and read it back? So, A is –

**Christina Caraballo – Audacious Inquiry – Co-Chair**

So, I have 2A. I’m writing it in real time as we’re doing this. So, I have 2A include destinations for both mobile and land lines. The software should support multiple phone numbers specifically identifying a mobile number.

**Terrence O’Malley – Massachusetts General Hospital – Co-Chair**

Okay. And then, for B?

**Christina Caraballo – Audacious Inquiry – Co-Chair**

I’m still ironing that one out.

**Terrence O’Malley – Massachusetts General Hospital – Co-Chair**

Okay. Maybe we’ll come back to it. Well, while you’re working on that, Christina, we’ll go down to Recommendation 3. This is simplified a little bit to just focus on collecting email addresses the first time around and V2 can look into more detailed ways to contact the individual. So, really just sort of sculp it down a little bit to let’s get email addresses to start. It won’t be everything that everyone uses but it’s easier than specifying everything that could be used. Is that okay with people?

**Steven Lane – Sutter Health - Member**

Yeah.

**Sheryl Turney – Anthem Blue Cross Blue Shield - Member**

Yes.

**Terrence O’Malley – Massachusetts General Hospital – Co-Chair**

Okay. Or maybe I’m going to ask it a different way. If that’s not okay with somebody, speak up that way you don’t have to answer. Okay. And 4 was consent to authority. It’s individuals with authority to consent. That was pretty much unchanged. So, 5, the last four digits of the social security number. There are a couple of comments in our ballot about security concerns. And so, this was sort of you split the difference. It said included we’re aware of the security concerns.

**Clem McDonald – National Library of Medicine - Member**

The security concerns, the last four digits are there are 300,000 people with each last four digits on average because the early digits are more identifiable. But the last ones just churned. Is there a definite – maybe there is one but do they give specifics when they complained?

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

No. But when you read about Google being able to tell who you are based on 10 pieces of data, knowing you within 300,000 people makes it really easy because then, if I had anything else, where you lived, your town, there's probably only 300 people with the same last four. So, I think 20 years ago that may not have been a problem.

**Clem McDonald – National Library of Medicine - Member**

Okay. I get it. Never mind.

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

And then, we said optional to make space for government issued IDs, in particular, driver's license and pass ports.

**Clem McDonald – National Library of Medicine - Member**

Good idea as long as it's optional, yeah.

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

Yeah. And then, self-reported gender identity. That was pretty unanimous. Okay. Christina, you let us know when you've rewritten the phone number. So, on the provenance data elements, this was – so, the discussion was around how hard it is to tell who the author is depending on the data type. And we sort of flipped it around and said what if we say just use author for notes and for prescriptions and if the patient is the author because those are three unambiguous situations. There's going to be an author for each of those that we can identify. And for everybody else, for any other data class, any other data elements, we just are satisfied with the author's organization but we don't have to know the author.

**Steven Lane – Sutter Health - Member**

So, for notes, are you including textual notes like radiology reports?

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

Yeah, I think so.

**Steven Lane – Sutter Health - Member**

Textual results, I should say.

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

Yeah. I think we're talking about clinical notes.

**Steven Lane – Sutter Health - Member**

Yeah. But I would include textual results.

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

Okay. We made it broadly to clinical notes, in general. And that may not be the right thing to do.

**Steven Lane – Sutter Health - Member**

Yeah. But it seems to me ambiguous as to whether you consider a path report or a radiology report or the interpretation of a sleep study to be a clinical note. And each of those clearly has an author.

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

Yeah. I would consider them a clinical note.

**Steven Lane – Sutter Health - Member**

And that's fine. I just wouldn't immediately. So, I would just say let's just say including textual results.

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

Okay. So, do we want to add that piece in?

**Steven Lane – Sutter Health - Member**

I would, personally.

**Clem McDonald – National Library of Medicine - Member**

I'd suggest we add something – there is a big activity around this in the standards organization. They're actually of the Internet Engineering Task Force has defined a whole spec for provenance. And I think we should say this should be adjusted according with consultation with the appropriate standards groups because I don't know that we can write a spec that well.

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

Okay.

**Clem McDonald – National Library of Medicine - Member**

I think it's good what we've done but I'm just worried that –

**Steven Lane – Sutter Health - Member**

Yeah, but we're not writing specs. We're saying what belongs in USCDI. Any data class or element in USCDI, someone has to be responsible for the spec.

**Clem McDonald – National Library of Medicine - Member**

But you're specifying how it has to – there are some details you're putting in here that may collide with things. You may not need them because they're somewhere else in the message. I just think we shouldn't overreach and just say adjust as needed in accordance with the evolution of the standards. I'm not criticizing what we've done but I just worry that I don't know enough for sure about how it's going to evolve.

**Steven Lane – Sutter Health - Member**

But, again, I think the standard speaks more to where it is in the message. And we're at a higher level than that. We're sort of saying that for USCDI, it should include these data. ONC shot across the bow that it should include the author. And we're sort of saying it doesn't really need the author in all situations. It only needs it in certain situations where it's unambiguous.

**Clem McDonald – National Library of Medicine - Member**

Well, I'm happy with what's written. I'm still not confident in the long term that we're not going to collide. And what's the harm of suggesting that it should be adjusted as appropriate for what's the – because some of this has worked out all right and we haven't studied it.

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

And, Clem, I think we'll give ONC the benefit of the doubt that that's exactly what they're going to do. They're going to take our recommendations because we don't get to write them. We get to offer them. And ONC will say this is a great idea but A) there are no standards so we'll see later or if there are conflicting standards or we like this one.

**Clem McDonald – National Library of Medicine - Member**

They're on the phone, right, with us?

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

Yeah. Al is –

**Clem McDonald – National Library of Medicine - Member**

Do you understand that this is something you would take with – you'd adjust as needed?

**Adam Wong – Office of the National Coordinator for Health Information Technology – Back up/ Support**

This is Adam Wong. I think you can assume that ONC will do the research and due diligence to ensure that we do it properly.

**Clem McDonald – National Library of Medicine - Member**

Thank you. You won't blindly follow our command.

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

Fortunately. Follow us over this cliff. I don't think so. All right. So, how far did we get? So, the author is designated for all of the data classes. We're going to include text blocks that don't have an author. Okay. And then, the other change was instead of author's time stamp or author's organization's time stamp, and I think it was Sasha who said why don't you just call it time stamp because time stamp is really a local issue. We're asking a local system to place a time stamp on data and be able to use it for the provenance of that data element. And how they do it is really up to them. We were afraid we were trying to get too much into the weeds and be too specific about how that should be done.



**Steven Lane – Sutter Health - Member**

I like that. I think that's a good suggestion.

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

Yeah. It simplified things in my mind like that's true.

**Clem McDonald – National Library of Medicine - Member**

For the record, if they're using any of the standards for messages, time stamps are specifically defined. But it's allowed to be longer or shorter. Some of them, you can actually define the Greenwich Mean Time in the time stamp.

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

And that's fine because all we want the time stamp for is to have the generating organization be able to tell us. And whenever they say it was born is when it was born rather than when the author released it or whatever that was proposed earlier. And then, there's an addition, which sort of clarifies. On Recommendation 12, and that was remember we had said consider creating a unique patient identity. So, instead of that, the substitution is the system should indicate when the patient is the author of the data. So, we're not trying to create a universal system of patient identity. We're just saying your system should be able to tell when it is the patient.

**Clem McDonald – National Library of Medicine - Member**

I think we'd like that but we can't ask for it.

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

Of course, we can. We can say we need to know when the patient is the author.

**Clem McDonald – National Library of Medicine - Member**

I'm agreeing with that. I was talking about the idea that it might be asking for a unique identifier, which I wish we had but we can't get.

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

Yeah. And then, we go down in those weeds. And I think the second a universal patient identifier is available, it will be a year but it's going to be an act of Congress. Okay. We're okay? Any nays in whatever section we were in?

**Clem McDonald – National Library of Medicine - Member**

No nays.

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

Great. So, now we're into clinical notes. And this is where I think it was Sasha primarily who made some recommendations about eliminating some notes. So, we just said the list that ONC proposed, those eight note types, we said definitely back five of them. And Recommendation

14 is change imaging narrative to diagnostic imaging report, which is about to be released and should cover everything that the imaging narrative would contain.

**Clem McDonald – National Library of Medicine - Member**

So, Terry, I like everything it shows here but it wasn't crystal clear. Those things that say take back, people are agreeing with that. Is that not something that's – I agree with them but I just didn't know whether each of them was a separate decision that we should agonize over.

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

And, hopefully, we're all in agreement about consultation, discharge, history, procedure, and progress.

**Clem McDonald – National Library of Medicine - Member**

It's a succeeding recommendation. I just want to know are there mixed opinions on Recommendation 14 through 24 or could we consider them as a block?

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

Yeah. I'm sure – go ahead, I'm sorry.

**Christina Caraballo – Audacious Inquiry – Co-Chair**

No, I was just going to say per recommendations from ONC, we put them individually so it would be easier to reference them.

**Clem McDonald – National Library of Medicine - Member**

I meant in terms of our positions in this discussion, are these mostly vetted and we can just say we like them all? Or do we need to discuss each of them?

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

I guess the question would be if anyone has any different opinion then, we ought to just see these as a block because they're, basically, saying don't add these note types because there's another note that already is available that covers it.

**Clem McDonald – National Library of Medicine - Member**

Yeah. I like all of them. I think somebody did some good thinking.

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

Yeah. Well, it wasn't the co-chairs so that's good. Good. And then, the next one is we said to include all of the following things. And there are really three that we said you ought to include. The continuity of care document, the operative note, and the miscellaneous note. Miscellaneous just being a place holder for stuff we don't know to put anywhere else. Are there any –

**Clem McDonald – National Library of Medicine - Member**

I think they're all good.

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

Okay. Any nays on those? So, then we pulled out there were a bunch of other recommendations. The transfer of care, advanced directive, and the care plan note. And we proposed that they be made optional this year. Really, they get our toe in the door. And it also gives a pretty strong heads up of what's coming.

**Clem McDonald – National Library of Medicine - Member**

Those are also good ideas.

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

Speak up when you don't like it. And then, we push referral note and long term services support notes to a future version.

**Clem McDonald – National Library of Medicine - Member**

I like it.

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

Okay. We're all okay? That was the hard part. The pediatric vital signs came through unscathed, I believe. We just, basically, said on the calculated versions that we adopt all of ONC's. Before, we said no, we don't want BMI. We don't want weight for age. We said no. But what then, we said you could use them in certain circumstances. So, we really accepted them. So, we accepted all of ONC's recommendations with the caveat that if you don't store it then, you don't have to send it, unless you give it to the patient in which case you have to have a copy, even if it's a PDF of a nomogram or a note or something. It doesn't have to be discrete data because there were two concerns. One was how hard it is to send it if you don't calculate and store it.

And the other was if you do give it to the patient and the next clinician down the line needs to have that information, too. So, you've got to store that and have it available. So, that was sort of the thinking behind this. And it's the same for 25 and 26.

**Clem McDonald – National Library of Medicine - Member**

I like how it came down.

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

Going once, twice. And then, Steven, we amended the ONC description of the item weight for length percentile by age and sex.

**Steven Lane – Sutter Health - Member**

Yes, I saw that. Thank you.

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

That captured yours. All right. On to 27. Unanimous, show no frontal circumference. Passed

without descent. Okay. So then, we get to are there elements that we ought to propose in other data classes that we were not asked to comment on that are important. And there are really only two – three, sorry.

**Clem McDonald – National Library of Medicine - Member**

I'm sorry. Could I back up to 27 for a second? I thought head circumference was already embedded in a HIPAA and being done already by rule.

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

I don't think so.

**Clem McDonald – National Library of Medicine - Member**

It's one of the vital signs.

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

Well, if it's there, it will be easy.

**Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead**

This is AI. It was an optional vital sign for CCDS.

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

Oh.

**Clem McDonald – National Library of Medicine - Member**

So, we're just saying we should make it required? Is that what we're saying? Or was it optional because it could only be done on kids?

**Steven Lane – Sutter Health - Member**

It's only used in kids, yeah.

**Clem McDonald – National Library of Medicine - Member**

I mean, just clarification. It has been in some spec already, is that what you just said? So, then I think what we're saying is we make it required? Because otherwise, we're being redundant or we're saying something to do that's been done.

**Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead**

Yes. My read on that is not proposed to be optional like it was implemented to be optional in CCDS.

**Clem McDonald – National Library of Medicine - Member**

Okay. So, we should highlight – this is the same proposal – we're saying to strengthen what has already been done to make it required. What it looks like we didn't know about the past and I don't think that looks good.

**Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead**

Well, ONC proposed that this be a required element within the USCDI. So, the recommendation here would be that the task force agrees with ONC to make it required rather than having it as optional previously.

**Clem McDonald – National Library of Medicine - Member**

Yeah. I was just looking for some clarification that this isn't brand new. And I agree with what you're proposing. I'm not disagreeing but just make it clear that this wasn't a green field. We're going to make what was optional we're making it required. So, the vendors don't have to scratch their heads. They just have to throw a switch and say it's required rather than scrape around and figure out something new to say. Do you know what I'm saying?

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

Do you want to just add something as a required element?

**Clem McDonald – National Library of Medicine - Member**

Yeah.

**Christina Caraballo – Audacious Inquiry – Co-Chair**

I think this is implied. So, I think that anything that is being proposed in B1 or USCDI by ONC that we are looking at is implied that it's already required somewhere and has been already kind of made it up to that optional status at some point at least if it's not already required.

**Clem McDonald – National Library of Medicine - Member**

What I was just saying is they currently require optional occipital frontal circumference for children of 3 is going to be made required. I think that's what we're really saying, not to start from scratch or am I missing something? I may be missing something.

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

Just if ONC is proposing it –

**Clem McDonald – National Library of Medicine - Member**

As required. So, we're disagreeing. Okay. Never mind.

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

Unlike some of the other times when we didn't.

**Clem McDonald – National Library of Medicine - Member**

Yeah.

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

So, going on down to 28, care team member data class. Why don't you throw in some

demographics so you know who is on the care team? And we'll leave it to ONC to figure out what the identifier is because we couldn't. And for medications, No. 29, what we did is we took out the reconciled med list and who reconciled it because it's clear that that's an important process but it's not a uniform one and it's not done well across the board. So, we left that out just because of lack of clarity but left in the indication of associated diagnosis with each medication.

**Clem McDonald – National Library of Medicine - Member**

With the CMS requirement to include any medication data they have and deliver it to patients and providers and I heard at the last HL7 meeting that some of the non-CMS controlled ones are thinking they'll do the same thing, we might finally have a unified record of all of the prescriptions that would make it easy to do reconciliation. We're not there yet but I just wanted to put that on your mind.

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

That's great. And it's going to take that because it's such a difficult process. And the places that do it well spend a lot of time doing it. It's not easy. So, that would be wonderful. That's great. So, any nays with demographics for care team members so we know who they are?

**Steven Lane – Sutter Health - Member**

Love it.

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

Okay. And then, No. 29 is the meds. Okay. And then, the last is we moved the homelessness designation out of the address to Recommendation 29. No, I'm sorry, No. 30. My apologies. So, there's some way to designate when someone is homeless or displaced or a refugee. Yeah. The use case that comes to mind most recently are the wildfires in California where there were thousands of displaced persons who had to have their medical care managed.

**Steven Lane – Sutter Health - Member**

Yeah. It's interesting that displaced, refugee, and homeless all have very different connotations. I don't know if at the level of USCDI they're all the same or if they're different.

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

Yeah, good point. I think the commonality of it is almost – these are people that it's really hard to know where they are or where they're from or where they're based. And yet, we have to manage the care. Do we need a heads up that tells us that this is the case? That's what this designation would do. It would be something as simple as just saying you don't have a fixed address.

**Steven Lane – Sutter Health - Member**

So, maybe it's just a simple designation that they don't have a fixed address. Though in the case of the displaced, I think you mentioned the fires. People may have an address that's still their legal address but they aren't using it currently or it's not available or it's been flooded or burned or blown off or something. I just don't know if we just want to get a simple yes/no, this

person doesn't have a fixed address of if we want to ask for more than that. Maybe keep it simple for now. It's like the designation in the family history screens that says adopted. It's just one little piece of data but it tells you a lot.

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

So, Steven, you're saying amend this to a designation for individuals without a current fixed address?

**Steven Lane – Sutter Health - Member**

Yeah, I think that's fair.

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

Something like that?

**Steven Lane – Sutter Health - Member**

Yeah.

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

And then, we'll get rid of the homelessness, displaced, and refugees, which sort of muddies the water.

**Steven Lane – Sutter Health - Member**

No, I think those are okay. I think it's okay. I, frankly, think the way you've got it written is pretty good. You maybe just need to get an e.g. For patients without a fixed address, e.g., those experiencing homelessness, displaced, or refugees.

**Clem McDonald – National Library of Medicine - Member**

Yeah. That's a good point. It helps clarify.

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

Great.

**Steven Lane – Sutter Health - Member**

Now, the reason I threw in that language about address entry standards is because this is something that we have struggled with in the current state where we don't have this designation. Where we said if we don't have a way to say that they're homeless, let's at least all agree how we're going to enter homelessness in the standard address fields so that we can understand that when we share information across organizations. So, maybe if you have the designation as a discrete field, you don't need the address entry standards. But that's where I was coming from when I suggested those words.

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

Yeah. I think the address entry standards if I'm remembering correctly, were that it needed to be somehow married to the other address standards.

**Steven Lane – Sutter Health - Member**

Right. What do you put in the street, city, state, zip when someone is homeless?

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

Right. No value, can you accept a no value in your address –

**Steven Lane – Sutter Health - Member**

Yeah. I think that's still worth including here.

**Christina Caraballo – Audacious Inquiry – Co-Chair**

So, in the descriptions, what would you add?

**Steven Lane – Sutter Health - Member**

Maybe just the idea that our standards specification of what should be put into discrete address fields for people with this designation.

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

Okay. So, we're recommending to ONC to do something. So, we want them to include a designation –

**Steven Lane – Sutter Health - Member**

A specification of how the address should be entered for people with the designation of no fixed address because what happens is that the systems are trying to do patient matching on the address and they can't do it because different organizations have come up with different ways to fill out the fields for homeless folks.

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

Okay. So, include a specification, is that what you said? I hope somebody is writing this down.

**Christina Caraballo – Audacious Inquiry – Co-Chair**

There, it's in the chat.

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

Wonderful. Okay. Any nays, concerns, allergic reactions?

**Steven Lane – Sutter Health - Member**

That looks good, Christina. Thank you.

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

Great. Okay. And then, we said we have a missing data class because we didn't know where else to put this. So, this is No. 31, and that was the quality measures data class recognizing – so, we took out all of the stuff we had in before about how one might do it and what the



process might be to just say start a process to build this data class recognizing it's not going to be easy. There are a lot of quality measures that are not harmonized. But if we don't start somewhere, it's going to stay the same. So, any thoughts on that? We're okay?

**Steven Lane – Sutter Health - Member**

Yeah, okay.

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

No qualms or concerns? Okay. Then, the last one was instead of assigning a unique identifier to begin the process to assign a unique and persistent identity for each data element with this governance structure. And this is what we're essentially doing and AI agreed we can do this is just punting this whole problem to ONC and just saying this is a real problem and we need to solve it. Have at it without any guidance.

**Steven Lane – Sutter Health - Member**

So, why did we give up on all of the thoughtful ideas that we've come up with? Because this came up in ISPTF. We worked on it further here and now, we're just sort of throwing that all away?

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

No. I think it's just to do the first step. If you want to add more, we can add more to the paragraph. I took most of the verbiage out just because –

**Clem McDonald – National Library of Medicine - Member**

It's a messy space, Steven, and the pathways aren't settled. The CQLs are just kind of now available or almost available and how that will work and how it will change things. And there are a lot of changes going on now in what they want to do in quality measures.

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

And the quality reporting data architecture, the QDRA, which CMS is pushing. So, I think there will be a lot that a data class like this could help support. And I see this in the long run as being just another way to get a group to come forward to be the stewards for a data set or a data element to get into the –

**Steven Lane – Sutter Health - Member**

Well, I guess the one thing, Terry, that you stripped out that I'd recommend we maybe reintroduce is not so much all of the detail about you need one for the first one and one for each instance, etc., but just kind of the use cases that we identified, the importance of being able to de-duplicate in version. Maybe if we could at least grab that sentence and keep it in.

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

Sure. Right. Okay. Got it.

**Christina Caraballo – Audacious Inquiry – Co-Chair**

De-duplication and what was that, Steven?

**Steven Lane – Sutter Health - Member**

Well, we worked it pretty hard before. I'd go back to the earlier version. It was de-duplicating and versioning were the two that come to my mind. I don't remember if we had another third one that we had come up with.

**[Crosstalk]**

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

Those were the two, I think.

**Christina Caraballo – Audacious Inquiry – Co-Chair**

So, did we make it through all of them, Terry?

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

We made it through all of them.

**Christina Caraballo – Audacious Inquiry – Co-Chair**

Okay. So, in the chat, and I'm sorry it came through weird with the spaces, I copied and pasted what I captured for the patient demographics. I might have missed part of it so I want to make sure we got that right.

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

Okay. So, are we feeling okay for Monday? And we'll make sure that the slide deck syncs up with the changes we've made to the transmittal letter. And we'll flag the changes that we made today in the presentation just to give a heads up to the HITAC. Okay, folks. So, a great piece of work. Next week on the 17<sup>th</sup>, Steve Posnack is going to come by and give us an overview of Phase 2, which is going to be sort of the advancement process for how data elements go from being proposed to being in USCDI. We took a stab at that a year ago and came up with six steps, which Clem thought were four too many. And ONC agreed it was at least three too many.

So, it kind of got it down to three steps now. Anyway, it's the way it is. But they absorbed most of what we said. They just telescoped it a little bit. But not to steal Steve's thunder but I think the important part was that it's a wide open process to nominate data elements that it would become part of a publicly maintained data set where you can see it and see what's happening to it. And then, that goes through the steps of clarity, harmonization and then, attaching it to standards or encouraging standards to be attached to it until finally, it gets tested and into production and then, finally, into USCDI.

**Steven Lane – Sutter Health - Member**

I'm excited to hear where they want to go and how our task force is going to be able to help support that. The other real open question, which comes up a lot is not only what's the process for introducing new ones but what are we going to do with that proposal that came out over

a year ago now of what was supposed to be added in 2019 and 2020 and 2021 and beyond. Is that going to be dusted off and actually is that work going to begin at some point? Is that all just being thrown out as a lot of interesting ideas and we're going to start from scratch? Is that part of what Steve is prepared to talk about?

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

I don't know but that's a good question. We can ask him.

**Steven Lane – Sutter Health - Member**

I didn't know if maybe you guys had a pre meeting already.

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

No. We saw the slide deck but we didn't delve into any real detail. But those are all good points.

**Steven Lane – Sutter Health - Member**

Yeah. Because when you're out there talking to people, everyone is enthusiastic about USCDI, especially as it's been named in the NPRMs, etc. But everyone immediately asks. So, what about that glide path? Not just the process but the actual content as they've been proposed. So, let's be sure that Steve knows we want to talk about that, too.

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

Yeah. And what strikes me is how many potential high value data classes and data element sets there are and how limited appears to be the bandwidth to get them incorporated and tested into vendor systems. And it's just a huge mismatch. And so, the prioritization is going to become really important. And I'm not sure we have a mechanism for prioritizing.

**Clem McDonald – National Library of Medicine - Member**

But, Terry, some of the constraints or the bottle neck is that many of those require manual entry and currently would fall on physicians who are resisting it.

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

Yeah.

**Clem McDonald – National Library of Medicine - Member**

Maybe appropriately.

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

And you're right so that's sort of a third dimension. So, this is valuable for somebody. This is the pain that the vendors are going to have getting it into their electronic systems. And this is the workflow agony that's going to result from adding this. You're right. So, there are three constraints, three gates on this process.

**Clem McDonald – National Library of Medicine - Member**

And the last gate, unless we figure out some easier way to capture this stuff, I think it's going

to be almost absolute because, at least in primary care, there's not any time left and people are fleeing it because of this non-patient care activity how they consider it. I think it's a very strong barrier. But it doesn't mean that we can't automatically understand videos or something and figure it out or get some of that stuff in in a different way.

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

Try a whole new data class that includes –

**Clem McDonald – National Library of Medicine - Member**

Al.

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

Yeah. It will be an interesting Phase 2. And Steve will tell us what our timelines are going to be, too. I suspect it's going to be pretty tight with fall being the target date if I recall. So, anyway, we've now poked at it and Lauren or Adam or Stacy, have we sent out the calendar invites for Friday afternoon through the near future?

**Stacy Perchem – Office of the National Coordinator – ONC Staff**

I believe so.

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

Okay.

**Stacy Perchem – Office of the National Coordinator – ONC Staff**

We can confirm if not after. I'll follow up with [inaudible] [01:11:29].

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

All right. Just because I suspect it's going to be a pretty tight timeline. We'll know more in a week. So, any parting shots before we open it up for public comment?

**Clem McDonald – National Library of Medicine - Member**

I'd just like to compliment the chefs.

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

All right. Well, there were many chefs that made this almost edible. This is an amazing group that's had to work really hard to get this done so we're trying as much as we can to follow your lead. Thank you, Clem. So, unless there are any more comments, questions, concerns, the train is leaving for Monday. Okay. Lauren, open them up.

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

All right. Operator, can we open the lines?

**Operator**

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

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

Thank you. Are any comments in the cue?

**Operator**

There are no comments at this time.

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

Okay. If there is nothing else, Terry and Christina, we can adjourn.

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

Yeah. No more housekeeping stuff.

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

Not from my end but good luck on Monday.

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

Great. Thanks, everyone.