



# Interoperability Standards Priorities (ISP) Task Force

Transcript  
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Virtual Meeting

## SPEAKERS

Name	Organization	
<b>Kensaku Kawamoto (Co-Chair)</b>	University of Utah Health	Co-Chair
<b>Steven Lane (Co-Chair)</b>	Sutter Health	Co-Chair
Andrew Truscott	Accenture	Member
Anil Jain	IBM Watson Health	Member
Arien Malec	Change Healthcare	Member
Clement McDonald	National Library of Medicine	Member
Cynthia Fisher	WaterRev, LLC	Member
David McCallie	Individual	Member
Edward Juhn	Blue Shield of California	Member
Leslie Lenert	Medical University of South Carolina	Member
Ming Jack Po	Google	Member
Raj Ratwani	MedStar Health	Member
Ram Sriram	National Institute of Standards and Technology	Member
Ricky Bloomfield	Apple	Member
Sasha TerMaat	Epic	Member
Scott Weingarten	Cedars-Sinai Health System	Member
Sheryl Turney	Anthem Blue Cross Blue Shield	Member
Tamer Fakhouri	Livongo Health	Member
Terrence O'Malley	Massachusetts General Hospital	Member
Tina Esposito	Advocate Aurora Health	Member
Valerie Grey	New York eHealth Collaborative	Member
Victor Lee	Clinical Architecture	Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer

**Operator**

Thank you and all lines are all now bridged.

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

Good afternoon, everyone. Welcome to the ISP task force. With us today we have Ken Kawamoto, Steven Lane, Anil Jain, David McCallie, Terry O'Malley, Sasha TerMaat, and Victor Lee. Are there any other members on the phone?

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

Sheryl Turney is on.

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

Hi, Sheryl.

**Cynthia Fisher - WaterRev, LLC - Member**

Cynthia Fisher.

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

Hi, Cynthia. Anyone else? Okay. With that, I will turn it over to our co-chairs.

**Steven Lane - Sutter Health - Co-Chair**

Great. Thank you so much, Lauren. And welcome, everybody, to our oddly scheduled meeting of the Interoperability Standards Priority Task Force here on the first day of October. Thank you all for coming together to continue our review of the comments and suggestions that we have received on our draft report to the HITAC. We spent a lot of time at our last meeting focusing on the section around orders and results. We have only a few meetings left together as a task force before we deliver our report to the HITAC. And as such, I wanted to suggest that we rather than continuing to work from the top of the document down that we jump to the second section on closed loop referrals and care coordination and work through some of the comments that have come in in that section. And then, perhaps at our meeting next week start in, if it seems appropriate, at the final section on medication and pharmacy data so that we can as a task force review a diversity of the suggestions that have come in.

So, I'm interested in any feedback from Ken or others on that approach as we start today. All right. Good. Then, let's do it. So, I think we're going to – let's go through the slides here before we jump right in. Do you want to go to the next slide? Just as a reminder to all task force members and the public that are joining us today, this is the charge of our task force to make recommendations on prior uses of health IT. I'm not going to read through the entire thing. The next slide should be the members of our task force. And, again, thank you all for taking the time to join us today. Next slide. This is the timeline of the work that we're doing. You can see there we're checking things off as we go through them. We're at the 10/1 meeting. We have another meeting scheduled next week a little earlier in the day on Tuesday. And

then, on the 16<sup>th</sup>, we have a plan to present our final report to the HITAC. So, we're working our way through this.

Next slide. Good. Okay. And now, I think we can switch over to the Google Doc and we are going to start, I believe, on Page 22 where we have our draft recommendations around closed loop referrals and care coordination. The first comments to come in related to the illustrative story, which Ken was kind enough to actually draft for us initially. Ken, do you want to go through the comments here?

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Sure. Let's see. I think there's a comment a little bit higher up maybe. No. Let's see. Or maybe not. No, okay. That's good. Okay. So, the first comment from Ram and, Ram, are you on? No. Okay. So, his comment was this capability, and this is with regard to who is accepting referrals, is presented and demonstrated at the recent ONC third interoperability from Day 1 during the content, interoperability track 360X project listed in the closed loop communication observation developed as a discussion. The referring physician may have to electronically ping several specialists before one is found who is available and has appointments open in a reasonable amount of time. So, the main thing that **[inaudible]** **[00:04:57]** was can see who is accepting referrals in the specialty so it's been added. I don't know if we actually talk about who is accepting referrals.

So, I don't know if that's in our recommendations. But assuming it's at least maybe hinted at, I think we can include that.

**Steven Lane - Sutter Health - Co-Chair**

Yeah. I think that's a good add to the story. I don't think we went into that in detail, of course. And 360X is looking at that in more detail but I think calling that out is a nice add.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Okay. So, let's add that. So, the next one –

**Anil Jain - IBM Watson Health - Member**

This is Anil. I had my hand up. I just want to quickly make a comment. Isn't this adding a certain level of complexity? Are we willing to accept that complexity of understanding who is in their plan, who has got an available appointment and all of that? I think it does add another layer. And I just wanted to make sure that we're not going beyond what our original point was in this.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

I'm not sure we imply here who is – well, I'm not sure we're saying –

**Anil Jain - IBM Watson Health - Member**

We do.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

That it's insurance based. I guess it might be implied. But there is nothing here that it's – I guess the question is like you're getting at I accept Blue Cross Blue Shield but no Medicaid patients, please, right?

**Anil Jain - IBM Watson Health - Member**

Exactly. Yeah. It's accepting referrals in a specialty. It's clearly put there. Anyway, it's a nit-picky point.

**David McCallie - Individual - Member**

It's David. I was thinking the same thing. I'll just jump in on the tail of that. I think it's a desirable capability but the chances of actually implementing it in most real world settings would be really challenging due to insurance limitations, network constraints, geography constraints, scheduling constraints. You could design software that allows it to be displayed if it's available but we shouldn't imply that it's a requisite part of a total solution I don't think.

**Steven Lane - Sutter Health - Co-Chair**

And, again, I think that – and Cynthia we see your hand up. I'm going to try to monitor the hands as they come up. I think that it was an add to the story but we didn't take the time to then add it to our observations and recommendations. So, I think what we're hearing is it may be inappropriate to add it to the story if we're not actually addressing it more specifically in our recommendations. Cynthia?

**Clement McDonald - National Library of Medicine - Member**

Could one just talk about encouraging it there when possible or something?

**Steven Lane - Sutter Health - Co-Chair**

Thanks, Clem. Cynthia, you had your hand up. We're going to try to use the hands.

**Cynthia Fisher - WaterRev, LLC - Member**

Yes. Thank you. I had my hand up. Yes. My one concern here is that some of the problems in a hospital system that self refers to a laboratory or self refers to another specialist in that hospital then, that patient doesn't have a choice to perhaps go to a more price efficient or more convenient laboratory or one that might not have facilities fee. And so, just having that access and control in a broader level of choice where the patient is first, I think, is really important that we're not – because we're technologically trying to deliver referrals. We're not narrowing options that would minimize choice and freedom to go elsewhere. Do you know what I'm saying? So, I think if anything, it needs to be broad and it needs to allow here's what you need. And it's a big problem when you go and you're told to go across the hall and there is a \$275.00 facilities fee and you don't know.

And it's 11 times more than the lab 3 blocks away. So, these are things that are real issues. And I think we need to make that as accessible and as broad and as Google searchable or in a broad scale searchable for care. And the same is also for continuum care plans. So, I know in the elderly cases, when they need to be discharged or even say a burn patient needs to have follow up in home care. There is a tendency for self-referrals to hospital owned nursing agencies or care agencies. You can get well, here is the hospital's agency and yet, you'll have the price of 100 others but we don't know anything about the others but we're the hospital. So, then the patient just defaults to the hospital one. So, I think we have to really allow for broad access and not know because –

**[Crosstalk]**

**Steven Lane - Sutter Health - Co-Chair**

Cynthia.

**Cynthia Fisher - WaterRev, LLC - Member**

Yeah.

**Steven Lane - Sutter Health - Co-Chair**

Thank you for that. That's a little bit off topic from where we are where we're really talking about referrals and care coordination. But I think you make good points. We have a lot of hands up so we're going to keep moving ahead. Terry.

**Terrence O'Malley - Massachusetts General Hospital - Member**

Yes.

**Cynthia Fisher - WaterRev, LLC - Member**

I was talking about referrals. That was the primary care giving referrals within the system.

**Steven Lane - Sutter Health - Co-Chair**

Yes. We got it. Thank you. Terry.

**Terrence O'Malley - Massachusetts General Hospital - Member**

Yeah. So, I think this is an important capability and I agree with Bob. It's going to be adding a level of complexity. But think through the impact of not having that information up front when you're trying to make a referral. You're going to get a series of bounce backs. And I think, in my mind, it's almost analogous to writing a prescription but not knowing what the formulary is or what the drug coverage is. So, I think it would be important for us to push ahead in this space just to make sure we actually get a referral that sticks. Thank you.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Thank you. And just to comment here. I think maybe we should have started with the story when we were working on these recommendations because it starts identifying where gaps are when you kind of see it from a patient centric perspective. At the same time, the purpose of these stories and the purpose of right now is to just clean up the recommendations we came up with. So, my suggestion is we can even have a parking lot or maybe we put it in the future directions. I would say anything in the cost and patient choice kind of thing goes very nicely into one of our main recommendations of hey, we really need to focus on this general area moving forward.

But I think it would be useful for us to just at least for this initial pass because we really only have two calls left to focus on where are we actually wrong in the statements we make and then, put into parking lots ideas that we probably should have considered maybe the first time but we haven't at least until we get through all of the comments of existing recommendations. And then, we can circle back to those either in a future iteration of this task force or in this task force if we have more time. David?

**David McCallie - Individual - Member**

I would agree with that although I think that maybe we could mention even in this story here the notion of costs, estimated costs being a part of the standard. I think Cynthia's concerns are really good concerns but they're mostly on the policy side. Our job would be to create a standard that could make that policy possible. So, the standard that's negotiating the referral should have cost included in it. So, I think that might be an addition that we would be consistent with what we said elsewhere.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Since we put ideally, I think it's fine if we say ideally. Arien.

**Arien Malec - Change Healthcare - Member**

Yeah. I just want to jump on the same point, which is I think there is a standards opportunity here. There are existing referral standards in the ENC X12 space. The EPA work that Davinci is piloting is in a very similar space. I think it is a reasonable part of the coordinated referral workflow to include both administrative availability and price estimation as part of their referral workflow. I think we know in the pharmacy workflow for similar situations in cases where you catch EOB or pricing mismatches up front at the order time, you drive a much better patient experience. To David's point though, I do think the appropriate place for us here is to think about the appropriate standards base.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Okay. Jack.

**Ming Jack Po - Google - Member**

Yeah. I actually would also like to chime in and say that it would be actually helpful in the story to have choices because I feel like otherwise, the story doesn't sound as realistic. I know in almost all of the encounters that I've had when I get to a point where my primary care doc does need to me see a specialist, they hand me a list of names that they have printed and they just have a piece of paper. So, I think the story right now, if it doesn't include some way of saying that we can ping the number of specialists and at least get some sense of whether they're even taking on patients or they're covered by my insurance and I think was as just mentioned how much the cost might be. It seems like we almost purposefully left a hole in this story. But I see everyone's point that we don't really discuss in terms of how we can tackle some of the problems.

But I do remember in some of the conversations earlier, I think it was just mentioned as well, Davinci does mention that they have that capability or they have some of that written already. So, it seems like we're not completely starting from scratch here.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Okay. Cynthia.

**Cynthia Fisher - WaterRev, LLC - Member**

This is a question perhaps Arien can answer with knowledge of Davinci. But I think the key thing is to make sure that the patients have access and aren't narrowed into a singular relationship or specialist. So, if someone needs to see a pulmonologist from their primary care then, how is it if your primary care

is out of one facility that they just aren't narrowed into that facility of pulmonologists? So, how do we represent the American independent doctors or independent oncologists that still practice out there that are outside of this system? So, could someone help me understand what Davinci does in the standards or how that is addressed that a broadcast of physicians is represented?

**Steven Lane - Sutter Health - Co-Chair**

I don't know that we have the expertise on the phone to address that question right now.

**David McCallie - Individual - Member**

And it is a policy question I think.

**Steven Lane - Sutter Health - Co-Chair**

I did make an attempt to capture, Cynthia, what you were saying earlier the notion that the patient can also see what their options are. I tried to capture that in some of the language.

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

So, this is Sheryl. Just to clarify to Cynthia's question. The Davinci development is really focused on the implementation guide for the application programming interface, Cynthia. So, it's really technical. It doesn't really define the business process, nor does it define a particular type of referral. What it's going to define is what data should be exchanged and what's the format for the data but not the choices. So, I do think there's a business process that you're talking about but that's not what Davinci will document unless to the extent that they're trying to describe it in a use case. So, I think what's important though is what you want to say the standard support are options for choice by the provider or the patient depending on whatever factors each wants to consider. And that's what should be communicated and discussed.

So, I think to that extent, we should say the standards should support options in order to support that.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Before we go to Jack, just sort of meeting flow comment. This is just one of many, many comments that we need to get through and we probably used up about an eighth of the time we have for the task force. If we can, try to focus on what's listed wording wise on the screen. And you can even go in and suggest them. Let's try to focus on what do we need to change in the wording as well and, specifically, I think these comments – Steven and I have put in some suggestions. Does it address it or does it not? And if not, what needs to actually change in the wording? Jack.

**Ming Jack Po - Google - Member**

So, I do like the proposed comments where it says you can also see what providers are available. I'll just mention, I think, briefly because it sounded like there was some discussion about whether this is policy versus standards. From some of the work that we've been doing at Google, I would say that this is not a policy question because we have in the past looked into solving this issue. If somebody were to search pulmonologists, we would love to bring up a list of pulmonologists in the area, what insurance they might carry, whether they have availability or not. And right now, what we have to do is, essentially, integrate

with lots and lots of different systems all of which use different standards and there are other issues involved. So, I would say that this is actually a standards issue right now.

We don't actually have any policies stopping us but we right now are stuck basically doing infinite numbers of integration in order to get that data.

**Cynthia Fisher - WaterRev, LLC - Member**

Thank you, Jack. Jack, what would Google need in order to have that be totally smooth for Google to play that role or another Google-like application to be able to play that role? So, any pulmonologists –

[Crosstalk]

**Ming Jack Po - Google – Member**

Yeah. I will talk more generally about what somebody what that might need but it would be helpful to have a standard. And I think Davinci does have – I think I asked Davinci about this. Davinci does have a standard but it would be helpful to have a standard where people could make available their availability information, what insurance they might have, as well as other types of metadata. Some way to negotiate, essentially, scheduling. So, either tentatively claim a spot or permanently claim a spot on that person's calendar. And then, I think the part that is policy is, essentially, enforcement. So, force people to actually open those API's because right now, a lot of those API's, even when they are available, are essentially trapped internally inside whether it happens to be Epic or Cerner or some of the other systems right now.

**Steven Lane - Sutter Health - Co-Chair**

So, I'm going to try to move us along here because I think this is a great discussion and it speaks to the fact of how much more work could be done by this task force or one like it. But I think we've tried to sort of capture in the story here a little bit more of this nuance. But we really need to move on to our observations and recommendations because that's really the meat of our report back to HITAC and the ONC.

**Cynthia Fisher - WaterRev, LLC - Member**

Steven, this is Cynthia. I'm just concerned that if we write it within what the structures are within the system that we're making it a competitive barrier against what Jack just mentioned that would be broader. And so, I want to just make sure that we as a committee by not addressing it aren't putting up a competitive barrier for keeping Epic users to keep patients within their hospital system. So, I'd just like to go on record in this that we have it as a flag that we enable a standard for broad access that any pulmonologist could participate with the patient scheduling or that we could provide a broad standard and the open API's from Epic and Cerner and Sutter and whomever else is out there that those API's get open so that we can have broad access.

**Steven Lane - Sutter Health - Co-Chair**

And, again, Cynthia, I don't think anyone is arguing against that. I think at this point in the history of our task force, that's a whole new area we just haven't had a chance to explore. And at this point, we're trying to finalize our report. So, if you would like to suggest a sentence or a paragraph that would fit into



the report that would capture that concept or set it as a place holder for future consideration, I think we'd love to consider it. But at this point, I think we need to move on to our recommendations.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Okay.

**Cynthia Fisher - WaterRev, LLC - Member**

Okay. Jack, why don't you and I put something together for them.

**Ming Jack Po - Google - Member**

Yeah. Sounds good. Thank you.

**Steven Lane - Sutter Health - Co-Chair**

All right. So, scrolling down through this, Tier 1. You've got those up. We don't have any specific comments on these so we'll scroll down to, I think, Sasha's comment on Page 24. Sasha, I think you're on the call.

**Sasha TerMaat - Epic - Member**

I am here. I was just talking with others here. We see other standards that are being worked on for prior authorization, maybe of which were actually discussed by the task force and mentioned in other sections. We didn't want to waste time duplicating work putting that into 360X when there are other standards either currently available or being worked on for that.

**Steven Lane - Sutter Health - Co-Chair**

So, your suggestion would be to either take out the reference to 360X here or perhaps expand it to say 360X and other potential solutions?

**Sasha TerMaat - Epic - Member**

Yeah. I guess I would just take out the reference to prior authorization here or indicate that multiple standards might be used but that the flow should ideally include that information.

**Steven Lane - Sutter Health - Co-Chair**

Would you like to – or Ken, are you going to take a stab at it?

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Yeah, I will.

**Sasha TerMaat - Epic - Member**

Ken can do it or I can do it, sure. I'm happy to put in some language.

**Steven Lane - Sutter Health - Co-Chair**

Great. We can come back to that. If we go down a little bit further, we'll just pop back up. Ram has a suggestion on Page 24 where we say there is a need for specialty specific standards regarding what information referred to clinician acquires from the prior clinician to provide an effective and efficient

clinical response. He says resolving this issue means balancing professional practice attributes a specialist considers to be differentiators in the need for patient centric care. I think that's a good point. So, and Ken suggested maybe minimum standards or baseline expectations. So, we could certainly make that change. I think I can just enter in standards. I think that's a good suggestion. That should resolve that. And then, Ken, you added here the last sentence, these payor requirements must be aligned with best practice guidelines determined by recognized medical specialist organizations.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Yeah. There was a comment from someone saying you can't just make these requirements not based on anything.

**Steven Lane - Sutter Health - Co-Chair**

Right. Good. And then, there was some colored text here in the last bullet. This need is also relevant to transitions between care settings. It is a [inaudible] [00:26:34] future setting versus department from any source and discharges from acute to post-acute care. I think that's a point that Terry has been making pretty consistently is that these issues apply in multiple care settings. So, I don't see any hands up so let's scroll back up to the page above and look at how Ken captured Sasha's comment.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

A little bit higher. Right there. Do you want to take a look at that?

**Steven Lane - Sutter Health - Co-Chair**

Make sure the referral approach whether by 360X or an alternate mechanism includes insurance and prior authorization information to determine acceptability. Sasha, does that capture it?

**Sasha TerMaat - Epic - Member**

Yeah.

**Steven Lane - Sutter Health - Co-Chair**

Wonderful. Great. We made a little progress. Let's keep going. That brings us down to Ram's comment on Page 26. The challenge of small physician practices being able to manage the clinician to clinician patient specific messaging. And Ken responded to that by ensuring small physician practices have sufficient support as a recommendation. Okay. Good. Then, Sasha, your comment under responsibilities. Again, we're still talking about clinician to clinician patient specific messaging.

**Sasha TerMaat - Epic - Member**

Yeah. So, one of the gaps that my co-workers and I have seen in this is not knowing addresses for the clinician you want to message with. And so, we thought highlighting the ongoing work from CMS about the NPPES directory would be important to one potential, I guess, policy level or responsibility here that would further the goal.

**[Crosstalk]**

**David McCallie - Individual - Member**

And that's deliverable under Cures already, a national directory?

**Sasha TerMaat - Epic - Member**

I think it was actually maybe prior to Cures. I don't remember. I feel like it maybe went back to macro. But yes, I think they have that responsibility and now, they're going to publicly shame the people who don't provide their addresses. So, it's in progress.

**David McCallie - Individual - Member**

This is David. To manage referrals, you're going to need more than a direct address. You're going to need a lot of other kinds of directory information about what kind of referrals they accept, what payors they accept, what their costs are, etc. So, this is just a start but it, obviously, is a start. If you can't even talk to them, you're not going to get very far with automating the referral.

**Sasha TerMaat - Epic - Member**

Right.

**Clement McDonald - National Library of Medicine - Member**

Could you give clarification on the issue about shaming those who don't provide – which address they don't provide?

**Sasha TerMaat - Epic - Member**

Clem, I'll put a reference to what CMS said in the chat so you can read up.

**Clement McDonald - National Library of Medicine - Member**

Okay. Thank you.

**David McCallie - Individual - Member**

I believe it was around the directory address.

**Steven Lane - Sutter Health - Co-Chair**

I was just going to say, Ken, you identified this as CMS encouraging directories. Is that CMS or ONC that's pushing on that?

**Sasha TerMaat - Epic - Member**

It's CMS.

**Steven Lane - Sutter Health - Co-Chair**

Okay. Very good. Thanks, Sasha.

**David McCallie - Individual - Member**

ONC has a role on the standards side. CMS has the role on the policy side typically.

**Steven Lane - Sutter Health - Co-Chair**

Perfect. Sasha, let's scroll down to the next page while Ken is crafting that language. This was under the recommendations section.

**Sasha TerMaat - Epic - Member**

So, I think we would also like to see in this nationwide standards for provider directories an affiliation with an organization. So, another bullet point for organizations. I can just add that.

**Steven Lane - Sutter Health - Co-Chair**

Very good. Okay. So, this was the standard for provider directories and what should be included. And that makes perfect sense. Does anyone object to that?

**David McCallie - Individual - Member**

It would probably be plural because some providers will have multiple.

**Sasha TerMaat - Epic - Member**

Yeah. I guess or you'd have multiple address listings for each organization or place of business. Yes, either way.

**David McCallie - Individual - Member**

Again, to manage referrals, you're going to need a lot more than just those bullet points. But those would be minimum for at least making contact.

**Clement McDonald - National Library of Medicine - Member**

Well, this is initially for messaging, correct, Sasha?

**Steven Lane - Sutter Health - Co-Chair**

We're actually in the section on referral management.

**Sasha TerMaat - Epic - Member**

I think the previous comment was under a clinician to clinician patient specific messaging. This one is very similar but it's under referrals. But it's about that same concept of a directory, which I guess gets to my next comment, too, which is that in this section also, it made sense to me to endorse the work that CMS is beginning with NPPES. I agree with David's comment. It's sort of not sufficient for everything that we would like to have here but it is work that's started.

**Clement McDonald - National Library of Medicine - Member**

Well, my point about the messaging is you don't have to do quite as much to make that work versus what you do to make referrals really work.

**Sasha TerMaat - Epic - Member**

Right. That was the earlier section though.

**David McCallie - Individual - Member**

Yes. It's necessary maybe not sufficient but you can do a lot with just direct communication around a referral. That doesn't have to be so completely automated that you don't communicate. I think that's probably a long way off.

**Clement McDonald - National Library of Medicine - Member**

Here, here.

**Steven Lane - Sutter Health - Co-Chair**

Okay. You can scroll back up, Ken or I guess it was Sasha, some collective group updated the language under the policy levers, responsibilities. CMS continued to encourage directory population information. I'm not sure what the word population is adding there. The population of directory information, right, is I think what we're talking about. Such as through the existing effort to establish a central repository of direct addresses for providers via NPPES. Is everybody comfortable with that?

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

And I don't see direct addresses in NPPES for some people I looked at but I assume that's the effort, right? My understanding is NPPES is the center repository that CMS established for provider information. And the idea is they're encouraging people to put addresses in there.

**Sasha TerMaat - Epic - Member**

I think it's called interoperability endpoint or something. It's not necessarily called direct address. But I'll get the language and put it into the chat for everyone who is interested.

**Steven Lane - Sutter Health - Co-Chair**

Great. Thank you, Sasha. I do see, Cynthia, you've got your hand up.

**Cynthia Fisher - WaterRev, LLC - Member**

Yeah. Just I don't know if there are web addresses, phone numbers, just whatever makes it more readily accessible for search or scheduling of appointments or having access to broad. Again, going back to what makes it feasible for patients to have broad access and not limited within one institution.

**Steven Lane - Sutter Health - Co-Chair**

Okay.

**Clement McDonald - National Library of Medicine - Member**

Well, just a twist on that, I think making physicians' telephones, for example, the public can be a big burden. They usually have some interceptors. Now, maybe you prefer they don't but I think we should be conscious of that in our recommendations.

**David McCallie - Individual - Member**

So, the unwillingness of providers to share these endpoints has been a big problem and that's one aspect of it. Direct has wrestled with that for a decade now. And that's why there are some policy requirements probably that are necessary to drive it forward. But there are ways to prevent that from being a burden on a physician's office that are well established. And it's, I think, an overblown fear. It's not real.

**Clement McDonald - National Library of Medicine - Member**

Well, after talking to my physician friend, it's not overblown. But at least to qualify that this is not just public access to their phones for everybody. There are certain areas where it could be difficult. They need to have a life, too.

**Cynthia Fisher - WaterRev, LLC - Member**

I thought we were talking about referrals, Clem.

**Clement McDonald - National Library of Medicine - Member**

Well, if the directory has all of these numbers that are not limited to the phones. I'm fine with the referral part for sure.

**[Crosstalk]**

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

How about the current wording? CMS continues to encourage addition of contact and communication addresses needed for interoperability for providers via NPPES. Because I'm looking in the specific way it's listed right now. It's called a health information exchange endpoint. Something you can add. And Sasha, you can provide us any updated suggestions for wording.

**Sasha TerMaat - Epic - Member**

I think what is in there is okay. Now, it's changing.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

I think Steven is just writing out what it stands for.

**Steven Lane - Sutter Health - Co-Chair**

All right. And I also added just up above, Sasha, I grabbed some language from your comment that there should be a standard way to query this directory whether it is [inaudible] [00:38:12], which I think is –

**Sasha TerMaat - Epic - Member**

Yeah. That would make it more useful.

**Anil Jain - IBM Watson Health - Member**

Isn't there a way to do that? This is Anil. I think there's already a way to query NPPES.

**Steven Lane - Sutter Health - Co-Chair**

There is. But, again, I think we're speaking a little more broadly here. Whether we're specifically talking about NPPES or under their –

**Anil Jain - IBM Watson Health - Member**

Got it.

**David McCallie - Individual - Member**

And it's not typically built in or very friendly. It's not API appropriately.

**Steven Lane - Sutter Health - Co-Chair**

All right. Let's go on. Sasha, you commented on Page 27. Oh, we did this, right? We added the organization so we can resolve it.

**Sasha TerMaat - Epic - Member**

Yes, that one is done.

**Steven Lane - Sutter Health - Co-Chair**

Okay, good. And then –

**Sasha TerMaat - Epic - Member**

The next one is, basically, the same sort of point about directories that we were just talking about in the previous recommendations.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

So, I guess it's kind of similar, right.

**Sasha TerMaat - Epic - Member**

Yeah. I don't know if we'd want to sort of take the recommendation we just drafted above and paste it here also. It's going to be relevant to both use cases.

**Steven Lane - Sutter Health - Co-Chair**

Both to the messaging and to the referrals.

**Sasha TerMaat - Epic - Member**

Yeah. It would seem so, right?

**Steven Lane - Sutter Health - Co-Chair**

Yes. Absolutely. Okay. Good. And then, we have a section on governance. And I think a lot of this came from Terry. So, you had a question, Sasha, about the meaning.

**Sasha TerMaat - Epic - Member**

Yeah. We just weren't sure what snap on government meant.

**Terrence O'Malley - Massachusetts General Hospital - Member**

Yeah. That's just shorthand for a pre-existing governance structure kind of like what TEFCA does that Direct has. So, it's really an outside agency that's establishing the governance that anyone can sign onto once they've gone through the necessary identifications.

**Sasha TerMaat - Epic - Member**

Terry, are you open to just cutting out the purpose?

**Terrence O'Malley - Massachusetts General Hospital - Member**

Yeah. That's fine.

**Sasha TerMaat - Epic - Member**

Be [inaudible] [00:40:37] for just purpose. I think the term snap on governance is just –

**Terrence O'Malley - Massachusetts General Hospital - Member**

Yeah, absolutely. Thank you. Big improvement.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Also, so Steven, I think the – I see. Okay. Perfect.

**Steven Lane - Sutter Health - Co-Chair**

It was a good term though, Terry. I liked it. This is probably clearer. All right. Let's go on. So, we're down to Tier 2 issues and recommendations. Ken, did you have –

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

The first bullet there was just we had included in here things that we called general observations. And we have three categorizations, Tier 1, Tier 2, and general observations. And I just took what we had in general observations and I think this is the tail end of these Tier 2 issues and recommendations. But they look like recommendations. I'm not quite sure why we specifically classified them as something different. So, I think it's okay. I just pointed out that that's what I did.

**Steven Lane - Sutter Health - Co-Chair**

Okay. I think the way you did it looks fine to me. Okay. Going on. Sasha.

**Sasha TerMaat - Epic - Member**

So, I think we would want to add language here. And I can suggest some if helpful but that this recommendation would be to transition to standards based messaging. I think that was implied in our discussion but it isn't called out in the recommendation. And then, I think it might be helpful also to indicate that the purpose of this messaging, in particular, was still in the closed loop referrals use case because, of course, there are many messaging use cases and our conversation focused on that.

**David McCallie - Individual - Member**

Yeah. Let's have a – oh, never mind. Never mind. I was going to say something snarky.

**Steven Lane - Sutter Health - Co-Chair**

Thanks for sparing us.

**Clement McDonald - National Library of Medicine - Member**

Yeah, don't do that.

**Steven Lane - Sutter Health - Co-Chair**



Okay. I think we captured that. Sasha?

**Sasha TerMaat - Epic - Member**

Yeah, thanks.

**Steven Lane - Sutter Health - Co-Chair**

Perfect. All right. That brings us down to Cynthia's comment. I'm trying to see what this refers to.

**Cynthia Fisher - WaterRev, LLC - Member**

I just have a question if someone timely could define closed loop referrals.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Yeah. It's the notion that you refer and then, you get communication back in a closed loop rather than like non-closed loop would be like you refer somebody and then, you don't really know what happened.

**Steven Lane - Sutter Health - Co-Chair**

Cynthia, it's a series of sort of administrative messages that, essentially, tell you whether or not the referral has gone through, what its status is. It automatically picks up if the referral breaks down at any point. The patient didn't show up so you never get a report back. So, if the patient doesn't show, there's another message that comes back to you that says didn't show. So, since you know where your referral is in the midst of the process and all of its potential failure modes until it's completed.

**Cynthia Fisher - WaterRev, LLC - Member**

And then, say you refer it to an ortho with an MRI, do you get the MRI? Do you get the ortho feedback in that closed loop? Is it inclusive of the various steps? Or is it just physician based closed loop referral?

**Steven Lane - Sutter Health - Co-Chair**

My understanding is it's the referral itself rather than the content. The content is sort of a different – related but different issue. So, how does the information flow? How do you know your referral is actually progressing until it's completed?

**Anil Jain - IBM Watson Health - Member**

This is Anil. I think CMS would define it as having the original physician get a report of the results back, too. It's actually closing the context of the visit itself according to CMS.

**David McCallie - Individual - Member**

That's typically what would be done I think, the final report.

**Cynthia Fisher - WaterRev, LLC - Member**

Thank you. And how does that, for independent docs or folks outside of that system or outside of the network that the patient may choose to go to, how does that work interoperability wise?

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

So, for example, if it was Direct, there would be messaging going through so that whether the independent doc is the referrer or the person being referred to that communication would happen. This would go directly at the notion of avoiding, I guess, not being able to go out of network because there are no communications outside of a closed network. So, I think what we're talking about here is directly enabling that kind of, I guess, patient choice.

**David McCallie - Individual - Member**

And, again, I'd say it's necessary though not maybe sufficient because you have to have some way of enforcing those choices. But without the standard, it's kind of moot. So, I think our focus on the standards is an appropriate starting point.

**Cynthia Fisher - WaterRev, LLC - Member**

Okay. So, the standard addresses both the interoperability of access to – across out of network well into another network or to another independent physician as well as the content, yes? So, it's both of those?

**David McCallie - Individual - Member**

Standards typically don't carry that authority but without the standard, you couldn't impose the requirement that you communicate with all providers. So, it's the necessary step but you need business arrangements or policy forcers to make it stick. I think that's been our consistent issue all along is the standard needs to enable good policy and good business.

**Arien Malec - Change Healthcare - Member**

Alas, standards do not create business models.

**David McCallie - Individual - Member**

Yes. Have we not learned that?

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

So, Steven, it looks like you're addressing Cynthia's comment that's here and elsewhere like when we don't have a policy lever, can we put one in. So, it looks like you're suggesting something here.

**Steven Lane - Sutter Health - Co-Chair**

Yeah. The thought that I was having was just suggesting that this be considered as a part of EHR certification. I don't know whether that would be too strong. I know, Sasha, you're sensitive to that and appropriately so.

**Sasha TerMaat - Epic - Member**

So, what would be included in the certification? I guess I'm not sure what functionality of an EHR you're saying is appropriate to include there.

**Steven Lane - Sutter Health - Co-Chair**

Well, this is under the category of automatically incorporating patient information into the EHR.

**Sasha TerMaat - Epic - Member**

I guess I would think that that would need to have further definition before you could certify to it. And you'd probably want ONC to certify to it, not CMS. So, once there was a standard for automatically incorporating relevant patient information, which was part of the recommendation then, you could have certification to that standard be part of ONC's certification program. But we kind of need the standard first or the certification won't be meaningful.

**Steven Lane - Sutter Health - Co-Chair**

Yes.

**David McCallie - Individual - Member**

And as Sasha implies, it's a complicated space where there are many different layers of automation that can be applied depending upon the trustworthiness of the source, whether the data has been matched to existing data and isn't a duplicate. All sorts of complexities make that – I think it's an actor variant for development for the vendor community. And, certainly, there's not a standard way to do it at this point.

**Steven Lane - Sutter Health - Co-Chair**

And I think it is appropriate for our report to include these kinds of recommendations. Perhaps these go more under recommendations than policy levers and responsibilities but I don't think it makes a strong difference one way or the other.

**David McCallie - Individual - Member**

Some of the things that would make it easier to accomplish that we've discussed elsewhere in our document, things like accurate provenance, identifiers that track all the way back to the source, use of standards to actually convey the data so that you understand what you've got when it shows up and can easily decide if it's something new or important or wrong patient, patient identification, lots of things to make it easier.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

How is what's specified there?

**Sasha TerMaat - Epic - Member**

Is the second one really CMS?

**David McCallie - Individual - Member**

It would be ONC.

**Sasha TerMaat - Epic - Member**

I thought you were talking about certification so then, it would be having ONC include it in certification for the second one.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Solution and certification criteria once available and validated. How's that?

**Sasha TerMaat - Epic - Member**

That's more clear from my perspective. Thanks.

**Steven Lane - Sutter Health - Co-Chair**

Excellent. Thank you. Going down shifting now into patient clinician electronic messaging, which, of course, could engender a tremendous amount of discussion. We did get some feedback at our HITAC meeting a couple of weeks back that simply observe that we have this as a Tier 2 while we have provider/provider communication listed as a Tier 1 recommendation. So, there wasn't a strong statement that we needed to change the priority here. I think most people acknowledge that the patient clinician electronic messaging is occurring today largely through portals, less so through direct messaging or other means. Many people utilize unsecured email. But when we discussed this earlier, we decided that since this was going on today that it makes sense to include this as a Tier 2 but I just wanted to share with the task force that that discrepancy was pointed out.

I made some minor editorial comments here clarifying that we're talking about electronic messaging in both the title and the observation. And minor editorial changes there. Ram commented here that in underserved areas, he suggests that patients may not have access to portals or don't have computer expertise to access the portals. I'm not sure that that's been proven by the data but that's his observation. Do we need to reimburse the physician for all of the communication or is this part of the physician's duties? Obviously, that's a huge topic we're not going to solve in our task force discussing standards. I'm not sure what, if anything, people want to add regarding that.

**Anil Jain - IBM Watson Health - Member**

This is Anil. My hand is up. I'm not sure if –

[Crosstalk]

**Steven Lane - Sutter Health - Co-Chair**

Oh, okay. Go ahead, Anil.

**Anil Jain - IBM Watson Health - Member**

I was just going to say this is an interesting point because we have to make the physician who decides to share things electronically with their insights electronically, we have to make that reimbursement the same as if that physician had picked up the phone and gone back and forth with that referring physician. So, I think there is something here from a standards based way that we could somehow recommend at least the creation of some new codes that say that you've done an electronic follow up, if you will, with the referring provider the same way you would if you had picked up the phone and done a consultation.

**Steven Lane - Sutter Health - Co-Chair**

So, are you speaking, Anil, specifically about codes that would be used for clinician to clinician messaging after a consultation? Because we're now in the section on patient clinician messaging. So, I just wanted to be clear where you're going.

**Anil Jain - IBM Watson Health - Member**

I am sorry. I'm sorry. I take back what I said. But I think the same could apply if providers are using counseling visits for a face to face. If they're going to do electronic messaging and have that same conversation then, we should make it advantageous for them to do it electronically rather than bringing them in for a Level 2 or Level 3 office visit.

**Steven Lane - Sutter Health - Co-Chair**

Cynthia, your hand is up, too.

**Anil Jain - IBM Watson Health - Member**

If that makes sense.

**Steven Lane - Sutter Health - Co-Chair**

No, it does. It does, Anil. I'm trying to figure out whether it fits here.

**Cynthia Fisher - WaterRev, LLC - Member**

My hand is – right now, we're thinking about patient and physician communication access. And I think what's really important is the train has left the station. And patients and physicians are communicating by text messaging. And there's texting. There is What's App. And then, there are other even forums of texting that are secured as far as applications. But for the most part, most physicians will give their cell phone number with a follow up and follow up with care and concern for their patient. And that is being utilized with texting and photographs are being shared in texting as well to remedy a concern or a situation. Let's take an example of cellulitis and expansion of infection and rings around the wound and a photograph being shared.

So, this is being done. And my concern is patients do not – if it's difficult and they go down a portal then, they will be less engaged in managing their care or communicating with their physician. So, if you optimally want to provide the best quality of care, it's opening up that pipeline and that communication. So, I guess I would just say to the degree that we empower or the train left the station and let the patients choose, we had a great conversation with this in person, was let a communication forum work for what works best for both physicians and patients. And if the patients want to go outside of HIPAA and say look, I want to have open communication about this and it's totally okay by me then, that should be the patient's right. And that should be the physician's right to also be able to communicate with the patients in that format.

**Clement McDonald - National Library of Medicine - Member**

Here, here on that. We've got it so strangled. So, anything we can do to open it up, man, you ought to be cheered for.

[Crosstalk]

**David McCallie - Individual - Member**

I do think that's fundamentally a policy.

**Cynthia Fisher - WaterRev, LLC - Member**

More efficient. And I don't think it's policy. It's let's let it happen and let's not try to put patients down a narrow – and physicians down an egregiously narrow pipe. It doesn't fit.

**David McCallie - Individual - Member**

It is policy in the sense that many physicians would consider it prohibited to use unsecured channels whether that's correct or not. That's a policy interpretation that many physicians have. And I totally agree with you that it should be the patient's choice and physicians should be comfortable living with he patient's choice. However, I think the challenge for us is to come up with a standard based way to make it secure. And that doesn't mean a new standard. It could be something that exists already but do it in a way that is standard and secure. SMS is neither. And the task force, I think, can focus on standards –

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

If I could just ask folks to raise their hand. We have Arien and Anil with their hands up. And if others can raise their hands, too, to get in the cue. Arien, do you want to go next?

**Arien Malec - Change Healthcare - Member**

Sure. Gosh, this is an area that I happen to know maybe a little bit about since I got my start in patient clinician messaging in healthcare 16 years ago. So, No. 1, it is already just to the points that have been raised, it is already HIPAA policy that patients may request the form and format of their access. HIPAA does not prohibit the use of open channels as long as patients write and clinicians may request clarification that the patient understands the privacy indications. And I just encourage people to read the OCR FAQ's on this topic. With respect to making patient clinician electronic messaging more readily available, in my experience, Paragraph 3 at this point is absolutely correct. You can make tools available but if they don't agree with the EHR's then, providers just won't use them. And that outside of basic messaging, patients really desire access to scheduling, to more precise workflows that are more patient workflow centered as well as opened messaging.

And that EHR's should need to provide access to routing rules and other kinds of rules to make sure those messages get into the right part of the clinical workflow. This argues for a set of Fyre based API's into the EHR's that open up the EHR's and allow a wider range of patient friendly and patient controlled applications. Right now, the world is very much a portal sprawl and garden wall approach. So, I think we maybe need to be a little bit stronger here, which is that if we want something other than locked in portal based access and if we want to market for expanded patient access, we also need Fyre based API's that are workflow sensitive into the EHR's.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Thanks. Anil.

**Anil Jain - IBM Watson Health - Member**

Yeah. I agree with the idea that we need to expand the choice that patients I have, I think, making sure that information is made available in the EHR through everything Arien just talked about is critical. But let's keep in mind that when messaging occurs outside of the current workflows and the current longitudinal record, mistakes are more likely to happen. I recently saw a patient who tells me that they texted with their community physician back and forth about adjusting a dosage. And I look at the

electronic record and there's nothing in there that tells me what was going through the physician's mind when that decision was being made.

So, I think it's incredibly important that we balance out the need to improve the way that we communicate with whatever modality that patients might want or the physicians might want but realize that the whole point of having an integrated electronic health record is to reduce the errors that happen when you have fragmented information. And if the communication is occurring in a fragmented way, we're only going to add to the problem. So, until we get all of those things that Arien spoke about with the API's and allow for that information to flow, I think we have to be very careful and help educate our providers and our patients that it may be in the best interest to sort of facilitate communication with modalities that end up coming back into the electronic health record. Otherwise, I think we're in for some unintended consequences.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Okay. I think Clem was next and then, David. If you're finished if you wouldn't mind lowering your hand so we can know when you raise it again. Clem and then, David.

**Clement McDonald - National Library of Medicine - Member**

Okay. I want to come back to the point of making it easy and light. And I'm glad that Arien reinforced the fact that it is available now and it is true that a lot of organizations are so afraid of it they scare the physicians from using it. But we shouldn't add more stuff to be sure that it gets in the record. We should add really a security, as David was saying. That's all we worry about. We should add ease of ability as was originally suggested. Let people talk if they want to. It's going to be more important than getting it perfect. But we have to have that one little step where the patient says you may do it.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

David?

**David McCallie - Individual - Member**

Yeah. I agree with Arien's points. I just would point out that an app running on your phone is also a portal. And portals don't have to be limited to external web based approaches. And the analogy I would make is if you do a lot of travel, you probably have one app for each of the airlines that you travel with. And the fact that you have different apps for different airlines is a minor inconvenience compared to the power that those give you. And I don't think anyone would say that we should have one universal airline app. So, I think the notion that providers could deploy apps to patients' phones with the patient's acceptance, of course, because that gives you a threaded way to have much more elaborate conversations than simple text messaging, which typically disappears. But just remember that phone apps are portals as well.

**Arien Malec - Change Healthcare - Member**

I've got lots to say there but I'll raise my hand.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

It looks like Cynthia –

**Steven Lane - Sutter Health - Co-Chair**

Cynthia has got her hand up.

**Cynthia Fisher - WaterRev, LLC - Member**

Yes, I'm glad you mentioned that app, David, because I happen to be in Europe traveling. I'm on the side of the road with this comment. But I think let's look at an example that David just utilized. So, each of the airlines has its own app where you get your online digital ticket or your boarding pass. But how readily available is it that we have Apple Passport, right. So, no matter what airline I fly, as I go country to country or city to city, I can move it into Apple Passport when I conveniently need by boarding pass. The same thing could apply as we talk about patient messaging. So, to Arien's point, having a Fyre based – having sort of this open API is the ability to allow patients to broadly communicate and doctors the way they want to. And should it be relevant to their EHR, simply move it into an Apple Passport type modality that keeps a record of all of the relevant boarding passes I have, right. So, the same thing would apply. We could get there.

We just need to open things up and allow for the broad competitive ways of communicating through choice. So, I think as we do that as the standard, we open things up and allow the app world to provide that Apple Passport or whatever vendor provides a passport into the EHR.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Thanks. And we have Arien and Jack next. And if we can, try to keep it moving and specifically if there are any wording changes needed in what we have here. Thanks. Arien.

**Arien Malec - Change Healthcare - Member**

Yeah. So, I agree since I was going to give the exact same Apple Passport comment. And the question to me would be is the patient portal that's tethered to an EHR more like an airline specific app or more like banking where you want information to flow and be able to manage information universally. If you look at the range of applications that we'd like to integrate into a workflow, for example, I've already mentioned scheduling and schedule management, digital shopping experiences, care management, and care coordination workflow experiences, there are a ton of areas where you really want to drop a patient message or a physician message, scheduling or other kinds of workflow into the app experience. So, it's not so much the need for one uber portal to rule them all. It is that there are a whole bunch of needs for improved care coordination that are currently not well served by the tethered portal app.

Now, I might be a little bit energetic about this topic because I've spent far too much of my life fighting EHR vendors to open up their API's so we could integrate portal capability. But it definitely is a need and it's a need that app innovators are looking for.

**Clement McDonald - National Library of Medicine - Member**

Here, here.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Okay. I think –



**Cynthia Fisher - WaterRev, LLC - Member**

Thank you, Arien. Could we add that to the line item, please? Thank you.

**David McCallie - Individual - Member**

I'm just curious – go ahead, Jack. Never mind. Go ahead.

**Ming Jack Po - Google - Member**

Oh, sorry. So, I actually want to talk a little bit about what happened in SMS, which I think is actually kind of instructive to this story here. As some of you might know, SMS was actually originally a carrier specific standard. So, there was an AT&T standard. There was a Verizon standard. There was a T-Mobile standard, etc. And what ended up happening was because of some policy push and because of some market push from Apple, they got together and started figuring out one standard. You might actually remember there used to be a time in which you talked to Verizon customers if you were a Verizon customer and it's free. If you talk to a T-Mobile customer, the SMS would cost you \$0.10 or \$0.15. So, a lot of that friction was because there was 1) not a policy push but also 2) sort of a refusal to get together on a standard.

And iMessage was actually one of the reasons why, basically, carriers got scared enough to actually go and get towards a standard, which became SMS and now some version of RCS. I think what would be helpful on the patient clinician electronic messaging is for us to do something similar. For us to basically say that there should be some version of standard, Direct might actually be a decent way or potentially some other standard that everybody has to do in patient physician standards, patient clinician communication. And then, to I think everyone's point, it's okay if they end up surfacing it in different portals. Like SMS is pretty transparent in iMessage and pretty transparent in Hang Out. You can talk to someone from Hang Out's iMessage and not realize that you're in the background where actually both Google and Apple are doing conversions into the RCS standard. So, to the extent that we can do something like that, I think would be extremely beneficial.

**Clement McDonald - National Library of Medicine - Member**

Here, here to that, too.

**Cynthia Fisher - WaterRev, LLC - Member**

How would you write it?

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

And David, do you have your hand up?

**David McCallie - Individual - Member**

Just to put out maybe the obvious that we're talking about different layers of a technology approach here, a lower level layer where you use the standard across all covers like say Apple Wallet, Apple Passport, or secure messaging like Direct, which is built into more advanced capabilities, which may not be standards based simply because the standards don't exist or because there's desire for proprietary advantage. iPhone and Google compete with each other or Android compete with each other. We don't

demand a single standard for phones but they share enough lower level standards so that messages can flow back and forth between them, conversations can be had, and so forth. So, it's a more complicated technology layer diagram needed to capture all of these points. I'm not sure that's what we're called on to do here.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Okay. So, maybe we can, at this point, pause, review what's here, and see any specific wording that we need to be changed. So, the additions and edits submitted so far, in the absence of established standards patients and providers utilizing insecure message for electronic communication, e.g. email, SMS texts, which are not protected by HIPAA privacy and security controls, even though such insecure access may be allowed, I guess it should say methods, may be allowed where explicitly requested by patients. And then, we have the second two bottom ones. Reimbursement policies maybe need to be adjusted to encourage electronic non-traditional communications between patients and providers. And adequate connectivity, e.g. internet, cell phone, basic [inaudible] [01:12:59] may be needed for effective communications to occur.

And under recommendations, if you scroll down a little bit, it says solutions to support patient clinician communication should ideally integrate with existing EHR workflows to support efficiency for clinicians and appropriate documentation of communications and healthcare decision making in the patient's medical record. Is there anything else we need to add right now? Okay. Go ahead.

**Clement McDonald - National Library of Medicine - Member**

I think it overstates – this is kind of a two-sided thing. This is saying we're doing bad things by letting them do stuff freely. I think we should swing that in a different direction and say we should allow more and encourage the use of these things when the patient gives permission because the balance is way off. If you talk to almost every Medicare patient, they're not worried about their privacy. They're worried about getting the deal done. So, I just think we should fiddle with the wording and not make it sound like we're doing something bad because, with permission, providers can communicate directly and simply with the patient through a phone call or something.

**Steven Lane - Sutter Health - Co-Chair**

I think we've got that captured in the observation. Is there a recommendation there, Clem?

**Clement McDonald - National Library of Medicine - Member**

Well, the wording is inverted from what I think it should be. It starts out with HIPAA doesn't – we're skipping HIPAA control by patients talking directly to privacy –

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

There are commercial solutions as far as I'm aware where you don't need to pre-register. You don't need to put apps in place. And yet, the texts are secure. I don't know how they do it.

[Crosstalk]

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

But they do it. So, there are solutions, which I think, essentially, are SMS in the user experience and yet are secure. Again, I don't know how they do it but we subscribe to one of those.

**Clement McDonald - National Library of Medicine - Member**

Why is that the top priority to have it be secure if a patient doesn't care? I haven't read anything in the paper about these things going bad or amuck. I hear all of the time about millions of records going out. We're just not thinking about this right.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Does everybody agree?

**Steven Lane - Sutter Health - Co-Chair**

So, I think, Clem – I don't think anything in this suggests that we should limit the use of these sort of more open market solutions. But the concern that I have and that I've tried to incorporate here is that there is a need to consider the workflow of the clinicians who are trying to respond to these messages. And if they're coming at them from six different sources, SMS and Apple messaging and Facetime and email and the portal and Direct that they're just not going to be able to safely manage that within the constraints of their job. And then, the other one is appropriate documentation. That while it's great to use What's App to talk about some aspects of clinical care, there are clinical decisions that need to be documented into a patient's record.

And unless these solutions have some means of integrating and capturing appropriate documentation then, the conscientious provider is left trying to copy and paste things into the record and we know that's not very scalable.

**Clement McDonald - National Library of Medicine - Member**

Well, I agree. It's almost less points but I think this point that's five from the bottom still argues it. It sounds like the prime directive is to be secure against all odds no matter what. And I think it's overbalanced. And we should say it's America. If someone wants to do it, they should be allowed to do it. I don't know why a patient can't just call their doctor and talk or vice versa if the patient is okay with it.

**David McCallie - Individual - Member**

Well, that is the law and it is true today.

**Clement McDonald - National Library of Medicine - Member**

No, it is. But we're sounding sort of all fanatical about the privacy side in that line that's five bullets up.

**David McCallie - Individual - Member**

The focus of our group is –

[Crosstalk]

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Sorry. Cynthia, Jack, and then, we'll keep moving on.

**Cynthia Fisher - WaterRev, LLC - Member**

Excuse me. I've had my hand up. It's Cynthia and I think there have been some –

**Steven Lane - Sutter Health - Co-Chair**

You were just called on, Cynthia.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Yes. We've been saying Cynthia, you're next. Please, go ahead.

**Cynthia Fisher - WaterRev, LLC - Member**

I totally support what Clem is saying and what Arien said earlier. I think we have to really be careful here. What I'm concerned about that I'm hearing the protectionism of the EHR, the protectionism of getting it captured in the EHR versus protectionism of getting the patient the best quality of care. And the best quality of care comes from that patient and physician communication being as fast as it can. And so, I think what's very clear is that I think Clem has a very good suggestion is you flip it on its head. We heard from Jack. We heard from Arien. And we're not seeing the changes that the rest of the committee has been asking for is this train left the station. That's how really great physicians are communicating with their patients to ensure the best quality of care.

So, why don't we let the openness of the EHR's, which Arien mentioned, we encourage openness of the EHR's so that the apps can be utilized and built to capture appropriate messaging, text communications that need to go into that EHR? But in the meantime, we should flip it on its head. And I totally support Clem because we need to put the patients first. It's not about protecting what gets captured from metadata for the EHR AI in the future. Really, this is about delivering on patient care in the most readily accessible way to all patients. We are Americans and we deserve that freedom.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Next is Jack and then, David.

**Ming Jack Po - Google - Member**

So, I'm actually somewhat torn between what Clem and Cynthia just mentioned. And I'll mention why I'm torn. So, the reason is, and I'll use SMS as an example again, one of the reasons why we were able to convert people into a standard was that at some point, everybody got together and insisted that there has to only be one standard. So, I think my ideal scenario is something like a common standard that if you were to have a patient physician conversation, you have to use the standard and you have to provide an open server that can authenticate and talk to another open server kind of like what we ended up doing with XMPP because the concern is always that if you allow people to somewhat divert off of chat or divert off IM then, these pockets will always end up separate. And it will be impossible to connect them again.

And I haven't thought deeply about it but one way that you can theoretically do it is, for example, let's say that you insist on the direct standards that if a patient physician conversation happens, it has to

happen on the Direct standards then, it will force everybody to, basically, implement Direct in the back end and potentially hide it from the consumer but implement Direct. That way, let's say you do it on an SMS gateway, it will also implement Direct in that gateway so that that gateway can now talk to Epic's gateway if let's say I'm a patient at Stanford. And it can also talk to the gateway at Anthem or something like that. And that would allow the standard to actually flourish. One of the reasons why many of us haven't really built Direct servers right now is because, frankly, nobody uses it.

All of these messages kept getting diverted into the other hidden pockets. And I don't know if we were to even push for more open choice whether that would just exacerbate the problem. I would love to hear what everyone thinks actually.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

And just as a reminder, all of the task force members have access to this document in track changes suggestion mode. So, please feel free to put suggested wording of what expresses your desires here because I think we do want very concrete proposals that we can review and say we agree or we don't agree. David and then, Anil. David, you're up.

**David McCallie - Individual - Member**

I'm sorry. I was on mute. We have to remember that we're tasked for making recommendations about where additional standards development is needed. So, I think the question that we should be asking here is maybe what additional areas of standardization would facilitate patient provider communication. That's out topic here I think. And I'm not sure we've thought about the problem that way. I don't think that we're prepared to say that SMS is adequate. I do think we all agree that if that's the best choice for the patient, they should be allowed to use it and the physician should be encouraged to support that. But I don't think we're saying that's sufficient. So, what standards do we want to encourage that would improve this or what are the requirements for those standards if we're not in the mode of actually specifying a standard?

So, open, all providers, there are a variety of things you can pick off and then, you can decide whether Direct is adequate, whether Fyre is adequate, whether we need something completely new, go back to XMPP, which was the original proposal behind Direct as Arien well knows, etc.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Anil?

**David McCallie - Individual - Member**

Just think of it from the standards that we need is, I guess, my point.

**Anil Jain - IBM Watson Health - Member**

Yeah. I was just going to say I think we're having two different conversations. One is what are the technical underpinnings of facilitating patient doctor communications electronically through whatever mechanism. But the other one is what is this committee going to be able to do in terms of either proposing interoperability standards but also recommendations, as we all discussed earlier, policy levers or other levers. And I come back to something around adoption. Many of us have been responsible for

EMR deployments and implementations years ago. And it takes two to adopt. We cannot be pushing for something we know is going to cause trouble with the clinical workflows downstream. Otherwise, this will fail.

So, I do want us to be thinking through from the point of this committee are there things that we could do to lower the barriers for those who do want to communicate but recognize that there is going to be a steep learning curve if clinicians have to deal with dozens of modalities, how are they going to communicate. And I know Steve has said this but I still practice part time. I still get communications in different ways and I have to do a lot of copying and pasting. And if you ask the patient do they want this information in their record, they say yes because I'm not their only physician. There is a whole host of a care team. And so, just simply having communication with me isn't enough. So, until we get everything else to catch up, we have to be very careful that we do not push too hard on this otherwise, it will go in the other direction.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Okay. Cynthia and as a note, we have public comments in a few minutes.

**Cynthia Fisher - WaterRev, LLC - Member**

Yes. I go back to the Point 3 that Clem had asked that we invert and put more of the emphasis that patients access the methods and physician access to texting and communication be there. I guess it just left my screen so I can't read it. The screen changed. The public comments are up. But anyway, we go back to Clem and invert that rather than make it restrictive. I think that was a request by several of us on this committee.

**Steven Lane - Sutter Health - Co-Chair**

So, we've changed the text, Cynthia. So, Cynthia, we have reordered and modified the text of both the observations and the recommendations to start to put the patients first starting with the patient's desire to choose their preferred application interface in the observation and the recommendation to provide flexibility to patients to select their messaging tool.

**Cynthia Fisher - WaterRev, LLC - Member**

Could you add that to the screen? Right now, it's not up on the screen.

**Steven Lane - Sutter Health - Co-Chair**

Can we pop back Excel to the Google Doc? Thank you.

**Cynthia Fisher - WaterRev, LLC - Member**

Thank you.

[Crosstalk]

**Clement McDonald - National Library of Medicine - Member**

We can make recommendations directly.

**Cynthia Fisher - WaterRev, LLC - Member**

It was Point 3 that Clem had mentioned. It's up at the top of the screen. It needs to be scrolled down.

**Steven Lane - Sutter Health - Co-Chair**

Can you say which one you're talking about since they're bulleted and not numbered? I'm not sure what you're referring to.

**Clement McDonald - National Library of Medicine - Member**

It begins with in the absence of –

**Cynthia Fisher - WaterRev, LLC - Member**

Okay. It's Point 2, in the absence of. Clem, you had said it so well. Do you want to add that in there? And I would just say let's change that to Clem's recommendation.

**Clement McDonald - National Library of Medicine - Member**

I don't write well on the fly. I think we could try to fix it as a comment into it unless if you've got an idea, go for it.

**Cynthia Fisher - WaterRev, LLC - Member**

I think it would just be to allow communication in the format that both the patients and the physicians choose to communicate in messaging. If it's text messaging or What's App that they could utilize that rather than making it so heavy handed. And just make it broad access for communication. And then, also I think Arien had mentioned about the standards for EHR vendors to open their API so that the gateways of this messaging could be what's relevant and pertinent could be shared into the record and it could go two-way bidirectional by the patient or by the physician. So, I think those are things that we can do and we could deliver on without punting it down the road.

**Steven Lane - Sutter Health - Co-Chair**

Okay. So, thank you, Cynthia and Clem. Again, we've got observations and we got recommendations. And Ken is taking another stab at tweaking the observations so that they feel right to the task force. I think mostly what we're talking about is recommendations. And we don't have one yet specifically about API and opening up the EHR's, API's so that varying methods of communication could be integrated. And Arien, you had some helpful comments about that as did you, David. Anybody who wants to take a stab at a recommendation bullet around API integration would be more than welcome. Otherwise, your co-chairs will do the best we can. It is time for public comment. So, we'd like to pop over to that.

**Operator**

Thank you. 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. And for participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys.

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

Do we have 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**

All right. Steven?

**Steven Lane - Sutter Health - Co-Chair**

Excellent. Okay. We can check back for comments again in a few minutes. Let's go ahead then. So, Ken, I think you have highlighted some text here. Do you want to talk us through that?

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Yeah. The highlighted yellows need folks' comments. Preferred methods for communications among patients and providers may include insecure methods such as email and SMS text and recommendation provide flexibility to individuals, patients, and providers to select the messaging tools of their choice and to easily manage messaging utilizing disparate HIT solutions. How is that?

**Steven Lane - Sutter Health - Co-Chair**

I think we just need to add while assuring that appropriate documentation is integrated into the medical record.

**David McCallie - Individual - Member**

I think, again, are we calling for a standard here or simply saying –

**[Crosstalk]**

**Steven Lane - Sutter Health - Co-Chair**

Well, I think we are. Yeah, I think we are, David. And I liked your idea of kind of specifying what should be included in such a standard because that really is our recommendation. That's our charge is to focus on standards. So, would that be the ONC's responsibility to convene stakeholders and develop a standard?

**David McCallie - Individual - Member**

Yes. That would be the start. Private industry could do it as well but ONC, typically, would set the standard. And then, whether that standard becomes part of an incentive program would be a CMS decision.

**Steven Lane - Sutter Health - Co-Chair**

And David, you started to rattle off earlier what you saw as the relevant components of such a standard.

**David McCallie - Individual - Member**



Yeah. I think it would be pretty much the desiderata that were behind Direct, which would be it's standards based, open to all, simple to implement, integrated into the workflow of the EHR so that providers can keep track of the conversations. There is a long checklist of things. I think maybe some of the things that were not part of what we thought a lot about with Direct would be the availability built into consumer devices. That's certainly something that's missing from Direct. And that's where tools like SMS or XMPP or some other approach might be preferred in the long run. So, freely available to consumers would be, I guess, maybe the requirement.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Please scroll down. The editing is occurring a little bit lower on the screen. And Cynthia, do you have your hand up?

**Cynthia Fisher - WaterRev, LLC - Member**

I was on mute. Yes, I had my hand up. I don't know if Arien is still on the phone. Arien, are you on the phone?

**Arien Malec - Change Healthcare - Member**

I'm here, yeah.

**Cynthia Fisher - WaterRev, LLC - Member**

You had mentioned about opening the API's and allowing for innovation for channels in addition to messaging. But you had talked about that earlier. And I think this might be a good place to flag your recommendation on having the API's open so that innovators could also provide that Apple Wallet or Passport.

**Arien Malec - Change Healthcare - Member**

Yeah. I think this text here really covers it.

**David McCallie - Individual - Member**

There is tremendous progress being made in opening API's. I think what we're adding here is to make sure a messaging is a part of that space.

**Arien Malec - Change Healthcare - Member**

That's right.

**Ming Jack Po - Google - Member**

Sorry, this is Jack. I think I'll add a few points in the comments and then, I would love to add folks in for further discussion. My concern is that I think if we open it too broadly – it's almost a tradeoff in the short term and the long term. By creating the silos in the short term, I think that is definitely the right thing to do for the patients today. But it might make the long term very difficult to sustain. But I'll clarify what I mean and I'll write a few comments add folks in to discuss on the doc.

**Steven Lane - Sutter Health - Co-Chair**

Thanks. We really do appreciate direct comments in the document. No hands up. Terrific. So, David and Arien, please feel free to add to or address the language that we put under the policy lever. And Jack, I see you've got a plan to add some information up under recommendations. So, if we can scroll just – I think we went through the observations, made some changes in response to the great comments and the recommendations. And now, we've added the policy lever. Are people comfortable moving on from patient clinician to electronic messaging at this point? Okay. We've got a little bit more time so let's see if we can tackle the next, which, again, is sort of a novel idea, the multi stakeholder, multi institutional care plan. And here, Sasha, you inserted a comment here.

**Sasha TerMaat - Epic - Member**

Yes. And Ken, I see you're typing it in, which looks good.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Okay. So, that's okay.

**Steven Lane - Sutter Health - Co-Chair**

Great. Are there any other thoughts? I know, Terry, you were one of the first to suggest adding this to our work. Are you comfortable with where this ended up?

**Terrence O'Malley - Massachusetts General Hospital - Member**

Yes, this looks good.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

And David has his hand up.

**David McCallie - Individual - Member**

Yeah. Maybe it's too divergent but I'm deeply skeptical that we'll get a whole lot of traction with API based approaches to shared care plans or shared documents for care plans. And it's going to be more of an Aflac approach. So, you've got that as a bullet point there. Over time, an app based approach is beneficial. Never mind. You've got it. Thank you.

**Steven Lane - Sutter Health - Co-Chair**

All right. Let's move on. I'll see if we can tackle one or two more of these. We've got real time text messaging and then, our general observations. We might actually get through this section.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

The thing about real time text messaging is we now have incorporated this quite a bit inside of the earlier one about patient –

**[Crosstalk]**

**Steven Lane - Sutter Health - Co-Chair**

Maybe we don't even need this.

**David McCallie - Individual - Member**

It seems redundant.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

I think we might be able to delete this whole section because we talked about SMS so much now. Are there any objections to deleting this now that it's incorporated in the one we were just discussing for about 45 minutes? Okay. Let's move on.

**Steven Lane - Sutter Health - Co-Chair**

All right. So, now we've gone to our general observations. And you fired out, Ken, earlier that – oh, we've got a hand up. Cynthia.

**Cynthia Fisher - WaterRev, LLC - Member**

Yeah. I think at the last meeting in person something that I remember Arien making a comment, too. On the real time text messaging and also real time patient access, is that also covered here? It's hard for me to read because the screen is just partial. But patient access to that real time information, where do we specifically address that here?

**Steven Lane - Sutter Health - Co-Chair**

What are you referring to?

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

I think we're talking about results release. I think that's earlier somewhere. Let me look.

**Steven Lane - Sutter Health - Co-Chair**

Cynthia, I'm not quite sure what you're asking about. So, we've been talking about text messaging for communications.

**Cynthia Fisher - WaterRev, LLC - Member**

Yeah. That's on patient care. That's going to go into the workflow as suggested. And so, rather than delay access in a portal to patients, where do we as a standard address patients getting real time access to their health information?

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

I remember it was somewhere.

**Cynthia Fisher - WaterRev, LLC - Member**

Through this process.

**Steven Lane - Sutter Health - Co-Chair**

So, if you're talking about results, we discussed that last time. That's up under the orders and results section.

**Cynthia Fisher - WaterRev, LLC - Member**

And what about the communication trail? Will they get – do we have real time access and real time messaging here? Will that be accessible to the patients? Real time notes and real time messaging.

**Steven Lane - Sutter Health - Co-Chair**

So, you're talking about open notes, essentially, the concept that patients should have access to review their records in their entirety?

**Cynthia Fisher - WaterRev, LLC - Member**

Yeah. Do we address that anywhere? Not just the lab results, not just the – the patients are also – if their family caregiver is part of the care team and themselves, think of them as part of the care team.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Big picture, open notes I don't think we have a section on it. If we were to add it, it would be an addition to probably across the main recommendations. That would be if we wanted to put it, that's where we would probably put it.

**Cynthia Fisher - WaterRev, LLC - Member**

Could we put that in as a recommendation to at least provide the type for real time patient access as a more complete record of the EHR and health information to be available?

**Steven Lane - Sutter Health - Co-Chair**

Cynthia, I think that's being addressed through information blocking.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

That's true.

**Steven Lane - Sutter Health - Co-Chair**

It's not a standards issue.

**Cynthia Fisher - WaterRev, LLC - Member**

In some cases, it's what gets shown to the patients is – we talked about it last time with [inaudible] [01:41:15] delayed and minimized. So, the question I have is can we lay a pipe of standards should it be institution or the EHR or the provider open up real time access for patients?

**Steven Lane - Sutter Health - Co-Chair**

Yes. That sounds like a policy as opposed to a standards question.

**Cynthia Fisher - WaterRev, LLC - Member**

Well, I don't know. I just want to put it in there because we're looking at real time messaging. We're looking at real time access to information.

**Steven Lane - Sutter Health - Co-Chair**

Clem?

**Clement McDonald - National Library of Medicine - Member**

Well, I hate to disagree with Cynthia but the delays are typically like for cancer diseases and stuff where it's pretty cruel to have it just show up in the mail. I think that's part of the reason there are often delays. You'd like to have a personal conversation. That's for people who scream about that actually that someone just called me on the phone and left a message saying your dad is dead or something. That's a bigger case. But I think it would be really bad to insist that all stuff has to go out immediately without any opportunity for human communication.

**Cynthia Fisher - WaterRev, LLC - Member**

Yeah. But I guess, Clem, I disagree with you there because so often, women get mammograms or they have situations where they wait and they can't get a follow up appointment for three weeks and they were supposed to hear back from the clinician and it gets dropped. So, having access allows the patient to engage. They are part of their own caregiver team to take action and follow up with communication. I think we just live in a different world.

**Clement McDonald - National Library of Medicine - Member**

No, I agree with what you just said. The difference between not getting it out in a reasonable time and having to get it out that second without a chance to do it verbally are different. So, we can agree to disagree maybe.

**Steven Lane - Sutter Health - Co-Chair**

So, I want to find out – we've actually come to the end of the time that we had scheduled for this meeting. We didn't have this go all the way to the hour because we needed to have a debrief with the ONC team. So, I think that we probably need to cut off the conversation at this point. We find ourselves almost at the very end of this section on closed loop referrals and care coordination. There were some general observations that have been made here. Sasha has provided a single comment that's on the screen here. But I think that what we're going to do is your co-chairs are going to attempt to go through the first two sections and wrangle with the comments that have been submitted. We continue to invite people to go in using your suggesting functionality and make additional suggestions we can then bring back to the task force.

But what we'd like to do is start our meeting next week on the 8<sup>th</sup> at the top of the medication and pharmacy data, which sits at the top of Page 32 and see if we can do as good a job with that section as we did with the middle section today. Are there any other comments before we close out?

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Yeah. A few quick ones. 1) Cynthia, I added a section across the main topics on patient access to data. So, if you want to review and provide comment on it, it's there now. And then, I think we do need to consider what we do if we run out of time because it's a good discussion but it's slow. So, that's something we will need to consider. I don't know how best to do it other than maybe meeting more. But I guess if we come down to it, maybe at the next meeting we'll potentially discuss other marathon sessions that we schedule or whatnot. But anyway, there is still more work to be done.

**Steven Lane - Sutter Health - Co-Chair**

Yeah. I think we should at least consider whether we want to squeeze in one last call on the morning of the 15<sup>th</sup>. But we are presenting to the HITAC the following day on the 16<sup>th</sup>. So, it's going to be very difficult for the ONC team and others to pull everything together in under 24 hours for that. So, I think we really do need to try to ask you all to provide specific suggestions over this coming week and we will try to get through everything on the 8<sup>th</sup>.

**Clement McDonald - National Library of Medicine - Member**

Couldn't we just think about that we can't get it all done and maybe another cycle next year or something like that?

**Steven Lane - Sutter Health - Co-Chair**

We're certainly suggesting that yes. That's definitely part of our recommendation, Clem. But we do need to get done at least what we're going to be presenting to the HITAC on the 16<sup>th</sup>.

**Clement McDonald - National Library of Medicine - Member**

No, I agree 100 percent.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Yeah. And maybe it's that next time, anything that's an addition of scope is just deferred and we put into a parking lot for things that we should consider when we have more time because this is hard.

**Steven Lane - Sutter Health - Co-Chair**

Okay. Thank you all.

**Kensaku Kawamoto - University of Utah Health - Co-Chair**

Thank you, everyone.