Transcript

HTI-1 PROPOSED RULE TASK FORCE 2023 MEETING

June 7, 2023 10:30 AM – 12 PM ET

VIRTUAL

Speakers

Name	Organization	Role
Steven Eichner	**Texas Department of State Health Services**	**Co-Chair**
Steven Lane	**Health Gorilla**	**Co-Chair**
Medell Briggs-Malonson	UCLA Health	Member
Hans Buitendijk	Oracle Health	Member
Hannah Galvin	Cambridge Health Alliance	Member
Rajesh Godavarthi	MCG Health, part of the Hearst Health network	Member
Adi V. Gundlapalli	Centers for Disease Control and Prevention	Member
Jim Jirjis	HCA Healthcare	Member
Hung S. Luu	Children's Health	Member
Anna McCollister	Individual	Member
Clem McDonald	National Library of Medicine	Member
Deven McGraw	Invitae Corporation	Member
Aaron Miri	Baptist Health	Member
Eliel Oliveira	Dell Medical School, University of Texas at Austin	Member
Kikelomo Adedayo Oshunkentan	Pegasystems	Member
Naresh Sundar Rajan	CyncHealth	Member
Fillipe Southerland	Yardi Systems, Inc.	Member
Sheryl Turney	Elevance Health	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Daniel Healy	Office of the National Coordinator for Health Information Technology	ONC Program Lead
Sara McGhee	Office of the National Coordinator for Health Information Technology	ONC Program Lead
Dustin Charles	Office of the National Coordinator for Health Information Technology	ONC Program Co-Lead
Michael Wittie	Office of the National Coordinator for Health Information Technology	ONC Program Co-Lead

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

Michael Berry
Good morning, everyone, and welcome to the HTI-1 Proposed Rule Task Force. Just a reminder that today's meeting is of the full Task Force, but the focus will be primarily on Group 2 recommendations. When developing your final recommendations, I encourage you to put implementation concerns aside for now so that we continue to move the interoperability of health data forward. We only have a limited time to spend on each topic area so that we complete Group 2 recommendations today. All of our Task Force meetings are open to the public and your feedback is always welcomed, which can be typed in the Zoom chat feature throughout the meeting or can be made verbally during the public comment period that is scheduled toward the end of our meeting. I would like to begin rollcall of our Task Force members, so when I call your name, please indicate if you are here, and I will start with our cochairs. Steven Lane?

Steven Lane
Good morning, welcome, everyone.

Michael Berry
Steve Eichner?

Steven Eichner
Good morning, welcome, all.

Michael Berry
Medell Briggs-Malonson? Hans Buitendijk? Hannah Galvin?

Hannah Galvin
Good morning.

Michael Berry
Adi Gundlapalli? Jim Jirjis? Hung Luu?

Hung S. Luu
Good morning.

Michael Berry
Anna McCollister?

Anna McCollister
Good morning.

Michael Berry
Clem McDonald? Deven McGraw? Aaron Miri? Eliel Oliveira?

Eliel Oliveira
Good morning.

Michael Berry
Kikelomo Oshunkentan? Naresh Sundar Rajan?

Naresh Sundar Rajan
Good morning.

Michael Berry
Fil Southerland?

Fillipe Southerland
Good morning. Good to be with you all.

Michael Berry
Sheryl Turney is on vacation, so she will not be able to join us today. Now, please join me in welcoming Steven Lane and Steve Eichner for their opening remarks.

HTI-1 Proposed Rule Task Force Charge (00:02:01)

Steven Eichner
Good morning, all. This is Steve Eichner. Welcome to this full Task Force meeting, where we are going to be working hard to finalize our recommendations for the report that we will be providing to HITAC for their review, modification, and subsequent submission to the Office of the National Coordinator. We have an awful lot of work to do today, so we are not going to spend a lot of time reviewing our charges. Just for the record's sake, our purposes are to review the HTI-1 rule and make recommendations to ONC regarding a wide range of topics. We will have a public comment period toward the end of our meeting today. We encourage and welcome comments from the public. It is really important to have public input as we form our recommendations. We do ask today that Task Force members do not work in the worksheet during the meeting. Steven Lane will be scribing for us and getting information into the worksheets, but please do not simultaneously edit them, so we want to make sure we are getting all the changes and not overriding each other's work. Steven, do you have anything to add?

Steven Lane
No. Thank you, again, for everyone's time and attention, and we are looking forward to pushing through a long list of recommendations.

Update and Revise Draft Recommendations (00:03:39)

Steven Eichner
I think we will go ahead and jump back in. We are going to start today at Row 4.

Steven Lane
Steve, if you want me to be in there, you need to get out of that cell in Column J.

Steven Eichner

Practice what I recommend, right? I am out. So, we are going to start today on Row 4, which is recommendations focused on things around the naming of editions. The first recommendation that we have drafted to put forward is looking at recommending that ONC maintain and release a table or tables of the specific criteria and the standards used for reporting data or exchanging data in the current criterion, both the immediate past, the current, and looking to the future as a reference guide to support both providers using certified technology and other entities that are involved with exchanging data with certified technology so there is a clear understanding and reference to what is actually being used and what is currently in regulation to help resolve issues if there are challenges in exchanging data. Are there any concerns or suggested modifications at this point?

Hans Buitendijk
Are we looking at Column G or J?

Steven Lane
J.

Steven Eichner
Sorry, ONC, we need to shift to J. We will give people a moment to read. Can we lock this down? If there are no comments, we can lock it and move on. Looking at the second recommendation, we are recommending that ONC include relevant information regarding compliance with messaging standards in deploying standards in deployed systems as metrics with the goal of including in the metric section of the proposed rule looking at tracking compliance or usage of existing or current certification standards, again, looking at a method of measuring the use of standards that are actually in regulation and serving as a measure for usage of SVAP adopted standards. Is this a good thing? Do we want to leave this in?

Hans Buitendijk
Ike, I have one quick comment on the first one. It has an extra word, “that,” after “information,” “tables of information that for each relevant criterion.” I think the word “that” is dropped in the sentence, otherwise something is missing.

Steven Lane
Sorry, which sentence are you in, Hans?

Hans Buitendijk
The very first line.

Steven Eichner
In the very first line of that.

Hans Buitendijk
There seems to be an extra word, “tables of information that, for each relevant criterion that is certified…”

Steven Lane
Got it, okay.

Hans Buitendijk
I think if you dropped "that," it is fine.

Steven Eichner
Thank you for that, Hans. Again, the second recommendation is looking at adding a measure or measures related to usage or inclusion of the standards that are in or actually working in the field, so we are reconciling what is actually in the certified standard with what is actually deployed. Any feedback there? Looking at the third recommendation, it is advising ONC to consider…

Steven Lane
Steve, you are back in the cell.

Steven Eichner
Sorry.

Steven Lane
It is easy to do.

Steven Eichner
Thank you for that. Looking at the third recommendation, it is advising ONC that it may want to consider the impacts of using an editionless evolution regarding the impact of more flexible modification and the interrelationships between adopting standards such as the USCDI and the impacts of the flexibility and the opportunities for things to be out of alignment, as well as being in a state of constant flux rather than looking at stable systems. Any recommended changes?

Fillipe Southerland
I am curious if this means that we are asking ONC to look at potentially batching criteria updates versus constantly having various criteria in flux. What are we driving at with this?

Steven Eichner
The current recommendation does not specify that as a strategy, but it is calling attention to the concept of if you look at not having an edition approach where you are operating all standards in one fell swoop, you are in a state of flux, and you have to worry about the interaction between the different standards and compliance in terms of looking at the effects of one exchange factor and another, and if you do not raise all boats simultaneously, you run the risk of having disconnections or lack of ability to exchange properly.

Fillipe Southerland
I see, okay. That makes sense.

Steven Lane
Eliel has his hand up.

Steven Eichner
Yes, sir?

Eliel Oliveira
Can you hear me, Steven?

Steven Lane
Yes.

Eliel Oliveira
So, it is not about this specific recommendation, but the way we are doing data alignment. I am having a hard time keeping track of the text to read because it moves, and sometimes we are talking about a specific one. Would it be okay to put a number in front of each one of those so when we say we are talking about No. 3, it does not get lost as it is moving across the screen? I am just having a really hard time finding what we are working on at times.

Steven Lane
Sorry about that, Eliel. I will do that for you and for all of us.

Eliel Oliveira
Thanks so much.

Steven Eichner
Or maybe an asterisk in front of the one… Oh, that was fast.

Anna McCollister
I would second that, actually. It is pretty hard to follow.

Steven Eichner
So, what we are asking is to consider the impact. Do we need to change it to a more specific recommendation about batching?

Hans Buitendijk
This is Hans. I have two notes, one in reaction to that. When we say "batching," we are effectively going back to editions because editions are effectively batches that group things together. The cadence might be different, but something has happened there that you are grouping them together. But, highlighting that they need to look at that because it has pros and cons, either one can work as long as you understand the total impact at any point in time, and I put a suggestion in the note to add to the first sentence something along the lines that it needs to not only look at the total impact of what is in the certification program, but keeping in mind that there is a lot of other HIT work going on that progresses as well and that is also going through upgrade cycles, training, and everything else, so we really need to look at it holistically and say what the total impact is, and as a result, what it takes for the providers and others to get this all done. It is not only in the certification program, but everything else that needs to happen as well.

Steven Eichner
So, basically adding a line that would say something along the lines of "changes in certification criteria impact not solely certified technology, but impact other systems and other exchanges."

Hans Buitendijk
It is not as much that certification criteria impact other components, it is that it contributes in addition to other HIT updates to workload as well. So, I put in the chat at the end of the sentence something like "including all other HIT updates that need to be managed as well," and they have the same needs of training, efforts, etc., and that is going to be… There is only so much in the bucket of a provider that they have available to spend on any updates, and they need to balance between the two of them what is certified and what is not certified, but that they still need.

Fillipe Southerland
I also wonder if we feel there is an effective feedback mechanism from HIT developers to ONC where, if something is introduced that developers feel is too high of a burden or too short of a timeline, do we have a method for developers to reach out to ONC in batch, or do we need a method?

Steven Lane
I am a little concerned that this feedback is going deeper than we have time for.

Steven Eichner
Yes.

Steven Lane
I think we need to nail these down and know that there are really smart people who are going to be reading them. We have a very long way to go today. Hans, I believe I added your suggested text at the beginning of 3. I think that is where you wanted it.

Hans Buitendijk
Yes, that helps, and generally, I think there are opportunities to provide that feedback as part of these responses. For example, EHRA is putting together, as they have done before, a grid looking all the criteria and determining if they are a small effort or a large effort and what has happened in total, so there are opportunities for vendors and providers alike to provide that level of detail. It is not a formal special channel, but real-world responses are being used to indicate how big of an effort it is that would be too big an effort for HITAC to do.

Steven Eichner
We need to move on. So, looking at Recommendation 4, it really acknowledges the concept that the data exchange occurs not only among certified HIT, but with other users, and they may not be able to upgrade on the schedule specified by certified technology. So, there does need to be alignment with technology upgrades outside the certification program.

Steven Lane
I think that this is general feedback. Oh, Clem, you had your hand up.

Clem McDonald
What is the implication of the fact that it occurs to things that are not in HIT? Are we saying we should not proceed or that they have to hurry up? I am not sure what No. 4 means.

Steven Eichner
I think the issue is when you are selecting a new criterion, you cannot do it in a vacuum, looking exclusively at exchange between certified technology, that you have to do a landscape scan to ensure that other noncertified technology is capable of adoption the same standard in the same timeframe. Otherwise, the impact of certified technology works well for exchange with other certified systems as an independent island, but not with other systems like public health reporting, as an example. It does not do providers much good to have an updated system required for use of certified technology if the public health system you are sending it to is still using an old standard.

Clem McDonald
But I still do not know what the implication… What is the solution, or is there one? In some states, public health is fairly underfunded for informatics and information systems.

Steven Eichner
I think that feeds into looking at the determination of what standards should be included and what the upgrade path looks like.

Clem McDonald
Okay.

Steven Lane
I think it is a general comment, a general suggestion. Again, I do not think it is going to fall on deaf ears, so I do not think we should dwell on it, and I do not mean to be rude to anybody. I think these are all important points, we just do not have time.

Steven Eichner
Looking at No. 5, recommending that ONC align or review with CMS alignment between federal programs such as the certification program and Promoting Interoperability so that the standards required in things like Promoting Interoperability are consistent with the standards required in certification criteria.

Steven Lane
Again, really, it is a general comment. It is not a very specific recommendation.

Fillipe Southerland
This is mine. I do want to make sure we do not understate this one. I think this is eloquently put, but maybe we should consider adding the rationale in here where what is happening today is that CMS incentive programs are based on certified electronic health record technology, but we have a modular certification program within ONC, and what is happening is that because the CMS definitions are based on CERT, we are effectively excluding modularly certified HIT from those programs, so it is a very big impact on the specialty EHR sector.

Steven Lane
I am trying to capture what you are saying here, and I am not quite getting it.

Hans Buitendijk

If you copy what Fil had on the right-hand side, in Column K. that seems to be a good starting point to clarify the rationale.

Steven Lane
The rationale that is there. Got it.

Fillipe Southerland
Thank you.

Steven Lane
Let's see how that flows for us.

Steven Eichner
One of the challenges with the language is that, by policy or practice, state, local, and territorial health does not usually require use of certified technology. It is recognizing the use of CERT for providers that are participating in federal programs, which I know was an element in Fil's text.

Fillipe Southerland
Right. I am not sure I caught the point you were driving at there, though, Ike.

Steven Eichner
Your suggested text included that there were elements of STLT law or STLT regulations requiring the use of CERT, and that is generally not true.

Fillipe Southerland
I know we ran into this as a vendor in New Jersey, as one example that comes to mind, where New Jersey required certified HIT, and I think that raises the question of does that mean certified base EHR, modularly certified, or CERT?

Steven Eichner
To refine it, the focus from a public health perspective is effectively modular certification. In other words, looking at exchange of data for immunization data, the focus on public health is not that the entire system meets every single cert element, it is the interoperability factor that becomes important from a public health end and compliance with the 1.5 standard.

Steven Lane
I do not think there is any harm in including this, but I do worry that we are going too deep. We need to move on.

Steven Eichner
Yes.

Steven Lane
So, can you live with this the way that we have captured it here, Fil?

Fillipe Southerland
This looks great, yes.

Steven Lane
All right, thank you.

Steven Eichner
So, keep on trucking. I think we are moving to the next…

Steven Lane
Moving to Row 7, which I will point out has 12 recommendations.

Steven Eichner
So, we need to go very quickly. This is a section looking at patient consent. The first recommendation is looking at a requirement that certified health IT incorporate patient-facing services enabling the patient to identify their preferences regarding disclosure of information. Any concerns?

Hans Buitendijk
This is Hans. If we are indicating that that is for this round of certification as part of a final rule, my concern would be with the timeline available to have such patient-facing services by relevant certified HIT given the prework that needs to be done to define good focus and consistency that can be used across providers. That would be my concern, not with the intent, but the timeline to achieve it in this round.

Steven Lane
I think that is a really good point, Hans, and let me just suggest that perhaps we move this to Tab 1. As we were discussing yesterday, Tab 2 is really specific feedback for this round of rulemaking on the patient-requested restrictions under HIPAA. Tab 2 is for additional areas of future focus for restriction. Hannah, your hand is up.

Hannah Galvin
I agree with that, and any patient-friendly terminology would need to be mapped to a semantic conceptual model which also needs time to be developed, so I agree with Hans that this is not ready for game day.

Steven Eichner
I do not think there is any reasonable expectation that it would be included from a functional perspective in the current iteration.

Steven Lane
Okay, I am moving it to Tab 1, where I think it will be happy.

Steven Eichner
Looking at the second recommendation, that ONC work with relevant stakeholders, including providers, **[inaudible] [00:26:54]** patients to define standard policies, and again, that may be more future-looking than the current rule. Hannah?

Hannah Galvin
Again, I think there is… Sorry, I was looking at 3. I will come back to it then.

Steven Eichner
Do we move the current listed recommendation to the general tab, or do we leave it as feedback in the current implementation or current rule?

Hannah Galvin
Actually, my comment applies to 2 as well. I think that standard policies and rules also… I think there needs to be a maturity model for both 2 and 3, and I think there is probably three to five years of development on this with the appropriate funding, so I do not think we are ready for certification on this, but I think that what we are ready for is bringing the industry together to work toward this, but I think we need a five-year maturity model.

Anna McCollister
I guess I am trying to understand what the one that we spoke about and this one are trying to accomplish. Is it basically taking it out of the structured codes and terminology with the structured codes and converting it into something a patient might recognize and be relevant with them? Is that what we are talking about?

Steven Eichner
No. 2 is looking at enabling the patient to make requests using patient-friendly terminology and convert it into functional capability.

Anna McCollister
Right, so it is converting it from ICD-10 codes or CPT codes into something my mother might recognize.

Steven Eichner
Right, so the patient can pick a disease name and not have to know the ICD-10 or the SNOMED code.

Anna McCollister
Right, okay.

Steven Lane
Hans?

Hans Buitendijk
Building on that, it is that level of clarity that needs to be defined to enable a patient to define their preferences and consent rules that, at this point in time, by moving 1 and 2, and possibly 3, into that, that needs to be worked on. I am jumping to 10 for a moment as an example, but then, in certification in this round, we need to say we need everybody to support data segmentation according to the use guides. What 1, 2, and 3 are looking at is the real core set within those guides that we need to recognize consent rules can be built around, and if everybody is going to go off on their own interpretation of these guides by just referencing the guide for certification, I think we are going to be landing in the wrong spot by being totally inconsistent across all the implementations.

So, I think they tie together in that until we have the **[inaudible – background noise] [00:30:23]** asking for general adoption of these more general standards is going to lead to very diverse implementations that may not be able to fit together. I think that is the primary concern with this topic. We are running a little too fast in one area, and we need to get there, but we are running a little too fast to get it into certification when some of the prerequisites are not in place yet to really make it work in a scalable, consistent fashion across the board.

Steven Eichner
So, do we push 10 down the line or pull 2 or 3 forward?

Hans Buitendijk
I would be more inclined to push 10 down the line based on the fact that we believe 1, 2, and 3, if you will, need to be the focus and get through as fast as we can. Then, we will know what we can ask everybody to do consistently.

Steven Lane
Eliel, you have your hand up.

Eliel Oliveira
Thanks, Steven. I think along the lines of what Hans is saying, these are good recommendations, but I think we are recommending things that make these harder to solve, and what I mean by that is consent for sharing a specific data element at the granular level is not going to be an easy task when we do not have a solution yet, even for general consent, but is understood electronically, that I know of. We have pilots of a few things in California, and it is very broad. The consent for mental health basically covers any sharing of mental health. It is not a specific element or a specific organization.

So, I think that maybe part of these recommendations here, which I mentioned in the Annual Report Workgroup yesterday, is maybe we want to think about the need for almost a strategic plan in terms of how this consent setup is going to work first to solve some data consents. As far as I know, even the HIPAA authorization that you collect today cannot be queried electronically. Let's address one problem first, get an infrastructure in place that works for just the generic high-level consent that then can be replicated and go down to the level of code, to deeper levels of sharing and consent. I hope that makes sense. I just think we are providing recommendations here that are very broad that are going to be very hard to implement as opposed to just trying something that works for the things we have today.

Steven Lane
A number of these recommendations are specifically about limiting the scope so as to make it more implementable. Clem, your hand is up. You are muted.

Clem McDonald
I meant to lower my hand.

Steven Lane
No, you are not muted, and your hand is down. Okay, Ike, let's circle back to 2 and 3. How do we want to dispose of these?

Steven Eichner
Without 2 and 3 in play in the short term, 10 does not really work because, as we pointed out earlier, they are tied at the hip. Anna?

Anna McCollister
I would say 2 and 3 are current recommendations to work with stakeholders and collaborate with stakeholders, and I think we talk about this as we do later on as a maturity model. This is not asking for certification now, but it is starting this process to work with stakeholders to put this together. I think it is okay to have her as opposed to move to the RFI piece because these are current recommendations for what to do now to move **[inaudible – crosstalk] [00:34:59]**.

Steven Eichner
Right, but they are not recommendations regarding the specific rule, and that was what we were tagging out, is that recommendations without action on the rule versus a more general recommendation.

Anna McCollister
That is fair. It is not putting the criterion into place.

Steven Eichner
Right. So, the issue here is that these are more general recommendations, but if you get to 10, which is a specific rule-related recommendation, you run into the issue that you do not have a consistent method of terminology supported by the standard.

Anna McCollister
It is not there yet.

Steven Eichner
So, how do we resolve those two pieces? Do we take 10 and add a line that says this needs to be done in the context of a minimum set of terminology as part of that recommendation, recognizing that you need to develop more later?

Anna McCollister
I do not think it is just the terminology. I think there are pieces of implementation guidance. There are a bunch of dependencies here.

Steven Eichner
Right, exactly, and that is why 2 and 3 came out as recommendations, but if you are thinking of just 10, if you do not have some guidance about how to do it, you have everybody going in their own direction. Hans?

Hans Buitendijk
If we have the overall recommendation along the lines of “While we absolutely recognize that we need to make progress here, advancing these standards in 10 in certification in the way it is proposed now is premature, and these are two or three things that you need to do and focus on to make it possible to move forward, and we really urge you to work on that closely with everybody to accelerate that as fast as possible.

But until that time, we do not recommend moving forward with the proposal that you have to include these standards as widely in certification." That seems to be the balance between the two.

Anna McCollister
I agree with that, Hans. With language like that, I might start with 10, that we are endorsing a standards-based approach, but with these dependencies.

Steven Lane
I am going to bring 10 up so that we are not running up and down as we make sense of this.

Hans Buitendijk
And you will keep the numbers the same?

Steven Lane
Yes, I will keep the numbers the same so that we are doing the best we can here. Okay, I changed it slightly to say "recommend ONC point to the following standards for use regarding disclosure of patient data," simply because then, we are going to go on to further clarify what we think ought to be done now, correct?

Hans Buitendijk
These are good ones to point to, but without the more specific guidance, we are concerned that it is premature to…

Steven Lane
Right, but I am just saying we were specifically asked to identify the relevant standards, so we want to give them what they asked for, and then we can go on to say **[inaudible – crosstalk] [00:38:46]** to point to.

Steven Eichner
Right, to successfully utilize the standards we have identified, you need to do Recommendation 2 and Recommendation 3.

Hannah Galvin
So, I read this as ONC asking about a standards-agnostic approach versus endorsement of standards, and if so, which standards, and so, at a high level, it sounds like this group, though I have not been a part of this subgroup as much, but I would endorse a standards-based approach over the standards-agnostic approach, and courting it on at the high level, but in order to move forward with a standards-based approach, there are then these dependencies.

Steven Eichner
But they are dependencies.

Hannah Galvin
Exactly.

Steven Lane
I agree, Hannah. I like that. Can we slip that in the front of 2, "pursue a standards-based approach"?

Steven Eichner
Well, I think that is 10. Ten is "We recommend using a standards-based approach for disclosure of patient data using these standards. To successfully utilize these standards, we need to do 2 and 3."

Hans Buitendijk
I like that.

Steven Eichner
Or you can do A and B. It does not need to be 2 and 3, and you can get it collapsed. So, you set the goal and the steps you need to do to get to the goal. There you go.

Steven Lane
Okay, I think I have this.

Steven Eichner
We are waiting for an update on the shared screen.

Steven Lane
Here it comes. Sorry, I am doing my best here.

Steven Eichner
No worries. It is a challenging task, and I am grateful for your help.

Steven Lane
Why don't you go ahead and start in on the next one?

Steven Eichner
So, looking at what is currently listed as Recommendation 4, ONC require certified health IT to provide patients' reports regarding past disclosure of their information to include name of treatment and operations and deidentified releases of data in standard file formats so that patients can download it and use it in other tools.

Anna McCollister
I am happy to speak about this if you are interested.

Steven Eichner
Please.

Anna McCollister
This is an improved version of what I suggested. I love the machine-readable ones. That is perfect. To me, I think this is important. If we are giving people the ability to restrict data, we need to actually tell them how their data is being used, and my rationale on this is actually several-fold. One is I got into health data stuff because I was frustrated with RCTs, and I think that real-world data is essential, but for people to support the use of either identified or deidentified real-world data, whether that includes for clinical care and

interoperability or the use of it for secondary data research, they need to trust and understand how that data is being used. I think it is essential both for clinical care and patient care and sharing data from one doctor to the other, as well as for the use of real-world evidence and development of real-world evidence, whether it is drug discovery, or cohort definition, or regulatory purposes in data for studies for FDA.

So, to me, this has been one significant frustration over time. I can share my video if it helps. It has been an area of significant frustration for me over time that we give healthcare institutions, developers, and data brokers lots of latitude over what they can do with data, and we do not let patients know what is happening. In a time of incredible lack of social trust, this is really going to bite us over time, and I think we are seeing the beginning of it, and we need to start taking interest.

Steven Eichner
There was prior investigation in the space 10 or 12 years ago, as you kindly shared, but the technology at that point was not as advanced as we are today. There was not as much exchange going on, so there were some challenges in operationalizing it. Now, with a focus on informational exchange and disclosing information electronically, it seems logical to be able to include a record of where that data is being passed with patient identifier information anyway and to make that information easily available for patients to consume.

Anna McCollister
Absolutely.

Steven Eichner
Hans?

Hans Buitendijk
I have a question I am trying to figure out. In light of the fact that there is already accounting of disclosure requirements in place, what is it in this recommendation that we can highlight that is insufficient for what you are trying to achieve? At this point in time, as I am reading it, unless I am unaware of some other things where the boundary is in place, it is not very clear what already is required in terms of disclosures and what should actually be added to that.

Steven Eichner
Because right now, Hans, it is impossible or incredibly difficult for a patient to actually get the accounting. I cannot go to my patient portal and pull down a link that says, “Hey, here is everywhere my provider disclosed my data.”

Steven Lane
Ike, I would argue that this recommendation is very important and does not specifically address the questions that we were asked related to this part of the NPRM around HIPAA patient restrictions, and that we should take it and move it back to Tab 1 for future consideration.

Anna McCollister
I disagree.

Steven Eichner
I would leave it where it is because I believe it to be directly related. If I am putting in restrictions about my data, I deserve an accounting to be able to ensure that those restrictions were followed, and this information provides that accounting. Otherwise, I have made a recommendation or request, but I have no way of seeing whether it was actually honored.

Anna McCollister
Exactly, and you can see my furtherance of the rationale. If I have been diagnosed with HIV or I have a genetic test that shows that I am going to get ALS or something like that, there may be specific clinicians that I do not want to be able to access that, but that information is important if I am in an emergency situation or it should be exchanged, but if I am afraid that everybody is going to know that I have HIV or I am going to get ALS at some point, I am going to want to restrict it from everybody, so if I can get a sense of how the data is being used, when it is being accessed, and by whom, there will be a much greater level of comfort in letting the data be shared amongst different clinical settings or even for deidentified data use, if I understand that it is going to be used for research to cure ALS.

Steven Eichner
We can clarify in the recommendation about that direct linkage to what we request to comment on, if that helps. To me, it was kind of obvious, but if we need to spell it out in plain text, I am sure we can.

Anna McCollister
I think there is a direct connection. I think it is a critical element. If we are thinking about restrictions, we need to give people a context to understand both the impact of the restrictions as well as why that might not be the best choice and give them a sense of comfort of what is happening with the data.

Steven Eichner
Clem, you have your hand up.

Clem McDonald
I think we have to worry a little bit about what it means to have that restricted. So, when someone reads a record and it is going to have someone do something that would be contraindicated given a given problem, will there be any signal that some data was restricted to the clinician so they would not make fatal mistakes?

Steven Eichner
That is a good question, but the recommendation at hand is about accounting, not about enforcement. Hannah?

Hannah Galvin
Just to speak to Clem's question, there is work going on to look at consensus-driven guidance around implementation of how granular segmentation would be implemented and operationalized in that way, and I think that would be part of a maturity model around granular segmentation. How would we balance a patient's very legitimate privacy request with informed consent with patient safety considerations? There is a Task Force that has undertaken that work through a modified DELPAC process that is going on currently.

Steven Eichner

That is wonderful to hear, but I want to keep us focused on our objective. We have big mountains still to climb.

Steven Lane
Okay, is 4 ready to wrap?

Steven Eichner
I think it is. Any dissention?

Steven Lane
Okay. Shall we continue to 5, or go back and revisit 10?

Steven Eichner
I think we should go to 5, looking at adopting a maturity model for data segmentation and granular consent, and again, this is tied into that 10 issue as well.

Steven Lane
I apologize, Eliel. I am moving things around so they can be viewed more readily. I hope that is okay. We have some screen limitations here.

Steven Eichner
So, do we include 5 in that 10 package?

Hans Buitendijk
I think that is the natural spot for it.

Hannah Galvin
Five and 10 package? I do not understand.

Steven Eichner
Looking at the relationship on where we go with adoption and the standards for privacy and data segmentation. This is tied in.

Hans Buitendijk
I think I am bunching two together for the moment, but 5 and 6 are to be C and D under 10.

Steven Lane
I like that.

Steven Eichner
Exactly. Thank you for being clear about it, though, Hans. That was where I was headed.

Clem McDonald
Can I comment on Recommendation 5?

Steven Lane
Go ahead, Clem.

Clem McDonald
The challenge really is free text, and an awful lot of data is clinical free text, and there is not any current simple way to isolate stuff that might be kept more private not in free text, and I think if we do not face that, we could put sand in the gears.

Steven Lane
Is it necessary here to comment on that? They are really asking us for standards.

Steven Eichner
Yes, and that is inherent in the development of a maturity model.

Steven Lane
So, are we comfortable with C and D, 5 becoming C and 6 becoming D under what is now 10?

Hannah Galvin
I am confused.

Steven Lane
Are you comfortable with 5 and 6?

Clem McDonald
I am not quite comfortable because no one has implemented it, and it obviously has some challenges.

Steven Eichner
Clem, the recommendation we are making is that in order to successfully implement the exchange of privacy standards, here are supporting activities, and supporting activities include developing a model that accounts for the data and limiting the scope, or at least the initial scope, to the following subset. I guess that would be a modification for 6, Steven, is to limit the initial scope.

Hans Buitendijk
I completely agree with Clem that 5 and 6, from our discussions, if they were to stand alone, that still requires work to make it happen, but if they were to become C and D under 10, which says that we want to get to standards-based but we have some work to do. Those are two areas where we have work to do before it can really be operationalized.

Steven Eichner
Right, exactly.

Hans Buitendijk
We are in sync with Clem in that regard as well, but we want to make sure focus is put on that space.

Steven Eichner

Eliel?

Eliel Oliveira
Just picking up on Clem's comment, the thing that I had is nobody has tried, even with the data consent that we have today, just generic, high-level HIPAA authorization, some consent to be part of a research project, which is basically giving someone the authority to do something with your information, and now we are talking about a really granular-level standards definition when we have not even tested the use of the generic one. I continue to feel that this is not going to necessarily lead to a lot of solutions until we actually have a pilot that can do the distributed access of what someone's opinions are. Anyway, that is still my feeling. I do not see anything in this document that is basically saying here is a recommendation to HTI-1, that before we get into broad standardization of data sharing permissions from patients, let's at least try some distributed way to know someone's wishes, even with the broad consent. Then we can get into **[inaudible – crosstalk] [00:54:48]**.

Steven Eichner
Eliel, would you be comfortable if we added an extra bullet or an extra item that said a pilot approach needs to be included or there needs to be iterative work done for the successful testing and deployment of an approach?

Eliel Oliveira
I think a recommendation to strategic discussion on how these ecosystems can be tested and piloted would be a good place to start, and then all these numbers that we have been talking to basically follow onto that.

Steven Eichner
Hans, I saw your hand go up.

Hans Buitendijk
Sorry, I was double muted. In Comment B under 10, I think that might be a good spot to further enhance, if needed, the statements around Advance, the LEAP Project, and hub and spoke. I think that probably speaks to some of that. How do you now operationalize that in an infrastructure, not only the vocabulary, the terminology, and what is easy to use, but that the patient's consent statements can be accessible and consistently accessible across the different data holders that need to act on it or not act on it, so some clarification on B at the end might further highlight that it needs to be based on some practical piloting experience before we really can say yes, it works, and now we should scale it up.

Steven Eichner
Right, because there is another recommendation that will probably come into that pile about looking at the central store for patients to maintain their privacy standards. That is another element that is a little bit further down, which I actually think is coming up next, that is going to be another element to be incorporated, but I do think to test and establish, yes. An iterative approach to developing infrastructure might be better, so rather than doing a pilot, you do an iterative approach that implies a pilot and subsequent improvements.

Eliel Oliveira
I have some comments, but I know Anna has her hand up, so I will wait.

Anna McCollister
Thank you. One of my thoughts on this is that we suggest that they work with stakeholders and develop a mechanism and a preferred structure for granular consent, and part of my thinking is that in my consulting work, I helped a client develop a system for granular consent, and rather than it being focused on specific types of data, and this is based off of focus groups, meeting with patients, and the design process, but we focused it more on granular consent for specific data uses. In this case, it would be clinical consent, sharing for research, used for real-world evidence, or whatever the case may be, but I am not suggesting we develop that list right now during this meeting, but I do think it is something that is worth considering because, again, for clinical care, somebody might be very happy to have their very sensitive data bout a genetic test for ALS, HIV, or whatever shared with one physician to another, but they might be concerned about that being incorporated into an insurance company's database somehow, either directly or indirectly, and you can easily use tokenization to find out and identify patients. Anyway, that might be a different approach that would enable better use for clinical care, but give patients the ability to determine how they want that data to be used and/or restricted.

Steven Lane
Anna, with all due respect to these amazing ideas, if we do not get through these recommendations, we will have none, okay? We have 20 minutes until public comment, and we have not touched 5, 6, 7, 8, 9, 10, 11, or 12, so, literally, we will shoot ourselves in the foot if we cannot move on. Not literally, sorry.

Hans Buitendijk
But I think 5 and 6 moves into C and D, if that works.

Steven Lane
Sorry, you are right. We moved up 5 and 6, so they will be no more because they have been moved.

Steven Eichner
I think we might be able to make something about that in a general recommendation. Eliel, do you have anything to add quickly?

Eliel Oliveira
Yes, very quickly. I was just responding to what Hans said earlier in this line about advancing the LEAP Project hub and spoke, which is good. I do not even necessarily believe that that is the real solution, so I have concerns of debating that this is the pathway forward as opposed to… We need to understand and come up with a strategy for that patient-centered consent to…

Steven Eichner
Okay, that is the recommendation that comes on short issue. Hold your comment for just a second. Let's go to the next recommendation. I think we can just scroll down.

Steven Lane
Wait. Can I move 10 below the line?

Steven Eichner
Yes, I think so. Any objections?

Steven Lane
We will refine it in the Word document.

Steven Eichner
ONC, can you move it down a little bit? Okay. Looking at Recommendation 7, adding a requirement that when individuals have a right to request a restriction on certain issues and disclosures as their PHI as an inclusion under the portal or API that it be included or recorded in the HIT module and that relevant metadata about that restriction is passed on in association with the data. Any objections or comments?

Steven Lane
Very similar to what we were discussing yesterday, the idea that restrictions could move, but here, it is limited to the patient-requested restriction under HIPAA. Yes? No hands?

Steven Eichner
No hands? Accept it and move on. Looking at 8, add a requirement that HIT certification includes providing educational materials to patients regarding patient's option regarding disclosure and instructions on how to change their disclosure limitations. A friendly modification: It should be for patient-facing HIT.

Steven Lane
This is under 8?

Steven Eichner
Yes. There is no need to provide educational information to patients if patients are not using the HIT system, right?

Steven Lane
Sure.

Steven Eichner
Any comments? None?

Clem McDonald
There are some internal operational issues.

Steven Eichner
Sorry, Clem? Were you trying to say something? You are muted.

Clem McDonald
There are a lot of little connections in healthcare that require communication in some standard, and this is such a broad recommendation, I just worry that we ought to look at it more carefully. Does that mean that a laboratory instrument that is sending data to the laboratory system cannot do it? We have to be careful about not breaking the system of healthcare while we think these through.

Steven Lane
He is only talking here about patient-facing HIT modules.

Steven Eichner
Or are you looking at Recommendation 9, Clem?

Clem McDonald
It does not say "patient-facing."

Steven Lane
It says it now.

Clem McDonald
Oh, okay.

Steven Eichner
That was my friendly amendment, recognizing that there was no need to include patient educational information in a system that patients do not see. In a purely back-end system from a provider standpoint, there is no need to include functionality that nobody is going to ever use.

Steven Lane
Are you comfortable with 8 as it is being displayed, Clem?

Clem McDonald
These little proposals… It is such a complex world, and I worry that we do this without enough thought.

Steven Lane
We have the time they have given us.

Clem McDonald
Well, I do not have a specific suggestion.

Steven Eichner
Moving on, looking at 9, including regulations of disclosure limitations selected by the patient should apply to a wide range of exchange, not just HL7 CDA, but also FHIR V.2, NCPDP, and proprietary message types. So, it does not matter how it is being exchanged, it will be fine. Hans?

Clem McDonald
I have the same concern for 9. You have a hospital system that is built on feeding its medical record through a whole bunch of systems, but is this also going to be qualified by a patient-facing?

Steven Lane
No, this has to do with patient restrictions, and the point that I think Hans introduced here is that we need to make sure that those restrictions can be respected regardless of the transport standard that is used. Hans, your hand is up. This is yours.

Hans Buitendijk
Yes. One suggestion is to move 9 into 10 as E because it needs to be part of that approach. It might be stepwise or otherwise, but we have to be very conscious about the fact that data flows in all manners, and if we only "plug the hole" for one, then that does not mean that the other ones stop flowing as well, so we just need to be aware of an approach that is deployable effectively almost regardless of the method of exchange being used.

Steven Lane
If you feel it tucks under the larger recommendation, I think that makes sense.

Hans Buitendijk
I think so, because the approach needs to be neutral as to which standard or nonstandard is being used to exchange data. If it does not include that, it does not work.

Steven Eichner
Right, which is what I understood to be the point of 9 in the first place. Clem?

Clem McDonald
I do not have anything.

Steven Lane
So, 9 has now become E.

Steven Eichner
We have already addressed 10. Looking at 11, recommending that ONC studies the applicability of proposed but never enacted FHIR security label standards to enable proposed criterion. I guess that becomes F.

Clem McDonald
Well, my comment on that is that an awful lot of clinical data is **[inaudible] [01:07:39]**.

Steven Eichner
Clem, you muted yourself.

Clem McDonald
I am muted. So much clinical data is text, is narrative **[inaudible] [01:07:53]**.

Steven Eichner
Clem, you muted yourself again, unfortunately.

Clem McDonald
Sorry, I am muted. So much of the clinical data is text, is narrative, and I think it is going to be hard to do DS4P in the real world of what is in medical records.

Steven Lane
But that is not to say we should not try to use it in all the ways that it can be used.

Steven Eichner
Right, and 11 is specifically about studying the applicability, not requiring that we adopt it. Hans, I want to recognize you quickly.

Hans Buitendijk
The way that 10 is now organized, recognizing the main standards 1 through 4 and everything else below it, I believe 11 has been covered, so I almost would suggest to strike it because all of that would have to be addressed, except maybe the last part of how TEFCA could be used or otherwise to further enhance it, but that is not really part of 10 and does not seem to be as applicable at this point.

Steven Lane
Do we need it to stand on its own?

Hans Buitendijk
I am not sure. I am curious what others think, but if we look at security label IG, that is No. 4 under 10, and DS4P was listed as No. 1, and they all interact, they all need to work together, so that is why I am not convinced anymore that 11 is adding anything.

Steven Lane
I can see your point.

Steven Eichner
I can support that, pending on his comment.

Hans Buitendijk
And the last part of the sentence might be dropped into 12 together with TEFCA.

Steven Eichner
Hannah?

Hannah Galvin
I will just briefly comment to Clem's point that, again, in a maturity model, the security label IG does support natural language processing and labeling free text as well going forward, so it is not just labeling search for data, and we are short on time, so I will leave it at that.

Steven Eichner
Okay, so we will take the last sentence, which also includes FHIR, or looking at applicability to TEFCA **[inaudible] [01:10:25]** and move that into other language in 10, and removal of "incompletely."

Steven Lane
I am not tracking that comment closely enough to be able to pull the relevant items from 11 and 12 into 10. Hans, do you want to take a stab at that?

Hans Buitendijk
Sure, and what I would be looking at is that the second sentence of 11, which starts with "it also includes," should be merged with 12, and drop the first sentence of 11. That would be the restructuring that I would be looking at.

Steven Eichner
You mean move it into 12, right?

Hans Buitendijk
The first sentence of 11 is already taken over by 10. The second sentence of 11 goes into 12.

Steven Eichner
Okay, so we can address that as part of our 12 discussion right now, recommend ONC clarify technology support for extension flow-down information, and then include the second sentence from 11. Does that work?

Hans Buitendijk
Yes, I think that needs a little bit of doctoring there, but those thoughts can go together on the TEFCA.

Steven Eichner
All right, Hannah, a question or comment?

Hannah Galvin
Sorry, I forgot to lower my hand.

Steven Lane
So, 12 is moving below the line, but still needs some editing, correct?

Hans Buitendijk
Yes, and I would be happy to do that if you want me to, if I can sneak into that cell for a moment and copy.

Steven Lane
I will give it to you in just a moment here. I am just trying to keep up with myself. All right, I am out of there, Hans. We have now got 4, 10 with multiple components, 7, 8, and 12, and obviously, they will be renumbered. We have seven minutes, Ike, before public comment. Do you want to work on revisiting any of those?

Steven Eichner
I hope we are good with this row.

Steven Lane
This is the last row. While Hans is in here, do you want to go back up to the top?

Steven Eichner

Yes, that is what I was going to suggest.

Steven Lane
So, back to Row 2?

Steven Eichner
Yes. So, we have taken feedback from the Task Force workgroup and made some textual changes, looking at recommending that ONC define and implement transparency requirements for patient care characteristics and attributes used in DSI development and training. Any challenges to that, or are we good? No comments? I think we are good. Looking at recommending that ONC include as a certification criterion the successful production of warning messages to the user by DSI when there are certain criteria met, like when clinical data input is missing, data provided to the DSI is outside the range or value set expected by the DSI, or the use of the particular DSI is contraindicated by data from a particular patient's health record in the EHR. That is a combination of several earlier recommendations that we were able to condense into a single line. Clem, do you have any comments or questions? Any questions or concerns?

Looking at Recommendation 3, ONC collaborate with the FDA and stakeholders to develop certification in DSI approval or criterion requiring the participant physicians/patients in the identification of relevant data inputs and outputs the and from a DSI module and for inclusion in a particular DSI function, and that would be a coordinated effort because ONC has responsibility for the interoperability criterion and FDA has oversight of actually reviewing or approving a DSI's content capability. Any questions there?

Anna McCollister
The only clarification I would suggest is that ONC require a description of how physicians and patients were incorporated just so it is a real incorporation of input as opposed to somebody asking their mother and saying, "I got input from a patient."

Steven Lane
So, including public documentation of how this was accomplished?

Anna McCollister
Yes.

Steven Eichner
I think we can accommodate that. Yes, Clem? You are muted. So, are we good with 3?

Steven Lane
Good. Hans has been hard at work, I believe, down below, so let's pop back down there. Are you out of the field, Hans?

Hans Buitendijk
I put it in K, not yet in J.

Steven Lane
Okay. Well, I can move it from K to J, I just cannot move it from comments into here.

Hans Buitendijk
Okay. I copied it from the comments into…

Steven Lane
Good. So, this is the new 12, and there is the old 12. So, it reads "recommend that ONC clarify technology…"

Steven Eichner
ONC staff, can we get to the right screen? Can you scroll down a little bit?

Steven Lane
Row 7.

Hans Buitendijk
It is at the bottom.

Steven Lane
This should particularly address elements of the FHIR trust contract profile with labeling capability statements for real-time verification that applies when sender and receiver are bound under agreements such as the Health Exchange DURSA or the QHIN technical framework and consistently applied to any exchanges under TEFCA. That is pretty clear.

Steven Eichner
Does that meet everybody's needs? Clem?

Clem McDonald
I was on 4.

Steven Lane
Well, let's put 12 to bed before we cut to comments. We are about to go to public comments. Thank you, Hans, for that, and ONC, let's pull ourselves to public comments, and then come back to Clem.

Public Comment (01:18:00)

Michael Berry
Okay, we are going to open up our meeting for verbal public comment. If you are on Zoom and would like to make a comment, please use the hand raise function located on the Zoom toolbar at the bottom of your screen. If you are on the phone only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. Let's pause for a moment to see if any members of the public raise their hand. I am not seeing any hands at this point, so I can turn it back to our conversation.

Steven Lane
Clem, which row was your comment in?

Clem McDonald

Row 4, if you can pull it up again.

Steven Lane
Let's take ourselves back up to Row 4. Which recommendation?

Clem McDonald
That is not the same 4.

Hans Buitendijk
I think it is Row 2, Recommendation 4.

Steven Lane
Okay, Row 2, Recommendation 4.

Clem McDonald
Never mind. I think I have lost focus on it.

Steven Eichner
Okay, Recommendation 4 combines a number of earlier recommendations because there are multiple needs for consistent, consolidated DSI attribute information. It needs to be provided to HIT module developers so that they can incorporate it properly into the EHR module as well as subsequent sharing downstream. It is necessary to share with providers for understanding how to use DSI, it is necessary to share with patients outside the EHR environment so that they can understand what the DSI modules do, and it is necessary to develop a comprehensive listing of all DSI modules.

Steven Lane
I think that last sentence there, as a first phase, goes up at the beginning, I believe.

Steven Eichner
It could easily go either place.

Steven Lane
And then, I think all of the "this information is essential for" is kind of the rationale.

Steven Eichner
Well, the idea was two phases, recognizing that there is interest in short-term before-standard… There is not a current standard, so at least initially, having information shared is critical. We do not want to necessarily delay sharing, at least for DSI information, with HIT developers so that they can incorporate data or an interface to the DSI.

Steven Lane
How do you feel, Ike, about how it is crafted presently?

Steven Eichner
I think that is fine.

Steven Lane
Any concerns?

Clem McDonald
Under 4, Sub 1, it is not just the attribute information that has to be consistent or shared, it is the coding system too. So, in other words, if one is using ICD-11 and the content that you have is ICD-10, it is going to break.

Steven Lane
Isn't that part of the attribute information?

Clem McDonald
I think of the attributes as the fields, but I may be wrong.

Steven Lane
So, you are saying attribute information, including the relevant coding system?

Clem McDonald
Correct.

Steven Eichner
I would consider that a friendly amendment.

Steven Lane
Okay, got it. Anything else on 4, or are we good with that? Fil?

Fillipe Southerland
I had a comment on 3. I am wondering if "physicians" in there needs to be broadened to "clinicians."

Steven Lane
We always appreciate that friendly amendment. I think we are often focusing too much on physicians as a subset of clinicians.

Steven Eichner
And it probably should include researchers as well.

Clem McDonald
Can we also ask that they would test these? Because when we were developing rules for our medical record system, we thought we knew everything, we were smart clinicians, but when we actually exercised them, they made stupid mistakes.

Steven Eichner
Looking at the release of DSI under an FDA regulation, that is in FDA's scope, not ONC's.

Steven Lane
Also, I think the testing goes without saying here. We talked about the approval criteria; obviously, that would include testing.

Steven Eichner
So, are we good with 3? Are we good with 4?

Steven Lane
I am going to just pick those up and move them down so that everything else can fit in the screen for us to look at.

Steven Eichner
Right. I am hoping we can knock out the next three in the next two minutes. "Recommend that ONC collaborate with FDA to help format **[inaudible] [01:24:25]** nutrition label or medicine information label for consistent sharing of high-value attribute data with patients." It may not be the entirety of all attributes, but at least these critical pieces for patient information.

Anna McCollister
I think this is essential.

Steven Lane
Any dissention? Any comments? Hearing none, I think 5 goes green. Looking at 6, "collaborate with FDA to provide a feedback mechanism for clinicians and patients to provide feedback to DSI developers and maintainers regarding issues with the DSI so that they can incorporate that feedback and improve the utility of the DSI. Any feedback?

Anna McCollister
I think that is essential.

Clem McDonald
I would like to emphasize that DSI is often not great, and it is often a burden to the physicians because the circumstances do not exactly fit.

Steven Lane
Which I think is a lot of what is behind these recommendations, which is identifying that there are patients for whom these do not apply, and the need to address them. Why don't you go on, Ike?

Steven Eichner
Looking at 7, limiting the interface and incorporation of large language models of AI DSI into certified IT until such time as the developer can articulate the data sources and how outputs are produced and until models are better understood.

Fillipe Southerland
I worry somewhat that the word "limit" might be too strong here, just given the exponential evolution of large language models. I would just hate for these to be fully excluded.

Steven Lane
Maybe more of "assure that it includes this"?

Anna McCollister
It has a qualifier. It says "until the DSI developer can clearly articulate data sources and logic used to produce outputs."

Steven Eichner
Fil, I agree with you. My initial reaction was the same without that clarification. If it was an absolute ban or absolute limit, I would read that as a challenge. I think the clarification is sufficient.

Steven Lane
Let's see if we can do 8 in our last 90 seconds.

Steven Eichner
"Recommend that ONC clarify the distinction between 'enables' and 'interfaces.'" We have actually already spoken to this, and it is a recommendation to clarify the difference, if any. Any feedback?

Steven Lane
So, similar to what we went through yesterday, Ike, as our workgroup lead, will work with ONC to turn these into items on the word document or the text document, which we will then have a chance to review prior to our Friday meeting.

Steven Eichner
Thank you so much for your time and energy today, and we will forward information to you as soon as it becomes available. Steven, can you confirm? Are we going to try to send out a copy of the draft Word document?

Steven Lane
My aspiration is that we will complete the Word document after tomorrow's Group 3 meeting and get it out to Task Force members for Thursday review prior to our Friday meeting.

Anna McCollister
I want to say thank you to Ike and Steven for all the work you are putting into this. This is a lot of work, and I know you guys have day jobs, new babies, and things like that, so, thank you very much.

Fillipe Southerland
Hear, hear.

Steven Lane
All right, we will see you all tomorrow.

Fillipe Southerland
Thank you.

Adjourn (01:29:05)