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National Committee on Vital and Health Statistics

Subcommittee on

Standards

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P R O C E E D I N G S 1:00 P.M.

Agenda Item: NCVHS Standards Subcommittee Working Session

MS. KLOSS: Here is what we want to accomplish in the time and the brainpower we have left. We want to go back over our slide deck output because we've updated it with the discussion from this morning and the summary observations that Bill made verbally at the end of the meeting. So if we can go through that again then we'll already have accomplished bullet number one out to-do list which was review Roundtable findings. I think we won't have to belabor that part.

The second thing we want to get done is talk through what we should be all working on, what we need to get done by the September meeting.

DR. STEAD: Since it is a scoping doc, we actually – it's what we need to get done before September task one; what we plan to do in Q4 task two and we actually I think know our options for 2019. So we can do that once we go through the slides.

MS. KLOSS: I think that will be terrific. I think we're further ahead right now than I thought we might be but that's because we have this deck.

Near-term opportunities. Let's look at that. And I don't think anything changed there.

DR. STEAD: We did not make any changes. That seems to be standing the test of time.

MS. KLOSS: I just ask does everybody understand all of what's on that?

DR. STEAD: And one of the things that we will want to do before September – because in September these would be draft recommendations, what we would have draft recommendations or themes, I don't know that we're supposed to have draft -

MS. KLOSS: It's not on a work plan to have draft recommendations.

DR. STEAD: But we need to have specific examples of what some of these things would be. Again, another piece of advice from John so that when it is passed off to somebody they have a specific example of something that's ready to be done in that space so they don't have to – that was another piece of advice of his, and it seems to me it would be useful to maybe walk through those at the September meeting.

MS. HINES: Are we moving the work plan up to September because we were going to do the themes for the recommendations after the September meeting.

DR. STEAD: I thought we were supposed to have the themes, not the text, of the recommendations at the September meeting so that we could – because that will be

the last time we're together and we then – so we need to have the buy-in of the full committee, the nature of the recommendations so that we do the wording before -

MS. KLOSS: One of the thoughts I had here is to go through the table report outs and pull together all the principles that were suggested regarding adoption, all the principles that were suggested regarding maintenance and organize sort of that. So I would think we could get more specific.

MS. HINES: I was wanting to type those up and so we can figure out how to mine those.

MR. LANDEN: My comment was actually to be what you just raised – under the transparency, there were a couple of specifics that were discussed at my table so if we're going to be getting into that from the results, I don't need to ask the question. If we're not, I can go one level deeper, specifically under transparency. The table discussion that I moderated was more about making the ability to request additions to terminology and vocabularies very simplified for the end user and a couple of steps around that.

MS. KLOSS: What is going through my head right now is that when we get down into the weeds on these, we're probably going to find that we can lay out principles but actually getting to the underlying systems that for each of

these we probably have a roadmap – to standup that kind of ideal simplified transparent or point to a good example of isn't necessarily short term.

DR. STEAD: But to adopt principles in the short term, then those principles drive subsequent decisions.

MS. KLOSS: I think we can get to the principle stage.

MS. GOSS: My question or comment is around process as you started to outline what we wanted to do in preparing a summary of principles and to be able to generate more specifically a set of themes that we can then socialize in September, look to coordinate with you as to how this Standards subcommittee will or will not be engaged as we move forward, especially knowing that the Standards subcommittee will vet the draft recommendations on Thursday for the standard – the transaction predictability roadmap and then work over the next month to hone some of our thinking through ONC collaboration and detailed wordsmithing exercises. So that means we're pretty flat out but I want to make sure that we're thinking ahead for the next quarter in managing the two different workloads and whatever else we need to do to prepare for the 13th Report to Congress and subsequent work activities.

MS. KLOSS: Hold that thought because we -

MR. COUSSOULE: Excuse me, this is more of a question around the publish cadence line and reflecting explicit cost benefit. I think we need to make sure we're talking about what the cost benefit is of. Is it the development process, the implementation process, the whole scope? Would there be differences based on the outcome there? I think there's some work that has to be done to make sure that we're mean - we all believe it means the same thing and that we would communicate would mean the same thing.

DR. STEAD: At this juncture I think we've tried to begin to clarify that there's a difference between the cost benefit of adopting a named standard and the cost benefit of what is the purpose of updates, what makes you need to update it and based on that purpose, what is the cost benefit of a cadence decision?

So there are two different concepts here that emerged. And I think the question is can we enunciate them clearly as principles because I think – and it plays a little bit into your other question – what I at least am hoping is that this round of terminology work is predominately at the level of principles and therefore it is a – at the end of the day, the committee will make the decision about the principles.

We will not have a hearing about the principles. We've had the – the Roundtable that we just had was the convening that is resulting in the principles and as long as as a committee we can keep the scope of those principles to what we vetted and talked about, what emerged from and we vetted and talked about at this meeting then I think that's on solid process ground and that also keeps it up at a level it's not likely to be controversial. The minute we go below those principles in to how one implements them than that's going to require additional hearings and additional work which would be part of the path forward in 2019.

MS. GOSS: One clarifying question about that comment though is whether or not the guiding principles for selecting PM or I standards as found in appendix three, is that considered in scope in what you just said?

DR. STEAD: Updating that is considering that within the scope provided it reflects the – I think the thing we've got to be careful about because scope creep is easy, I think for what I've just said to be correct from a backup process point of view, we want to keep the scope within what we have, in fact, discussed openly in this hearing and learn through this hearing. So that each of us at the end of the day vote on approving it will be asking

ourselves, is this within the scope of what we vetted at this Roundtable. And if so, I think we're okay.

MS. GOSS: And I think that there is always the reality that as a full committee of considered experts, as we tease out what we heard in the Roundtable or a public collaboration, there may be honed thinking that emerges and I wouldn't want to preclude our ability to at least weigh those factors into the final product.

DR. STEAD: And hopefully we will surface that honed thinking through the discussion in the September meeting.

MR. LANDEN: If I could add on to the discussion about the cost benefit. I'd like to think that we're talking cost benefit not at the line item detailed level, like each and every item updated in a version but the cost of updating – doing the version update - because if you're going to be investing a million dollars in a version update, you want to add another code or two, no big deal. No need to do a cost benefit for each line item. On the other hand, there may be some individual items that are big costs but difference in the level that we need to figure out in our principles at what level are we addressing them and at what level are we not.

The other point I'd like to at least not lose track of is there's a cost benefit for doing something but

there's a counterbalancing cost of not doing something. And I think from our position at NCVHS we need to consider the cost of not migrating to a new version.

MS. KLOSS: I think we have models for that because, if you'll recall, the RAND analysis that was done to support the decision to move to ICD-10 was both – included cost of doing it and cost of not doing it.

So we're okay with this slide. Let's move to the next and then we're going to continue to talk about process. So, in the near term, this is brand new. Again, we've placed it after the general near term and this is near term specifically to ICD-11. Again the thought that came out of Bob and Donna's presentation was that we can begin in the near term to review the process, to hold hearings, make recommendations on ICD-11, scope the project so that we're evaluating the fitness of ICD-11 MMS for US adoption for morbidity, mortality and interventions, and purpose and ROI potential of those US modification. In other words, apply the analysis.

DR. STEAD: We need to add an "of" between ROI and potential – and then this business of capturing the principle of computational engineered relationships between reference terminology and how that differs from that is an important concept and figure to get down probably as part

of the summary report if we can. That would be a nice place to -

MS. KLOSS: Bill, can you repeat that bullet, Purpose of ROI potential.

DR. STEAD: First, capture the principle of computational engineered relationships.

MR. LANDEN: Question on that previous one? Is that second bullet – I'm a little confused about what it's asking. Is that really asking the question should there or should there not be a US modification?

DR. STEAD: Based on the fitness of ICD-11 MMS, for those three different purposes. Then we need to evaluate the purpose in ROI of potential modifications and then we would be in a position to make a recommendation that we have some modifications or that we not.

MS. KLOSS: I think we may need to modify the first bullet because MMS doesn't really apply to interventions.

DR. STEAD: Then we need to evaluate the purpose in ROI of potential US modifications and then we would be in a position to make a recommendation that we have something about modifications or that we not.

SPEAKER: I think we might need to modify the first bullet because MMS doesn't really apply to interventions.

DR. STEAD: It doesn't? What gets ICHI into that equation. I thought ICHI was part of MMS. Is it? It's separate? So does it then need fitness of ICD MMS and ICHI? What's the right term – what would make that bullet make sense?

MS. PICKETT: Again, it depends on the scope. ICHI is not a vetted procedure interventions coding system as yet. It is still being developed so the first roll out for what WHO purposes are is ICD-11 so it may be good to separate them but to keep interventions on your radar screen but ICHI is still under development. And interventions are not included in ICD-11 MMS.

DR. STEAD: So we should delete comma interventions off of that bullet and then come back to ICHI downstream?

MS. PICKETT: You could, yes. If you want to take on what is currently known and available to be evaluated, yes, because ICHI would be a future step.

MS. KLOSS: So let's make it a separate bullet so it doesn't get lost.

MS. HINES: So right now it says fitness of ICD-11 MMS for US adoption for mortality and morbidity.

DR. STEAD: Good. If we're going to make it another bullet, let's make it a bullet at the level of Scope Me project two and in the future evaluate ICHI.

DR. MAYS: I am just trying to understand. I thought that one of the things that you were suggesting – and maybe it's I didn't get in the right places – that we go back and look at several of our letters and recommendations. It wasn't just the process about the hearings. But I have a sense there were other things you wanted us to draw in to use in the next process. Is that correct?

MS. PICKETT: That is correct. Part of my thinking was this. It struck me in looking at the slides yesterday and today that some of these things we've talked about previously, some of this is not new under the sun. And we need to learn from what we've done before, or to reevaluate what we did before because maybe there are things that from lessons learned we could do better. But not to lose sight of the fact that there were some guiding principles early on when we were looking at migrating from 9 CM to 10 PCS and CM so it's not like you're starting over. You're actually building from earlier work, earlier discussions, earlier evaluations.

Case in point, the second bullet under scoping a project to evaluate. I look at that second bullet point and return on potential and one of the issues that came up during the evaluation of implementing 10 CM and PCS was return on investment and what was the value added by moving

to these new code sets. And while I think we were all quite great at finding out what the costs were, I think it was much more difficult to determine exactly what the benefits were and how you apply a dollar valuation to those benefits. And so that became the crux of a lot of other discussions, which is well noted in some of the prior materials when these discussions were occurring and I know that there are some people in the room, and Rich, you might be one of them, that was part of that discussion when representing your entity. What did a return on investment mean?

And not everybody basically always had the same perspective of what that meant and that it you said better data, what does better data mean? And it turned out in many instances data meant different things to different entities in terms of what they thought the benefit would be to them. So it's like let's build from what we did because we don't want to start over if you don't have to. If you have to fine tune some principles, great. If you need to come up with new ones based on what has happened over the last 20 years, that's great too but let's not just forget that we've kind of gone down this path and there are a lot of lessons to be learned that I think can be applied.

MS. KLOSS: I think that is what we meant by bullet one.

DR. MAYS: To me the process I thought was what you did. So I think if we make sure we're including the letters and things like that.

MS. KLOSS: We just need to add review the process and outputs or -

DR. CORNELIUS: I want to expand on that though because one of the energies that was coming out later this morning is around positioning of people and where they were in their organizations as it related to this. And while we unearthed some of those energies, you can't just look at paper because they are people who are going to be part of this and somehow there needs to be an acknowledgment that moving forward, whether it's a modification with ICD-11, we have to acknowledge that there's spaces out there and that there are going to be conversations and people in help positions. So it's not just about reviewing everything on the website – which I think is great and it's important – somehow that's going to unfold into something that involves positioning of people's value sets. Do we at least acknowledge that's an issue, then we have the private sector handle that or what have you?

MS. KLOSS: I would imagine that if we push out this project – this is kind of reflecting let's understand our past so we aren't naively going forward and scoping a project. But I would imagine that really moving forward in

2019 is going to call for hearings. It's going to call for other activities that are kind of going to get some of those stakeholders back to the table to provide input. So I think this is the let's get our ducks in a row and understand and scope this a little better and use it to inform us how to go forward.

MR. LANDEN: And building on these comments and Dan Rode's public comment earlier about looking back over our shoulders to identify some of the protagonists, the antagonists and then make sure we include those groups in our process so they can work with us earlier on and we can use them to help us find solutions rather than oppose recommendations.

MS. KLOSS: Any other comments on this slide? Then on the halfway forward, we added a gap closure process. Well, first of all, we changed the wording under expand scope.

DR. STEAD: We pulled expand scope here instead of in long term because it's part of the journey and we added gap closure process comments.

MS. GOSS: I thought we agreed when we said mental health we were going to add in substance abuse.

DR. STEAD: Exactly.

DR. MAY: I was asked about coming up with something and I can tell you what I came up with and also

give you an example if that helps so that if it needs to be corrected you can get a sense of where I was headed. And Dave and I had a discussion about this. We just didn't get to finish it. So after the words clinical administrative domains I had bridge research to align with clinical administrative domains.

Here's the example that I'm trying to solve. At the National Institute of Health they have kind of rejected for research purposes the use of the DSM. They came out with their own which is called RDoC and they feel like RDoC is an example of what we should be doing. And they will tell you RDoC is not to come up with a clinical outcome even though it looks at clinical issues. So eventually what happens with RDoC research is it becomes very related to what happens in patient care, what happens in terms of clinical treatments, accepting or rejecting them based on that information.

But if you do into the National Library of Medicine, it's very hard to connect these things up. So I might have RDoC working on psychotic disorders and then when you have kind of a standard thing – it's going to be about schizophrenia, it's going to be all the traditional things so they don't get aligned. But yet when a patient or a clinician is looking for the most recent information what happens in terms of the brain and drugs and all that,

then that all aligned. So that's the example of what I'm trying to fix and there are other instances. There is something I could say in terms of HRQ but researchers will come out and say this is not adequate enough for me to do the research and they pull themselves out of the traditional clinical use of a title or term and then they never get connected back up.

MS. KLOSS: Say that once more – bridge research -

DR. MAY: Yes, bridge research to align with clinical and administrative domains. So what it means is that you find a way – you don't tell the researcher they have to line up and be exactly the same. It's like what somebody said today, we don't need to keep starting new things. Let them be. Let them do what they do but find a way that their terminology has to bridge so that clinicians and patients can get that information. It's all lined up.

MS. KLOSS: Would it be - named clinical and administrative standards? That seems restrictive.

DR. MAY: I am.

DR. STEAD: Let me ask another question. Are we actually talking about including the research terminologies in the scope? I'm wondering whether that becomes a fourth bullet under expand scope of named T/V standards to include or if that's inappropriate for named standards, do we want to incorporate them UMLS?

DR. MAY: The only thing that makes me nervous is the name T/V standards. This is kind of what Linda's asking, is that then it has the fit in a box that it's not fitting in and so then somebody has to adjust to link to somebody else and then nobody does it.

MS. KLOSS: I don't know how you bridge it.

DR. MAY: That's what I'm saying. I can tell you the problem. I just said to add the bullet bridge research to align with clinical and administrative domains so it says that when you're doing these clinical administrative domains, you should check, is research in some way being able to be brought back into that to inform it?

DR. STEAD: Are you saying bridge research terminologies to –

DR. MAY: Yes, it's the terminologies. So maybe we're getting closer.

MS. HINES: But keep domains of the clinical administrative domains?

DR. MAY: Yes, because that's the focus and I'm saying I want the -

DR. STEAD: Let me ask one other question. Can it be a last, either a next to the last or last bullet so that we're in essence saying that the current last bullet is a research bullet about the techniques, if you will, of terminology representation maintenance derivation and the

other side of that that I heard in your comments this morning was the research terminologies themselves. So is it better to put it up under bridge clinical administrative domains with bridge research. Bite the bullet is bridge research terminologies with clinical administrative domains. The question is does it go as a second bullet or does it go as either a last bullet or a next to the last bullet? In terms of a logical flow that helps people see how they relate to each other.

DR. MAY: I think what I am trying to not let happen is that it becomes in – as we say name T/V models. So I'm trying to make sure that it's clear that the problem is there is some unique terminologies and vocabularies here and so when it says named it isn't like I can go to the standard. So that's why I say I don't think it's the bottom unless we change the bottom.

DR. STEAD: The bottom does not have anything to do with name. The bottom has to do with research into T/V models by medical and -

DR. MAY: I know, but I think if you conceptually go through -

DR. STEAD: The named is actually up above.

DR. MAY: Right, I think if you conceptually go through it's going to be assumed that at the bottom that that's named. If you don't know this problem well enough,

it would get lost and you would assume that named is to be there.

MS. KLOSS: So then that would suggest putting it second?

DR. STEAD: Before you get into named, okay, that's fine. I've got a game plan.

MS. KLOSS: So the new gap closure process – does that look okay, integrate new concepts into existing terminologies if practical, importance of a community of practice to define scope of content area and perspectives to include and curation as a continuous process. Promotion of a concept of named status as evaluation shows it is ready for the purpose.

DR. CORNELIUS: Could you clarify the phrase community of practice? The reason why I ask is that one of the comments that was in the comment period was our ability to have a more widespread reach into the community. How does that comment relate to that bullet?

MS. KLOSS: It is different. But the community of practice came up in terms of the right subject matter experts being -

MS. ROY: Are you meaning the subject matter experts or -

DR. CORNELIUS: It's okay. And that comes to the other point that there was a point raised about our reach.

The space that we are in and what we're doing needs to be expanded, that one of the gaps is other parties that are not with us –

MS. ROY: That are currently involved in the processes and things like that.

DR. CORNELIUS: And the reference was in the community.

MS. KLOSS: And this means community of practice in the sense of bringing together subject matter experts.

MS. AULD: The community of practice – the way that it's used with SNO-MED that is their user community. The meetings of SNO-MED International are meetings of their community of practice and some of the other terminologies are starting to adopt similar language so it essentially means -

MS. KLOSS: Do they have a definition for what that means?

MS. AULD: I don't know that they have an express recommendation. We can look for that but that's how they tend to use it.

MS. KLOSS: There is a concept of community of practice that is defined as -

MS. ROY: Like LOINC has specific user groups. They have like nursing – and so they have particular expert communities that they work with within a particular domain.

MS. KLOSS: That is what we meant here.

MS. ROY: That is what I was trying to get at. Is that what – or do you want more?

DR. CORNELIUS: I think that is great, including the clarity, there still seems to me to be another thing to deal with the community outside. Like one example was a discussion from the American Psychiatric Association. I kept thinking persons with disabilities and conditions that are related to the intellectual space. Now if you have consumers who are in that space living that, their conversations about conditions and all that is different because they don't want to deal with the labeling, they want to deal with the life experience. We don't have those – we haven't had those conversations in the last two days yet that would be the representation of someone from a consumer community that's affected by the space where we name all these conditions and so on and so forth. That's what I mean.

MS. KLOSS: Coordination and governance. Here we moved the overlap and redundant effort to this slide.

DR. CORNELIUS: Did you do anything with my comment?

MS. KLOSS: No. Here's what I was thinking. I wasn't just dissing your comment. I thought we had that later on so I was moving forward.

DR. CORNELIUS: We'll talk another day.

DR. STEAD: What I am hearing in that other set of comments is how we incorporate what is now community engagement into these concepts which is where I'm tagging it. I haven't yet seen where that goes into the – the idea that the communities of practice need to include community engagement and intentional looking at D&I.

MS. KLOSS: I was fast forwarding to this last bullet here. It seems to me that that kind of broadening our view of stakeholder -

DR. CORNELIUS: There's a difference between us translating and a community translating. And I hear what you're saying about community engagement. Part of this is do you make that a parking lot issue for us to come back and just do some thinking and come back to this or not? I don't want to spend an hour on it.

MS. KLOSS: Well, let's add it to this slide. I think this is the right place for it.

DR. MAY: - translating?

MS. KLOSS: No, let's make it separate. Translating is John White's point. I think the policymakers understand why this is important and your point is engagement of those who are true stakeholders.

DR. MAY: Can we say something like engagement – you have translate why this is important to every American – and it's either engagement or process to allow the voices

of every American or something. I don't want to say community engagement, per se, because I think that really gets into a very narrow – but instead we should be trying to think of a process by which every American can be engaged. And when we do that what that means is that we have to use different kinds of media. It isn't just to say the PRM is out and somebody comments but it's social media for certain age groups, it's making sure that those with limited abilities can engage which the federal government is responsible for doing. So it reminds us that we need to be multimedia to allow everyone, and in allowing everyone, it means pushing it out so that they know.

MS. KLOSS: I guess I have a little problem with describing it as every American. I think purposeful engagement and input from those -

DR. MAY: You were saying not every person, but instead there can be representation that speak on behalf of those groups. So if it's said something like that, but it means that we have to really think about how to – that we need to come up with a plan to do that.

MS. KLOSS: Process to engage actual stakeholders, those who are directly affected, purposeful engagement. We'll kind of leave it like that now and we can refine it going forward.

DR. MAY: I am like you. I'll come back.

MS. AULD: I was going to say, looking at this from a slightly different perspective, when we start looking at SNOMED and LOINC, we put in place a project to have the two groups coordinate and find a way to work together. They produce a deliverable that is supposed to link the two together but we're finding that very few people use this and they are coming out and saying you can't use the two together. So I think part of the question is how do you – you can get the two groups working together and coordinating but how do you get them to ensure that all of the appropriate people are at the table and part of the solution, rather than – it's hard to describe it. We're having a hard time even getting people to come to the table and explain to us why the deliverable doesn't work them. They will just say it doesn't work.

DR. CORNELIUS: Part of that is the difference between us requiring and people wanting. They're doing it but they are doing it under duress. It's not the same as they are excited and they want to work out those differences.

MS. AULD: How do you get them to acknowledge that and move to the constructive piece of that.

DR. CORNELIUS: Stakeholders, guardian angel -

DR. MAY: Incentives. If you will participate, you'll get X, or you get early, or you get extra months of – I don't know, but incentives.

DR. CORNELIUS: Sometimes it's posing the question what would you find valuable to yourself in participating in this, and then you flip it around to help them meet that value.

SPEAKER: I haven't heard the word outreach and that's what I hear we're talking about. And then the plan down in the weeds on sustaining. Once you outreach and people want to participate then a plan to keep that going and coordinating I think -

MS. KLOSS: So Rebecca has process to engage actual stakeholders, those who are directly affected through purposeful engagement and outreach – through purposeful outreach and engagement.

Okay, longer term. We rearranged the third bullet. So we've made the header be calculate from clinical content. So read the second bullet – use clinically useful terminologies and then calculate from that clinical content payment class, decision support, quality and population health measures. So I think we got -

MS. HINES: Vickie, did you see that? Quality and population health measures.

DR. MAY: Okay, so have we got good draft output?

DR. CORNELIUS: So I'm going to be a troublemaker. Somehow yesterday there was a discussion about how some of these things are being linked up to payment and how we needed to figure out how not to get caught in that cycle. And so when I see payment classes I'm thinking about discussions about claim versus value-based care and asking myself, is that phrase where we are in the field, is that where we're going? I don't know, I just have to not assume.

DR. STEAD: What we are trying to say is that we want to use clinically useful terminologies in the EHRs. Then we need ways to, in essence, derive from that clinically meaningful record, the information we need for other purposes. And in essence, the utility for those other purposes actually needs to be an evaluation criteria, but it has to sit on the base and it's got to make sense to the clinician and the patient. And any way to clarify that would be helpful. That's what we're sort of talking about.

MR. COUSSOULE: I think the term payment classes is an interesting one. I think we're in the same place. We've just got to figure out the phrasing then.

MS. KLOSS: Well, we didn't want to just what the payment is but all of the other payment things, like groupers.

MR. COUSSOULE: There are so many different models in play as well. Just trying to make sure we're clear about this without either restricting -

DR. STEAD: So if we calculate – we'd like to be able to calculate severity of illness which might be something you want to do a payment on or not, the intensity of the intervention which might be something you want – so whatever the -

MR. COUSSOULE: I think the idea, if I can just take a step back, but I think the idea is to not require a separate activity beyond the clinical activities for payment to flow. I think that's really the idea. It's not requiring a different set of activities other than the provision of care and the documentation of that provision of care.

DR. STEAD: Do we want to add that as a bullet?

DR. COUSSOULE: I'm just trying to think of a way to frame that. Because I think we're all talking about the same thing. I'm just trying to get a way to frame that.

DR. STEAD: So we've got a couple so we could actually add a final bullet, whatever he just said.

MS. HINES: What I have is not require separate activities other than the data entered for provision of care.

MS. KLOSS: We used to call that capture once, use many.

MR. COUSSOULE: That is the idea. The idea is if I'm providing a clinical service that that in itself, by doing that and documenting that in the record should then flow through to a payment somewhere or a recognition of work for a payment, not always directly translated into a payment. Like I said, we'll have to think through the wording pretty carefully.

MS. KLOSS: So if we are good then we've got a first draft. We have agreement that we have a first draft. So, now let's talk about what's next. Here's what I'm thinking for September. We have environmental scan. We have a Roundtable meeting summary. And we have themes for draft principles that we've extracted from the discussion that then would tee-up a discussion of recommendations.

So some document that is principle based, includes key themes and maybe even if we get lucky in August, teases out some recommendations that seem fairly obvious based on what we've learned. And I think that's – I think we can do that. Does that make sense? Does that satisfy your veracious appetite for work? Balance with August vacations. So I think that would be a meaty discussion.

I'm a little fuzzier about what happens after. I think our goal still is to have – then to get enough input to proceed in quarter four with actually drafting a letter of recommendations. But I think we've teed some other things up that – and we've got to revise the project scoping document and probably the act of doing that will clarify how some of these short-term projects might drop in.

DR. STEAD: Because I think what we would want to do in Q4 as you said is to – the Roundtable summary, executive summary would be ready to transmit. We would have themes as a principle that we would get input from the full committee and get their help with and that would set us up to generate probably recommendations that – and probably also principles. So I'm sensing Q4 we would have one to three short lists of principles. We'd have an updated one on criteria, something which maybe our adoption stuff gets built into that. And then we have one on updating, maybe -

MS. HINES: Can you say those again, the three?

MS. KLOSS: Maybe it's related to the topics we've -

DR. STEAD: Right now more the current appendix three into an updated adoption criteria and then we might have a new adoption principle. So we might have a new set

of principles which we've got some first bullets on around updating. Curation. Then it seems to me the other thing we would like to do in that is the review of our history and scope of the ICD-11 project as a candidate for calendar 2019 that we scope in Q4 and we need to also work with NLM around the possibility of a Pop Health project around expansion of UMLS to include social and behavioral determinants, which would be a start in the scope work. So those two things could be parallel efforts in 2019 if we had -

MS. KLOSS: That makes good sense. So really we're tackling at principle level or at the review level, the first two slides, near term principles for curation and adoption and the historical review to frame up the 11.

DR. STEAD: The summary could include the long-term opportunities and it could include the path to convert the meeting summary because we don't need to turn those into recommendations, but we want to communicate them as part of the vision. We good?

MS. KLOSS: We're good.

DR. STEAD: Have we done what we need to do? Do we ask for public comment?

Agenda Item: Public comment

MS. HINES: We do. So if you could move us to the public comment part here I'll move this to the public

console outside. So one last time, if you'd like to submit a public comment to NCVHSmail@CDC.gov or on the WebEx. We do not have any comments on the WebEx. Anybody in the room? So with that, I do believe we are a wrap. Thank you, everybody.

DR. STEAD: Everybody, thank you.

(Whereupon, the subcommittee adjourned at 2:00 p.m.)