Conditions and Maintenance of Certification Requirements Task Force

Transcript
March 11, 2019
Virtual Meeting

Members/Speakers

Name	Organization	Role
Denise Webb	Individual	Chair
Raj Ratwani	MedStar Health	Chair
Carolyn Petersen	Individual	Member
Ken Kawamoto	University of Utah Health	Member
Sasha TerMaat	Epic	Member
Leslie Lenert	Medical University of South Carolina	Member
John Travis	Cerner	SME
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Cassandra Hadley	Office of the National Coordinator	HITAC Back Up/Support
Mike Lipinski	Office of the National Coordinator	Staff Lead
Kate Tipping	Office of the National Coordinator	Staff Lead
Christopher Monk	Office of the National Coordinator	SME

Operator
All lines are now bridged.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Good morning everyone. Welcome to the conditions and maintenance of certification requirements task force. We will start off today's meeting with a brief roll call. Denise Webb?

Denise Webb - Individual - Chair
Present

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Raj Ratwani?

Raj Ratwani - MedStar Health - Chair
Here.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Carolyn Peterson?

Carolyn Peterson - Individual - Member
I'm here.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Ken Kawamoto, I believe is still on vacation. Sasha Termaat? Les Leonard? And John Travis?

John Travis - Cerner - SME
Here.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Okay. Maybe others will join us here a little bit late but why don't we get started just for a quick review of the charge. I will hand it over to you, Kate.

Kate Tipping - Office of the National Coordinator - Staff Lead
So, an overview of the charge for the conditions of the certification task force is to provide recommendations on the API real-world testing and attestations conditions of maintenance of certification requirements. Any updates to the 2015 edition health IT certification criteria, modifications to the ONC health IT certification program and deregulatory actions related to certification criteria and program requirements.

Denise Webb - Individual - Chair
Thanks, Kate. And then today we're going to talk about, we deferred the discussion on the four options that ONC wanted us to contemplate concerning the fire release version for the API for stations and populations requirements. And for the consent management requirement, I believe. No, just for the API that's around the patients and population requirements. So, we were going to discuss that and

then we are going to talk about the modifications to the certification program particularly around some corrections and principles of proper conduct for the accrediting bodies. So, let's -- I think you have a couple of slides, Kate. Want to pull up the slides related to the API criteria? So, this relates to adopting the new API criteria that would become part of the 2015 edition based DHR definition and it supports the two types of API enabled services. So, this is for single patient data and services for multiple patient's data. And on pages 211 through 214, there is a discussion in the preamble on four options. The actual regulation text proposes option one which is to adopt fire release two for the proposed regulation. And we did have some discussion in this and there were some emails. I don't know, John, if you are comfortable to give us a summary, or if any of the ONC folks would, of the differences between the options and some of the nuances of selecting one over the other.

John Travis - Cerner - SME

Yes. And I saw Sasha joined and she might be able to speak as well. I think the main thing I would say is the R4 version offers a lot for a good industry starting point going forward and I know there was some exchange we had over the -- after our session last week on what – well, actually, I guess leading up to it on what normative meant to the industry. And, you know, conceptually that really speaks to it being a valid and accepted standard. So, it's really fairly literally descriptive of the standards process. And then there are summary sources within it that have also reached normative status. But it's better positioned for some of the use cases that are important to the rulemaking from what I heard from our API services team. I'm speaking of R4, should have prefaced that. For bulk data, well, bulk use cases would be the best way to say it. And also, it would be a good normalized basis for vendors to be on the same standard because we saw it in several places in the proposed rule proposals. But different versions for different purposes and although not all of them are required, by this I mean, the data segmentation for privacy criteria in G 11 was R3. We felt like being on a common basis and not having different versions in use across different criteria and different use cases would be very helpful to vendor development. So, those are some of the higher-level thoughts that I looked at and I'm going to look at the other information that I have to see if there is anything further to highlight but I think that was the gist of the feedback. And If Sasha is on, she could elaborate further.

Denise Webb - Individual - Chair

And just to refresh everyone that's on the phone. Option two was adopting fire release two and three. Option three was to adopt fire release two and four, and obviously, option 4 is to just stick with four. So, Sasha, are you online?

Sasha TerMaat - Epic - Member

I am. Hello. Yes. Sorry, I was a couple of minutes late. I agree -- I think John gave a great summary. I mean, I think like John said, our recommendation would be to adopt R4 that's what we are hearing from the industry, it has the support of, for example, the focus of the Argonauts group at the moment. There are enough technical differences between the **[inaudible] [00:06:39]** which has the current, I think, most widespread adoption and R4 that it makes sense to kind of focus future facing development on R4 and not split effort between ongoing work on two or three and four which are a bit different in the technical details. So, I think the sort of feeling is that to position ourselves going forward, R4 will be the most effective and the best area to focus.

Denise Webb - Individual - Chair
So, I'm just curious for anybody that can answer this. As I was reading about the data segmentation and how samsara has built that off of – with their app back off of fire release three. Does it, if we recommended going to four, with that also -- would four address the needs for data segmentation as well. What about that? Would there be an issue?

John Travis - Cerner - SME
Well, I guess I will offer a couple of perspectives. First, it is my understanding is that the consent to share is less standard than it is a reference implementation and a, how shall I say it, a guiding document for that particular approach. So, it is a fairly specific use of the API standards and specifications and for the consent resource. I couldn't comment well enough as to whether or not there is disruption cause or loss of capability by going to R4 as a basis for that. They just didn't work with it in terms of the consent to share efforts. But also observed that is not a required criterion in terms of it being part of the base E HR linked to the definition of certified E HR technology. It's not the downplay but it is still a discretionary item. So, a little bit of proper – give it its proper regard on that basis is probably not the reason to make the broad decision.

Denise Webb - Individual - Chair
Yeah, that is a good point. I think, you know, surely the community would have time to start working with release four, you know, at some point.

John Travis - Cerner - SME
You know, I think the other observation made, I know our folks highlighted it, is the DSTU is several years old now and in a lot of places regressed tasks yet. And part of the normal life meaning for R4 from my team, they share with me that the data type, data typing is normative and there just is a lot better opportunity for a go forward position for interoperability for API-based services and use cases using R4.

Denise Webb - Individual - Chair
So, what about option three that suggests adopting both two and four? You know when you said a number of entities, vendors have adopted fire release two into their products. What do you all think about that? And what would be the biggest downside of doing two and four besides having to maintain code to support both?

Sasha TerMaat - Epic - Member
I think, Denise, the downside is maintaining code to support both including one standard that has fewer capabilities and is several years old. What is the advantage of supporting two and four instead of just four?

John Travis - Cerner - SME
Well, and the other thing to consider is that while that statement is true, that I know a pretty significant of majorities of vendors adopted aspects of the DSTU to support the consumer use cases that were part of the 2015 edition when it came out several years ago, not all did. We are dealing with provided use cases as well which may have been fairly open to other development and there will be

gap development for all vendors to invest in to deal with the new requirements of the US EDI that were not part of this common clinical data set in terms of outright new development. And I think again, vendors prefer to be on a more progressive basis of a standard that is still considered in a largely normative status for a lot of key elements of it going forth. And so…

Denise Webb - Individual - Chair
Well, can anyone speak to the specific impact – I mean, obviously, I most recently came from an organization that had a homegrown system and also had a commercial system in the hospitals. But can anyone speak to the particular impact of one over the other of these for the provider organizations on the implementation side? And the production/operational side? Are there any nuances to be aware of?

Sasha TerMaat - Epic - Member
Denise, when I talk to folks, I don't think there would be a sort of implementation difference between the two standards. I suppose to some extent there might be some amount of additional complexity if two standards are supported just like the development would be more complex if two standards are supported. But I don't think that providers will find it particularly harder or easier to rollout two versus four. Four might enable more capabilities, right? So, from the perspective that both patients or provider users might be able to have more sophisticated applications that take advantage of the resources, four would offer that advantage.

Denise Webb - Individual - Chair
Raj, do you have any particulars perspective? Or Carolyn?

Carolyn Peterson - Individual - Member
I guess I'm just sitting here trying to rack my brain for who would really be affected, you know thinking in terms of large groups. What sorts of folks would be affected if we drop two or recommend that two is dropped? And individuals, companies whatever, have to make that sudden jump to four. Who are we leaving behind if we get rid of two?

Sasha TerMaat - Epic - Member
Carolyn, I don't think it's fair to characterize it as a sudden jump. Because the nature of this proposal is to say that 24 months from the publication of the final rule, we would have transitioned from whatever API standards are in use today to the new standards. It seems to give plenty of lead time for anyone who would be programming in this space to be adopting the first normative version of the standard.

Carolyn Peterson - Individual - Member
Okay. Well, even if it is not a sudden jump, maybe that's not a good term. But still, the question I have is who is actually affected? You know, what kinds of people are we talking about? Are we talking about large vendors? Or smaller firms that have developed apps for their particular user set? Or what, who is really affected if we advocate dropping two?

Denise Webb - Individual - Chair

Well, it's interesting because I'm on the time policy steering committee and I know Liz Johnson and a number of the CIOs seem to be concerned about -- and I shouldn't say a number – there was a number that was pushing to go to release four especially the CIO from Rush, Doctor Rob. Of course, he's on the cutting edge of things. But I think they were having some of those reservations to understand who's going to be left behind if we went with four. So, I know they were having the same discussion. I personally think that we shouldn't stymie the industry and we would be disadvantaging ourselves as provider organizations, you know, that I have been a part of if we didn't encourage or allow the vendors to be able to develop to the more current standard.

Carolyn Peterson - Individual - Member

I don't think that you would want to block them from going up to four if they wanted to. I think my concern is more situations, organizations that function on a fairly limited scale, where they have something developed that's working well for their particular users. It is not necessarily creating a problem for them in that having that upgraded to four or rebuild up to four -- what does it mean for them if only four is adopted? That's all. I mean, obviously, for major vendors, the push is always going to be to innovate and try to enhance and do things that allow you to do more. But sometimes small subsets of the very large population have particular uses where they don't have a problem and they're not looking to innovate anything more. They are just happy using what they have. And I'm just trying to get a sense of what the impact would be for those folks, that's all.

Raj Ratwani - MedStar Health - Chair

Yes, this is Raj, I have a similar question. I think that if you ignore the issue of resources, there's no doubt that release four would be the obvious way to go. But I think, thinking about potentially small to midsize developers that may have several things on their plate coming out of this rule, I am not sure how many resources would be required for them to move from release one to two or two to four. So, if anybody has insight on that, jump. And Sasha, to your point, I get there's a long runway here which is great, but I want to make sure we are taking that into consideration with everything else that may have to do that comes in this rule.

Sasha TerMaat - Epic - Member

Well, I do think that it's clear that if the goal is to conserve resources, we shouldn't advance the standard. Right? If people have already made investments in STU2 that has the most current widespread adoption both on the part of the HR developers, the implementors, health systems that have already posted their resources and their endpoint. And on the part of those who are currently building apps on top of those platforms. And if the goal is to sort of not invest more resources, then that would be the best path. But I think the consensus I'm hearing from the industry -- and this is not limited to any one party -- but it is that there is interest in taking advantage of pushing the standard further. That is why folks have started to adopt DSTU three in some cases and that's why folks are participating in standards groups that have created R4 and are pushing for R4 to be the adopted standard here. Adopting R4 is definitely more work for all parties. It is more work for – well, I don't know if it's more work for providers, actually. But it's more work for E HR developers to support and then if apps want to take advantage of the futures that are offered in R4 they have to do work on their end too. But I think that you know, in the sense of do we want to, not just now, but three years from

now when this standard takes effect, still be using DSTU 2 when better and more advanced standards have already been advanced by the industry? That seems kind of backward from my perspective.

Denise Webb - Individual - Chair
Well, I think the important point on this is that it is the point that Raj makes about health IT developers that are smaller companies with fewer resources that want to compete in this market, and they might be lagging – and that does get addressed on page 212 under the discussion of option three. You know, if the majority of the industry is pushing towards four, option three would allow them to continue. I don't believe, and Kate, correct me if I'm wrong on this -- but I don't believe the recommended option three that developer organizations would be required to develop to release two and four and then this would preclude them having to do four, pursuant to the standards version advancement process which ONC would not occur for about a year out. But this would be available.

Sasha TerMaat - Epic - Member
Denise, that doesn't really solve the – I guess I'm just going to ask a devil's advocate question.

Denise Webb - Individual - Chair
I'm just trying to get a discussion going here to see if we can land somewhere.

Sasha TerMaat - Epic - Member
Yeah. What will drive what an app developer needs to develop is what resources are available for their app to use. Right? So, if some HR developers adopt R4 under option three, if an app developer still only supports two then their app still only works with some of the health systems. Right? So, I think option three -- I guess if I understand it correctly -- it permits the HR developers to choose between two and four. I guess I think that's less desirable than option four, personally. But I don't think it actually achieves the fact of helping app developers. Am I misunderstanding?

Raj Ratwani - MedStar Health - Chair
This is Raj, I think you are laying out some very good clear arguments for why release four. What I'm grappling with is, why would the proposed rule even offer option three? Given that to what you just stated, you know, most of the industry and everybody's participating in four and pushing for standards for four. So, what I'm trying to understand is, they must've had some reason to provide option three. Rather than just trying to fill pages. So, does anyone have an idea as to why? I'm thinking they have some strategic reason there. And to your point, moving to four, then it seems like option three would just get everybody to four as well. I'm just trying to get to as why even have option three as a possibility?

John Travis - Cerner - SME
I think if there's anyone from ONC that can speak to that. I don't know what that does to vendors. I mean, as an app developer, what does that do to you to deal with differences in the level that API has evolved to form a standards perspective? I'm not sure I'm fluent enough to know that. It just seems like when you are different standards then you're going to increase the work or the burden on the app developers that may work with both. I realize in a given instance, you may not face that. A vendor is

going to make a choice in implementing, the provider is really kind of constrained to the vendors choice unless they are doing their own development.

Denise Webb - Individual - Chair
Well, here's a good question. What does it do to interoperability? You know, I was wondering if there -- so let's say, health system A uses vendor A who is on release two. And health system B who uses vendor B is using release four. Can interoperability occur between those two health systems if they want to share information if they are on different releases of the higher standard? And I'm not technical enough to know the answer to that question. In terms of APIs.

Sasha TerMaat - Epic - Member
If they were both interacting with an application, let's call it like app Z, right? App Z would have to support both the DSTU two and R4.

Denise Webb - Individual - Chair
So, the app would actually handle the translation between the two? Okay.

Sasha TerMaat - Epic - Member
Essentially. I mean, I think that would be the determination the app developer would make.

Denise Webb - Individual - Chair
Well, that creates another level of complexity for developers to have – I see the point about having to support both versions but driving everybody to four.

Sasha TerMaat - Epic - Member
Right. I think if we push for four, then app developers don't have to handle that complexity and instead, they could rely on -- it would be app developers to have one standard, whether we picked two or four, right? Four is, I think, the better choice, but –

Denise Webb - Individual - Chair
Well, and it will be to the advantage of the customers who don't have to pay the additional cost of them to maintain two standards. I mean, because that's what it ultimately comes down to. Costing everybody more money. So, how would this group feel about proposing, or recommending, and then having the broader committee discuss and having us bring this forth at the next meeting to recommend to go with option four?

Raj Ratwani - MedStar Health - Chair
This is Raj, I mean, I think it warrants further discussion. I think, I mean, there is no doubt that everyone being on the same release would be beneficial. And I'm always for pushing for the latest release because that's where the industry should move anyways. The point just gives me hesitation is the fact that the ONC is even putting this in as an option. Which makes me think that there is some legitimate concern around some smaller site developers having a challenge getting to release four.

Carolyn Peterson - Individual - Member
This is Carolyn, I agree.

John Travis - Cerner - SME
Yeah. I would say you want to probably, where we should ask this Mike Lipinski or somebody else from ONC if they have their own grounding. I don't remember from the preamble if they get into that a lot. But that would be a good thing to ask of them and then I think part of the perspective, I would offer you for smaller developers, they may be faced with significant new development. I hate to say it Raj, but it might be a neutral effect on them to move to something they are not already on regardless of where that sits and they may be the ones who had a more focused development that stayed with doing only what they needed to do given their size and their scale when they faced 2015 edition certification the first time. So, I don't know if we know a lot about how much was done by that scale of the vendor to address provider use cases, the bulk data is going to be probably entirely new. So, I guess my point is, they're going to have to move to a new basis of something. They might have been on a nonstandard basis and they're moving to a buyer for the first time at least for a significant chunk of their inventory. Those things all speak to whatever they are doing, they're doing something new. And it may be a fairly neutral factor for them to go on a given basis. So, in a way, an argument for R4.

Denise Webb - Individual - Chair
And when I think about patients and the number of patients-based apps popping up that patients can select their own app where they want to pull their data into – you know, a lot of those are entrepreneurial developers. They are not necessarily big companies that have the resources to support two standards to deal with in their app. So, thinking about it from the patient app side, you know, it really probably would be better if we are driving towards the more current standard.

John Travis - Cerner - SME
Agreed.

Denise Webb - Individual - Chair
So how would you all like to approach this in terms of a draft recommendation for further deliberation by the guidance by our full committee when we present this next week?

Raj Ratwani - MedStar Health - Chair
I think it would be reasonable to say that we are all leaning toward release four. Hearing from the larger group, whether they have any strong concerns with that given that we are noting that there could be an impact on smaller developers.

Denise Webb - Individual - Chair
Is everybody good with that? I mean, it is not a final decision. So, I think there is a lot of expertise on that committee and the broader perspective would be worthwhile.

John Travis - Cerner - SME
Yes, I agree.

Sasha TerMaat - Epic - Member
I agree this is Sasha. I jotted down, I've been taking notes on our conversation in the template from our previous API conversation. So, I tried to put everyone's points and then this proposal into the notes there for our reference.

Denise Webb - Individual - Chair
Thanks, Sasha, I appreciate that. By the way, is there just a link to that or – and is that on Google?

Sasha TerMaat - Epic - Member
Yes, I just went to the -- I got notes from 3/6 because that's when we first talked about APIs and put them in there at the bottom.

Denise Webb - Individual - Chair
Okay, great. Thanks. I just want to make sure I can find it after. All right, any other discussion on these four options? If not, we can move ahead to the rest of our agenda. Raj, I don't know if you wanted to take the lead on the next agenda item. I know you were away, so I don't know –

Raj Ratwani - MedStar Health - Chair
Yes, I have been away, and I haven't looked over these things, so if you don't mind driving it, that would be great.

Denise Webb - Individual - Chair
Sure. Okay. If we go to the next slide, and before we launch into this, and I will probably have you, Kate, give us a summary. But I noted on our agenda that – or originally there were two areas we had to address, corrections and principles of proper conduct. Let me get to my page here. Kate, for the corrections, is that under section five in the preamble? Modifications to the ONC Health IT Cert Program, corrections around auditable events and tamper-resistance and then amendments?

Kate Tipping - Office of the National Coordinator - Staff Lead
Yes. There should be four of them. The VDT.

Denise Webb - Individual - Chair
Yes. You download and transmit the third-party because I know this slide doesn't talk about the corrections. Do you want, or could you give us a summary of the corrections and then see if we can some discussion? I think the other one is mandatory disclosures and certifications are the four. Those are the four.

Kate Tipping - Office of the National Coordinator - Staff Lead
Sure. So, I will start with the corrections. A number of these were items left over from before that didn't make it into right text that we previously -- we may not need to spend a whole lot of time on them.

Denise Webb - Individual - Chair
I didn't think so.

Kate Tipping - Office of the National Coordinator - Staff Lead
We previously corrected these, the majority of these in our sub-regulatory guidance. So, we can, again, it's like there was a cross-reference in the auditable events and tamper resistance that we corrected in the amendments. Let me go back up here.

Denise Webb - Individual - Chair
I think on the amendments, what was a problem there, was the amendment certification criteria was being applied to capabilities that didn't necessarily have any patient data that would request an amendment. You all corrected that.

Kate Tipping - Office of the National Coordinator - Staff Lead
And then the third was the DDT -- VDT. And then the last one was just integrating the privacy and security certification framework. Basically, updating that based on prior changes that we had made that was included in this section.

Denise Webb - Individual - Chair
So, for the task force, are there any comments or concerns about the corrections? I think it is very straightforward.

John Travis - Cerner - SME
Not for me.

Sasha TerMaat - Epic - Member
I think it is fine.

Denise Webb - Individual - Chair
Good. Carolyn?

Carolyn Peterson - Individual - Member
I don't have anything.

Denise Webb - Individual - Chair
Okay. Good. Well, we hit an easy point. That's great. Okay. Kate, do you want to just summarize on the changes for the principles of proper conduct that we're going to deliberate on?

Kate Tipping - Office of the National Coordinator - Staff Lead
Sure. So, the slide that up basically goes over updates to the principles of proper conduct for the ONC ACBs. The ONC ATLs, the proposed change was one of the same as the ONC ACBs with regard to the records retention which was mainly a clarification. So, on this slide here, we have what the ONC ACBs, these are new requirements, these, the first six here. That they must accept test results from any ONC ATL in good standing. Review and confirm health IT developer submission of real-world testing plans and results and make them publicly available. Collect developers' quarterly attestations and note in the chapel when the modules are updated under the standards version advancement process. And ensure

health IT developers seeking to take advantage of the standards version advancement process flexibility comply with applicable requirements. Retain the records of the timing and content of the developers, notices and post each notices content publicly on the chapel. Review and submit health IT developers' condition and maintenance certification attestations. And then report to ONC any information that could lead onto to perform the direct review. Some new flexibilities, the role of the ONC AA would be eliminated and we go into more detail on that in the deregulatory action. Certain randomized surveillance requirements would be eliminated. ONC ACBs would be able to certify health IT modules that they evaluated for conformance with certification criteria without first passing through the ONC ATL as long as the conformity methods were approved by the national coordinator. And then two other items no longer required are the disclosure requirements and transparency attestations regarding the sharing of information in the mandatory disclosures. And those two items are also included in the deregulatory action section of the preamble.

Denise Webb - Individual - Chair
All right. So, if we can open the floor for discussion on any of these items. Or we can have a shorter meeting and go to public comment if you don't have any particular concerns. I thought most of this was very straightforward and was going to reduce some burden not on just the ACBs but as well as the I.T. developer entities.

Sasha TerMaat - Epic - Member
So, the only question that I had as I'm thinking about it, and I agree Denise, generally with your assertion that it seemed very reasonable. I started to think about the records retention requirements for ONC ACB's and ONC ACL's that's proposed. And it is tied to when ONC removes an applicable addition from the code of federal regulations. Which at first glance, I was like, well, okay, that makes sense, right? When the ONC 2011 edition was removed from the regulation, then records retention after, is it three years, I think?

Denise Webb - Individual - Chair
Three years, yes.

Sasha TerMaat - Epic - Member
Isn't pertinent any longer. When ONC 2014 edition is retired, which is just happening now, then three years from now records retention doesn't matter. But it started to make me think about the overall way in which ONC is approaching certification and addition versioning now. Because I think that the changes that are proposed here are pretty significant but the proposed changes to the ONC 2015 edition rather than as a new applicable addition, which obviously has other implications which I don't know if our workgroup should discuss that or others. I think that merits and larger discussion certainly. But one of the implications of not creating a new addition but instead proposing this as a modification to a previous edition is that it certainly affects how we have to think about any flow down effects on things tied to an applicable edition. Because records retention, in this case, isn't being sorted of updated. I guess I'm just thinking if for the next 10 years, ONC just keeps updating the ONC 2015 edition, then I have less confidence that this is an appropriate way to do records retention. I think it should be tied to a calendar date or age or something. Then if I feel that the applicable edition would

be routinely updated every 4-5 years with a new edition and old editions being correspondingly retired. Does that make sense?

Denise Webb - Individual - Chair
Yeah, you make a really good point. As I was listening to you, I was wondering what are the criteria for deciding that there would be, let's say a 2019 edition. And maybe it has to stand on its own as its own rule. I don't know. Lauren or Kate do you have anything to clarify as far as what the criteria are that ONC uses to decide to publish a new edition versus just modifications to an edition?

Kate Tipping - Office of the National Coordinator - Staff Lead
For this, at least for this proposed rule, we obviously didn't come up with a brand-new edition for 2019. We went with updating the 2015 edition, modifying, trying not to tie that to a specific year. But the end to that, you know, I don't have anything else to offer other than like we proposed the modification to the 2015 edition for the record retention instead of the new – you know, coming out with a whole new addition and trying to update that for every two years or every so many years.

Denise Webb - Individual - Chair
Well, I think Sasha makes a really great point about the methodology for the records retention. It doesn't seem to make sense – I mean, because think about how old the 2015 edition is already now, just when you think about when it first came out. The proposed rule and when it was final.

Denise Webb - Individual - Chair
What are others thinking? Carolyn do you have any thoughts on this or Raj? John?

John Travis - Cerner - SME
Yeah, I have, you know I'm trying to recall, and this may be an entirely stupid question, but is the record retention retroactive to the start of the 2015 edition or is it with the effective date of the final rule and applying to anything going forward? Does anyone recall? I do have some other comments.

Denise Webb - Individual - Chair
I think that originally the life of the edition, which begins with the codification of an edition of certification criteria.

John Travis - Cerner - SME
So, it would be retroactive, given that?

Sasha TerMaat - Epic - Member
Yes, that is my understanding, John. I mean, they are already preparing for the life of the 2015 edition.

John Travis - Cerner - SME
Yes. The other thing and I don't know that gets into a great amount of descriptive information, is just what are the documents subject to being retained? Because I can think of a lot of different things that pertain to that. So currently, you know, what that would tell me are the things that we maintain to be our basis of doing the quarterly reporting that we do. Now our ACB is Drummond. We do a quarterly

reporting to them for surveillance purposes on any software changes and any material things that need to be reported to them for their review. We get into product update situations. I'm sure those things -- I'm just curious if there is a better articulation. Because obviously, the ACB retains a lot of records as well.

Denise Webb - Individual - Chair
John does say that 2015 final rule specified ACB's to retain all records related to certification of complete, back then complete HDR's and health IT modules.

John Travis - Cerner - SME
Yeah, and I know what those would be. I think from the vendor's perspective, it's probably more the open question of, is it parallel to that? Or is it something more comprehensive?

Sasha TerMaat - Epic - Member
Well, and there is a separate provision for -- so the two provisions in this section that we are technically focused on now are for ACB's and ATLs. There's a separate provision for health IT developer –

John Travis - Cerner - SME
I'm sorry. I'm getting out of bounds a little bit.

Sasha TerMaat - Epic - Member
Yeah, and I think all of them have, in my mind they all have the same question. Which also in my mind I guess is a little bit bigger. I guess I'm questioning the decision to make very significant changes to certification without tying it to a new edition.

John Travis - Cerner - SME
Yes. So maybe if we switch focus a little bit to that. I mean, there's a number of questions and some of them are fairly tactical. But the ONC Chapel has not exactly flourished with high usability for its ease-of-use. Ease of search. Distinguishing information. It is gotten better. But we are introducing changes that largely are in place and are going to be staggered and in many cases are going to probably require maintenance of current listings and new listings and you know, if I'm a Chapel user, I'm probably going to really struggle with differentiating things. And a lot of things are going to have to be done to convey to me things like, you know, as vendor increment standards or as the vendor achieves certification of a newer capability. Maintaining access to older listings that are still effective that the vendor intends to have maintained. The potential for confusion is significant, I think.

Denise Webb - Individual - Chair
Well, what about –

John Travis - Cerner - SME
And we have to get a plan for how that gets maintained. I know ONC makes, speaks to identifying standards that a vendor has enabled the capability to that are higher than the specification version that's contained in the criteria. But you have a lot to convey through the same basis of the edition for

product listings that are going to create differentiation that we really have not seen how that is to be done.

Denise Webb - Individual - Chair
Hey John, you know I don't think there's anything that precludes us from making a recommendation, an overhead recommendation that reflects this discussion. Because as I'm listening to both of you and I'm thinking about this, and you know I have been out on the chapel. And it can be very confusing. And there are some pretty broad sweeping significant changes to the 2015 edition as a result of this rule. So, I don't know, as a basic user of the chapel, I would be very confused about you know, which version of the 2015 edition are we talking about here? I don't know, I would think it's even difficult for the federal government to keep track of it if it's just going to be 2015 edition.

John Travis - Cerner - SME
I agree. I think it's a broad recommendation to say this should be designated in some manner overall as a distinct criterion. All right, I'll say it. Edition. Or sub edition.

Denise Webb - Individual - Chair
I would say that we should recommend that it be a new edition. I mean, it has implications and we can describe that in our recommendation. The records report sums up –

John Travis - Cerner - SME
You know, there's a – I would say there are two or three things that we could certainly enumerate a list of the areas that are going to need to be visible and accessible in terms of understanding through the chapel. But let me give you a couple. So, in one case, the current basis of export is being removed as of the effective date of this final rule and they're introducing a new one at some point over the following two years. So that is a distinction. But yet they are maintaining for the API services, G8. Through that same two-year period, while bidders are expected to certify to G11. So, you're introducing a substantive difference in capability, appears underneath the same listings but kind of in different ways and different scales. And there's a number of things like that. The standards advancement process and how that is to be communicated and designated. Differentiating, certifying to the quality measure criteria because you're replacing the standard for C3. But otherwise, how am I to know how that appears. So yeah –

Denise Webb - Individual - Chair
Yeah, you as a vendor and the ACB have to retain all the records related to those things that are removed because the addition was not sunset. Requirements with sunset. Raj and Carolyn, any thoughts on this? Or do you think this is a good point to make?

Raj Ratwani - MedStar Health - Chair
Yeah, I think it's a good point to raise. I don't have any other thoughts on this. Appreciate it.

Carolyn Peterson - Individual - Member
Yeah, I am with Raj on that. I'm listening to the discussion and thinking we probably need the broader airing.

Denise Webb - Individual - Chair
Yes, it does – it's sort of an umbrella recommendation because it does have legs. You know, not doing this. And staying with the 2015 edition and just modifying that nomenclature. Okay, anything else that stands out for any of you on the principles of proper conduct for ONC ACB?

Raj Ratwani - MedStar Health - Chair
When appropriate I want to have a brief discussion on the randomized surveillance piece.

Sasha TerMaat - Epic - Member
I think that is a separate section, right? I have a comment on it also. In this section, I was curious, so, there's a – ONC proposes that there could be certain methods of conformity that would be presented to ACB's rather than ATL's. Is that in this section or am I –

Denise Webb - Individual - Chair
Say that again, Sasha? There is a what?

Sasha TerMaat - Epic - Member
Okay so, it's under the – in the slide, it's under new flexibilities for ONC ACB's, number three. I didn't actually understand what that meant. Could maybe someone from ONC give an example of what is envisioned?

Kate Tipping - Office of the National Coordinator - Staff Lead
Sasha, are you talking about in the light blue box, number three?

Sasha TerMaat - Epic - Member
Yes. What is that?

Kate Tipping - Office of the National Coordinator - Staff Lead
So, that's if you look at the preamble on the page, let me just pull it up here – okay so, it is on page 122. Of the preamble.

Sasha TerMaat - Epic - Member
I don't think it explains what it means there though.

Kate Tipping - Office of the National Coordinator - Staff Lead
So, basically, we are proposing -- so in certain circumstances allowing an ONC ACB to certify health I.T. that did not necessarily go through the ONC ACL, as long as it has been approved by the national coordinator.

Sasha TerMaat - Epic - Member
So, there would be no testing lab involvement and there would be some other type of evidence?

Denise Webb - Individual - Chair

Yeah, it says at the bottom of the page however we propose -- there has to be some method of determining conformity. But that method would have to first be approved by the national coordinator, so they are envisioning some other method of conformance evaluation. Other than testing through the lab. And it is not descript.

Sasha TerMaat - Epic - Member
Yeah, I guess, I found it intriguing of a proposal, but I didn't really understand what was envisioned. If there are specific examples of what is hoped to be implemented under this provision or if it's trying to open up a particular new opportunity. I just didn't – and then I guess, of course, I couldn't really respond because I didn't know exactly what to picture.

Denise Webb - Individual - Chair
So, think about, what I was thinking about this because if you look at the next page, that they are saying, they're acknowledging the broad spectrum of evidence of conformance that can occur. So, like in real-world testing or actual use -- let's say you put something out in beta, it is not certified. You are trying to work through it. I mean, there might be other -- I think what they're trying to acknowledge is that not everything necessarily has to go through a lab for testing. That there could be evidence elsewhere that proves that your module conforms to the requirements. That they want to see what that is first and approve that method before they allow the ACB to implement that. I actually think that's a good thing for the developers. It does create flexibility.

Sasha TerMaat - Epic - Member
I was very intrigued by it. I just did not know what it was.

Denise Webb - Individual - Chair
Now I know some of the things where we're going to touch on tomorrow on deregulatory.

Sasha TerMaat - Epic - Member
I think that is where the surveillance piece that Raj mentioned is. And I had some feedback on that also. Do we want to continue to do that now or just adjourn earlier?

Denise Webb - Individual - Chair
I mean, we could knock it out now.

Raj Ratwani - MedStar Health - Chair
The surveillance piece is listed as number two on the lower light blue box.

Denise Webb - Individual - Chair
Right. And the deregulatory text. It's on – I will show you where is.

Sasha TerMaat - Epic - Member
Thirty-nine, I think.

Raj Ratwani - MedStar Health - Chair

Yes, 39 and 40.

Denise Webb - Individual - Chair
Page 39. Yes, 39 and 40. Is that okay, Lauren and Kate, if we talk about that and get ahead of ourselves here? If we are finished with the modifications.

Lauren Richie - Office of the National Coordinator - Designated Federal Officer xyz
Yeah, it's fine for my perspective as long as you are all set.

Kate Tipping - Office of the National Coordinator - Staff Lead
Sure, I just sent out the Google document for the deregulatory actions, too.

Denise Webb - Individual - Chair
Okay. All right. So, it sounds like we concluded our discussion on the modifications that we could start some discussion on the next topic that was scheduled for tomorrow on deregulatory actions. Starting with the removal of randomizing surveillance requirements. So, Raj and Sasha, Raj, do you have some thoughts on this?

Raj Ratwani - MedStar Health - Chair
Yes, I just want to raise the general piece about removing the two percent requirement for randomizing surveillance up for discussion. And in particular, what I would like to see if we could do is get more data from the ONC if they are able to share it on when those randomize surveillance occurs when randomized surveillance occurs, what percent of those result in the identification of nonconformities? Because I think the reasoning behind removing this makes sense. You want to reduce the burden put on providers and others by doing randomized surveillance. However, if those events, if a good number of those events are turning up nonconformities then it's important to keep that two percent and maybe even consider whether that number needs to be increased depending on the nonconformities that are being identified. Thoughts on that?

John Travis - Cerner - SME
Well, we have been through that a number of times. I think where, if I recall and this was in the discussion. If you noted and as noted on the bottom of page 39 or the top of page 40 actually. When exercise enforcement discretion, I think they stated a lot of their reasons. They didn't give statistics per se, but they stated a lot of reasons about the value of randomized surveillance and the burden that it put on providers and I think there was a lot of skepticism about the ability of providers to really participate in that full understanding of what its intent was. And a lot of confusion about just what was being asked. You know, Sasha and I both I'm sure could share similar experiences of trying to help clients understand what was being asked of them. Because there was engagement with the HIT vendor to help kind of serve a bit of a translation if you will or some kind of supportive role to make sure that the surveillance instruments and things that we went through with ICSA and Drummond both and there was a lot of effort on our part to make sure the questions being asked were understandable or the survey procedures or you know, witnessed walk-throughs were understood. Because it, that was hard to get to. I think that was very challenging for the ACB's to put into place, methods and instruments that would be well understood and accurately answered if you will. The other thing Raj, to

think about, I got to believe real-world testing is almost a direct replacement for it in a way. Because that is exactly the kind of thing that was attempted through randomized surveillance and maybe not even to that point. And it puts the vendor and the position of having to take more responsibility for proving out the real weight of their capability for what is now the high-priority criteria. If you remember Anna and my surveillance was focused on a certain subset of what we are seeing as high-priority items and that has been ingested into the real-world testing proposals. So, you know, I think because that could also involve provider participation and there's a balance of trying to not put too much burden on the providers to have to participate in both of those activities as kind of a standing requirement that is not complaint driven.

Denise Webb - Individual - Chair

I'm going to concur with John. I mean, coming from a provider organization and having previously been the state health IT coordinator for Wisconsin and hearing the number of concerns that providers had around wanted -- when they raised an issue that a product was not conforming to certification as advertised, they are much more interested and I would be in the reactive surveillance meaning that I have identified something and – as a provider organization and I want the ACB to investigate it and check into it and get a remedy. Versus coming and occupying our resources and trying to look at something on a random basis to find nothing, is a waste of our time. So, I mean, that would be my position on it.

Raj Ratwani - MedStar Health - Chair

Yes, I think those are good points. I mean, I think coming back to John's comment, I'm not sure that real-world testing actually gets to this because the real test focuses on specifically on interoperability. And it may not touch some of these other issues. Denise, to your point, I agree. We never want to place a burden on any stakeholder whether it's a vendor provider or other unnecessary. That's why I sort of asked for data on this. The challenge with waiting for a reactive is that the issue has already occurred. You know, it's sort of like a reactive approach to safety. You never just want to rely on a reactive approach to safety because that means somebody has probably already been harmed or that hazard has been identified with the potential for harm. So, I think the motivation for having a randomized surveillance program is sort of incentivizing everybody to make sure that there are no nonconformities. So, I kind of see the logic for that. But if there are data here to help this and if it is the case then hypothetically out of 100 randomized surveillance activities, they find one percent of nonconformities, well sure, certainly then it makes sense to remove that, I think. So, if there are data available, I think that can help inform the discussion.

John Travis - Cerner - SME

Yeah Raj, I think -- sorry. I was just going to respond to the comment on the focused as a real word testing compared to the prioritized criteria of areas. I think in the balance to give just a review of that statement Raj, ONC is proposing to retire a number of criteria that may be a part of that and definitely, there were some in operability criteria where we are part of that. Things like the quality transition of care and things of that nature. So, I would invite given weight to the statement or evaluation. That statement in light of the current proposals for ONC retiring criteria and shifting others into the real-world testing to see if they still are included in something that is shall we say, field-based, to really kind of give some judgment of that.

Sasha TerMaat - Epic - Member
I actually have a different comment. And I certainly have someone from ONC has the data that Raj interested in, I would find that very interesting as well. My proposal is that if this is implemented, may be pending the data that Raj requested, the proposal does not make sense to me as it is given. So, the way that they are proposing to implement it in a regulatory text is that instead of saying ONC ACB's must conduct this testing, they say they may conduct the testing. Then they would remove the requirement to do it for two percent minimum. Remove the requirement regarding selected locations and also and this is the part I don't understand, remove the requirement that you are prohibited from consecutively selecting for randomized surveillance the same HIT module more than once during any consecutive 12-month period. And if they say that ONC ACB's still may conduct this, they're just not required to, it doesn't seem like we should retire the prohibition against consecutive selection. Because if an ACB decided to continue to do randomize surveillance, perhaps they found that it was an effective method per Raj's suggestion about data. They should still be prohibited from consecutively randomly selecting the same HIT product more than once in a 12-month period.

Raj Ratwani - MedStar Health - Chair
Yes, Sasha, I think that's a great point. It's an odd restriction there.

Sasha TerMaat - Epic - Member
Is it okay if I make a recommendation in our notes that if this whole provision is implemented that we recommend not removing the prohibition on consecutive selection?

Denise Webb - Individual - Chair
I agree because then one vendor's particular module could be subject to frequent within the 12-month period. Frequent surveillance.

John Travis - Cerner - SME
Yeah, I agree.

Denise Webb - Individual - Chair
And that doesn't seem proper.

Sasha TerMaat - Epic - Member
No, I mean, that's why they had it before.

Raj Ratwani - MedStar Health - Chair
I'm misunderstanding also Denise's latest comment. Are we saying that an ACB should be able to –

Denise Webb - Individual - Chair
No. No, they should not, they should not – so, what Sasha's saying do not retire the requirement that limits the number of times that the same IT module can be surveilled. So, if this is implemented, the ACB may of its own discretion still randomly surveil. But their randomness cannot result in hitting the same IT module more than once in 12 months. If we recommend to ONC that they do not retire this

requirement, which I agree with Sasha. They should not retire it if they will allow ACB's at their own discretion to randomly surveil, they're just not going to require it anymore. They should not retire this requirement. That's what we are saying. Are you following that, Raj?

Raj Ratwani - MedStar Health - Chair
Slightly.

Denise Webb - Individual - Chair
Okay, if you –

Sasha TerMaat - Epic - Member
I have the language, if I could project or you want to look at it in the Google docs it might be easier to understand looking at the regulatory language.

Raj Ratwani - MedStar Health - Chair
Yes, thank you. I can also pull up the email with that. You know, I think that minus the regulatory language, it seems like if you -- they should be able to randomly surveil, if they determine that is important to do. And in that randomness, if they do hit the same vendor again, I would say that they should be able to investigate for lack of better term if there were nonconformities that were found on the previous occurrence.

Sasha TerMaat - Epic - Member
Well, that would be reactive surveillance, not randomize surveillance, Raj.

Denise Webb - Individual - Chair
They can still do that.

Raj Ratwani - MedStar Health - Chair
Why would that be reactive? I'm saying that if they randomize surveil, and they find a nonconformity, and then they randomly surveil again, and they happen to stumble upon the same vendor. History should matter.

Sasha TerMaat - Epic - Member
Well, I think we're talking about different things. It could be part of finding one nonconformity that you were going to surveil that product again. And that would not be randomized surveillance but that would be reactive surveillance based on the first finding of a nonconformity. The randomize surveillance would say, you surveilled product A in January and found nothing presumably. And then you randomly two months later of all the products out there to randomize surveil, try to do product A again. And that, I think is inappropriate. Right? Wait at least 12 months before randomizing product A a second time. If you found something, then it would be fine to do reactive surveillance on the same product.

Denise Webb - Individual - Chair
Which they can do. And this requirement wouldn't prohibit that.

Sasha TerMaat - Epic - Member
Right. So, what they're proposing is to change the must word that is currently in the regulation to be may instead. So, it would still be allowed if an ACB wants to but does not require it. ONC proposes to ask what is in two which I haven't read. Because that requires two percent and that is what Raj asked for data about. And then scrolling further down, ONC proposes to get rid of both five and six also. Five is about how to select sites. If this is no longer required, then five doesn't seem necessary. They can select sites based on their own preferences. Six says if you are doing this then you can't pick the same HIT product more than once in a 12-month period. And I'm saying that these six should stay, even if it changes to may instead of must and two and five go away.

Denise Webb - Individual - Chair
And it evens says it does not apply to reactive and other forms of surveillance required under the subparts. So, it gives them the option that if they did a random, on a health IT module they found something, then they would go back and verify through reactive surveillance that was really taken care of or that they are not still operating with a problem.

Raj Ratwani - MedStar Health - Chair
Yes, that makes sense.

Denise Webb - Individual - Chair
All right, how are we doing on time? Lauren, what time is public comment?

Lauren Richie - Office of the National Coordinator - Designated Federal Officer
Just about seven minutes at 10:20.

Denise Webb - Individual - Chair
Okay. All right, and Kate, did you take an action to see if we could get some more data around –

Kate Tipping - Office of the National Coordinator - Staff Lead
Yes, Chris was going to follow up on that.

Christopher Monk - Office of the National Coordinator - SME
Yes, I can certainly do that.

Denise Webb - Individual - Chair
Thanks, Chris.

Denise Webb - Individual - Chair
All right. Anything else on this? Since we are in here, we have a few minutes, maybe we could do number two? Removal of the 2014 edition from the Code of Federal Regulations.

John Travis - Cerner - SME

I wouldn't think that one is controversial since it is not a referenced edition after the data already passed, relative to the 2019 program requirements we know.

Sasha TerMaat - Epic - Member
Yes, I'd agree.

Denise Webb - Individual - Chair
Of course, it will be concerned for entities that only have a 2014 edition.

Sasha TerMaat - Epic - Member
Well, it's other things that make that concerning for them actually, like CMS regs.

John Travis - Cerner - SME
Yeah, the only thing I can think of that we ran across -- but I don't think it would come into play by timing and when this final rule comes out, is there is a reference to the 2014 edition that is rather hardwired in the current chronic care management program that operates in a position fee schedule. And it runs on a year that goes July 1 to June 30 as I recall so we are actually kind of in a straddle right now, but I think that's going to be water under the bridge before any final rule comes out and that they would address that in the 2020 position fee schedule rulemaking.

Denise Webb - Individual - Chair
All right. The next is the removal of the ONC approved accreditor from the program.

Sasha TerMaat - Epic - Member
So, is this for my clarity is the ONC approved accreditor ANSI?

Raj Ratwani - MedStar Health - Chair
That was my understanding.

Sasha TerMaat - Epic - Member
That's what I thought I just wanted to make sure I was understanding.

John Travis - Cerner - SME
Yes, that is correct. The current accreditor is ANSI.

Sasha TerMaat - Epic - Member
I would, I guess, I did not have a great understanding of what this meant. The accreditation process that happens between ANSI and the ACDs is not something that I have a lot of insight into as a participant in the certification process. So, I think it would be feedback from maybe the approved entities that would sway me one way or the other. I don't know much about this part of the process.

Denise Webb - Individual - Chair
I read through this and I didn't have any particular concerns. I thought it made sense to reduce the bureaucracy around this and provide the ACBs the ability to maintain their accreditation through

existing bodies, standards bodies. So, they just need to maintain and obtain and maintain accreditation and they can obtain it from anybody that is a signatory to the multilateral recognition arrangement with the international accreditation forum. Which is a pretty known group. They just have to obtain and maintain accreditation to the ISO, IEC, 17065. And I am not knowledgeable on all of these things, either but it makes sense. Any other comments? Okay. The next item is the removal of certain 2015 edition certification criteria and standards.

Lauren Richie - Office of the National Coordinator - Designated Federal Officer
Do you want to go to public comment?

Denise Webb - Individual - Chair
Yes, I was just going to say since this has a number of items that might generate some discussion, maybe we should go to public comment.

Lauren Richie - Office of the National Coordinator - Designated Federal Officer
Sure.

Kate Tipping - Office of the National Coordinator - Staff Lead
Just give me time to pull up this slide here. Okay, perfect. And then, Operator, can you open the public line?

Operator
If you would like to make a public comment, please press star one on your telephone keypad and a confirmation tone will say your line is in the queue. You may press star two if you would like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the Star keys.

Lauren Richie - Office of the National Coordinator - Designated Federal Officer
Okay. And then Kate and Denise and Raj, it just occurred to me that since we are a little bit ahead of schedule, maybe for our next meeting, we would just kind of briefly recap the discussion today and then dive into the next topic so that members of the public who are following don't kind of get off schedule from what we posted in terms of our timeline of topics.

Denise Webb - Individual - Chair
That sounds fine. And I think probably since this next part has a lot of pieces, we should hold it until tomorrow.

Lauren Richie - Office of the National Coordinator - Designated Federal Officer
Okay. Let's see, operator, do we have any comments in the queue at this time?

Operator
There are no comments at this time.

Lauren Richie - Office of the National Coordinator - Designated Federal Officer

So, I will hand it back to you guys just to wrap up this portion and then we will adjourn after that.

Denise Webb - Individual - Chair
Okay. So, I didn't know if you want to take the lead tomorrow, we can talk about that after, Raj. But we will finish the deregulatory – well, we'll summarize what we talked about today on the deregulatory actions as the first part of the meeting tomorrow and then finish going over the rest of these removals. Just for the rest of the task force, Kate and I had discussed in the debrief meeting on Friday – she's starting to pull together from our notes in our Google docs and our various discussions, the themes around our recommendations to present at the meeting in Washington next week. And what we'll do is we will circulate these to the entire task force via email to make any type of comments. Or we can actually put them out on the Google drive so that you can make your comments right in there in the document that's going to be used to create the slides next week. Did I reflect that correctly, Kate, on what we are doing?

Kate Tipping - Office of the National Coordinator - Staff Lead
Yes, that sounds good.

Denise Webb - Individual - Chair
Okay.

Kate Tipping - Office of the National Coordinator - Staff Lead
And I just wanted to – since we discussed API slightly today, I just wanted to remind everyone that there is a -- when we meet tomorrow morning, so, I will send another reminder. But there is the API webinar on March 13 at 2 PM Eastern time.

Lauren Richie - Office of the National Coordinator - Designated Federal Officer
Thanks, Kate. And that is public, correct?

Kate Tipping - Office of the National Coordinator - Staff Lead
Correct.

Lauren Richie - Office of the National Coordinator - Designated Federal Officer
And do we have that registration or link on our website?

Kate Tipping - Office of the National Coordinator - Staff Lead
We do. It's on the health IT.gov\and NPRM on the right-hand side is the link to the registration.

Lauren Richie - Office of the National Coordinator - Designated Federal Officer
Perfect, thanks, thanks. Okay. Well, it sounds like maybe we could just give that nine minutes back to our days and then Kate and Denise and Raj, we will just debrief shortly.

Denise Webb - Individual - Chair
Sure. We'll dial in.

Lauren Richie - Office of the National Coordinator - Designated Federal Officer
Okay. We'll adjourn. Okay. Bye-bye.

Denise Webb - Individual - Chair
Thanks, everyone.

Raj Ratwani - MedStar Health - Chair
Goodbye.