

**HIT Policy Committee  
Quality Measures Workgroup  
Data Intermediaries Tiger Team  
Transcript  
December 11, 2013**

**Presentation**

**Michelle Consolazio – FACA Advisory Committee Act Program Lead – Office of the National Coordinator**

Thank you. Good afternoon everyone. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Quality Measures Data Intermediary Tiger Team. This is a public call, and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking, as this meeting is being transcribed and recorded. I'll now take roll. Marc Overhage?

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**  
Present.

**Michelle Consolazio – FACA Advisory Committee Act Program Lead – Office of the National Coordinator**

Eva Powell? Micky Tripathi?

**Micky Tripathi – Massachusetts eHealth Collaborative**  
Here.

**Michelle Consolazio – FACA Advisory Committee Act Program Lead – Office of the National Coordinator**

Kathleen Blake? Francis Campion? Jim Chase? Mylia Christensen? Richard Cramer? Peter DeVault? Prashila Dullabh? Jonathan Keller? Brendan Mullen?

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**  
Here.

**Michelle Consolazio – FACA Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks, Brendan. Janice Nicholson? Steve Ornstein?

**Steve Ornstein – Medical University of South Carolina**  
I'm here.

**Michelle Consolazio – FACA Advisory Committee Act Program Lead – Office of the National Coordinator**

Chris Queram? Alan Silver?

**Alan Silver – Improving Healthcare for the Common Good (IPRO)**  
Here.

**Michelle Consolazio – FACA Advisory Committee Act Program Lead – Office of the National Coordinator**

Walter Sujansky? Daniel Green? Molly MacHarris? And are there any ONC staff members on the line?

**Kevin Larsen – Office of the National Coordinator**  
This is Kevin Larsen.

**Elise Anthony – Office of the National Coordinator**  
Elise Anthony – Office of the National Coordinator.

**Michelle Consolazio – FACA Advisory Committee Act Program Lead – Office of the National Coordinator**

Hi, Elise. And with that I will turn it over to you, Marc.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Thank you very much, and if you could go to the next slide. And, Kevin, I'll ask you to please jump in here to facilitate this conversation, uh, as I go along, because I'm sure I will forget things because I've slept since I last thought about this. Uh, but basically, uh, as the various working groups and policy committee itself have been mulling over over the last months the recommendations that we made back in July, the thinking has I think continued to evolve, and Kevin, I'll ask you to comment on that in a moment a little. But what we wanted to do today was make sure that given not just the thinking evolving but all of our experience evolving, insights evolving, and the world evolving, that the recommendations that we made back in July were still the things that we wanted to take forward to the HIT Policy Committee. And in addition to that, uh, review the recommendations, uh, of the PSTT on data intermediaries to see if that informs our thinking any. So Kevin, I might ask you to take just a second, and, um –

**Kevin Larsen – Office of the National Coordinator**

Certainly, I'll just give a little context, because we haven't met since July. So the Data Intermediaries Tiger Team is an ad hoc task force that is part of the Quality Measures Workgroup, a subgroup of the Quality Measures Workgroup, and it was put together last spring after our Quality Clinical, Quality hearing, and gave a lot of input to CMS as part of its rule writing around registry use for PQRS, and also specifically around how that would work with alignment in, uh, with MU Quality Measure Reporting. And in general thought about the role of the Data Intermediary which included some EHR vendors, some data warehouse vendors, some analytics vendors, registry groups, a number of different groups encompassed, HIES, in this Data Intermediaries frame.

Our group gave its recommendations in July and it uh, the National Coordinator asked for additional thought be given in a couple of key areas, mostly around privacy and security. And so the Privacy and Security Tiger Team then met a couple of times over the Fall, invited members of this workgroup to participate in those discussions. That group made their presentation I think in October maybe it was and as we prepare, as the Policy Committee prepares its transmittal letter, we wanted to be sure that the Data Intermediary Tiger Team recommendations don't need any amendments in the six months since we last looked at them, or in light of the additional recommendations from the Privacy and Security Group.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Great, well, thank you. So with that, let me pause and see if there's any questions and comments from the group, and then we'll go through a little bit of the feedback from the, uh, Privacy and Security Tiger Team that was alluded to, uh, and then we can have our discussion. Any questions about that or thoughts? Okay. I'll take a crack at and again ask you to fill in any holes I leave, if we can go to the next slide please.

Um, the, uh, Privacy and Security Tiger Team in their sort of concluding remarks, which are summarized on a couple of slides here, uh, first they concluded that there was not an appropriate policy vehicle available at present to hold business associates accountable for greater transparency to providers around their uses and disclosures of data. And, uh, that they thought about a variety of options but just didn't see that. Also that the potential large number of agreements and, uh, the difficulties that come from trying to manage through a large number of agreements like that just made it kind of an unmanageable process to try to go through to use that as the vehicle for helping insure that this data was appropriately protected. And if we can go to the next slide. Excuse me. [Coughs]

A couple of other key points here is that, as they're summarized here, and these are lengthier and I don't want to read them all to you, but, uh, a couple of key points. Although the Policy Committee didn't make additional recommendations, it did highlight some points that were important, uh, going forward. And essentially, you know, as they're put out here, that, uh, I think this is really saying the same thing on the last slide in a different way, that given the desire to participate with data intermediaries for other reasons, that it's very difficult to, uh, sort of create any kind of a policy vehicle that really provided the protections necessary, and that's what kind of led to the conclusion that there really wasn't a way to, uh, provide the protection that might be desired. So any other clarification or amplification anybody wants to offer on that?

**Kevin Larsen – Office of the National Coordinator**

Yeah, this is Kevin, I'll just give a little bit more context. So as you remember the recommendation from the Intermediary Tiger Team was that no additional rules needed to apply beyond HIPAA, that this group felt that HIPAA uh, really was – gave the appropriate framework for this activity. And so as Privacy and Security was thinking about that and trying to think of what their goals and priorities were would there be additional policies that could be recommended? And they couldn't come up with any particular policies that they felt were really solutions.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Do you want us to respond now as we go along?

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

This would be great, especially in regard to the Tiger Team – Privacy and Security Tiger Team conclusions in particular, but yes, please.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

I'm a little concerned – this is Brendan Mullen from the ACC – so I'm a little concerned that – I understand their conclusions, the jump that they make in the recommendation I think is where I'm concerned. Is that we shouldn't be using any data or intermediaries that aren't already housed in the EMR systems to be able to generate quality reports. And, you know, I personally think this is one danger of operating in siloed Tiger Teams. Probably our colleagues on that were specifically tasked with thinking about privacy and safety. Um, and they weren't tasked with considering the entire value proposition to the individual patient, which I would argue requires a balancing of the associated risks between using information and having a bad outcome, and not using information and having a bad outcome. And the bad outcome of using information is that, you know, information can be inappropriately disclosed. Um, the bad outcome from not using information is that a technology or ability to inform physicians of a better care option may not actually be applied and thus the patient isn't going to benefit.

So you know, I – I guess I'd want to register concern, the idea that because those regulatory frameworks are not in place, instead of saying either we should change the regulatory frameworks or recommend that, or push forward with a view of total patient value, uh, that instead we're taking a sort of regressive position where we say, "Oh, maybe we shouldn't be doing this at all." And you know, I particularly worry because I've argued before is that all these laws and rules were written essentially pre-digitization, and especially pre-Facebook. And this is, I know, a little bit glib when I say this, but we give away on Facebook everything that the NSA hasn't already taken for us, and the whole idea that large data commercialization companies know almost everything about us, because I've had a chance to actually look at, you know, what they can do on our personal data, on our financial data, even inferring health-related conditions from purchasing decisions, and that we are going to restrict ourselves to not being able to use that to improve patients' health and improve quality, while Amazon can use it to sell anything they want to – I have a real concern with that as being the conclusion that comes out of those recommendations. Off my soapbox, thank you for allowing me to express my point of view.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

I think it's a very helpful point of view. I guess I had a slightly different take on what they were suggesting, and of course everybody – that's part of the danger here is everybody has their take on it – is that we sort of said we think that the tools exist. And we're going to come back and ask the question do we want to change what we thought. The regulatory framework was there, and what I sort of interpreted it as is they sort of said, yeah, but it's not necessarily – it wasn't necessarily workable, it wasn't practicable, and they did partly because of a symmetry with providers and data aggregators and partly because of the large number. And because of that, and the fact that they didn't see what the vehicle was to change that framework. They didn't see what the policy tools were available to ONC to change that framework might be. I think they were just questioning the sort of pragmatism of relying on that and also saying we're in a corner because we don't see how to change the framework. So I don't think they were necessarily disagreeing with what you were saying, they were just saying, "We don't see how to get there."

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. This is Micky, and I'm on the Privacy and Security Tiger Team, although I wasn't able to participate in all of the discussions. But I think you're right, Marc, I think that was one issue. And I think the other – and, you know, I'm still struggling with it in this presentation as well, which we'll come to, I think, as we go through this, is that they had sort of a particular, you know, sort of conception of what a data intermediary is, and I'm still sort of confused about what it is. [Laughs]

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Right.

**Micky Tripathi – Massachusetts eHealth Collaborative**

And so that's where they struggle, you know, and they get into this, we get it, we have similar issues in the Tiger Team when we discuss health information exchanges, because they have a particular conception mind, a particular conception about what degree of control a participant in either an HIE or a data intermediary has over the data that that, you know, either the HIE or the data intermediary has, and what degrees of freedom you've allowed through contract, you know, to that other entity. Um, so, for me, for example, we have a – we have a commercial quality data warehouse that's, you know, certified for 2014 edition, it's on the ... and everything. These issues -- were a business associate to our covered entity customers -- so these issues of patient control and autonomy, patients have no say in whether or how data intermediaries use their information. And if I think of it just in our particular example, well, right, the patients don't have any say, but they do have say through the provider, and we can't do anything that the provider doesn't allow us to do. So, you know, I get confused by, you know, sort of these kinds of statements.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

And Micky, I kind of question how they interpret it. So sometimes our legal guys take a very legalistic approach to me that is legally valid but it doesn't make any real difference in terms of patients being able to be involved in this. So, for example, they've told me that if we had our consents to use this data for whatever you wanted buried in an iTunes-like document that every time you agree to download a new version of iTunes you sell away your third born child or something like that, that that would legally cover it. And where I sometimes struggle is that you may legally cover it, and we may be completely fine, but I don't feel like that solves the problem anymore if you really believe that the patient should be actively involved in how their data is used. I was wondering, have you guys wrestled with that in this kind of legalistic versus practical sense of consent and control?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Do you mean in the Tiger Team?

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Yeah.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah, you know, and I can't say that I've attended every single meeting, although I'm going to start because I'm the co-chair now, but, uh, but you know that in general we kind of struggle with this issue of, you know, what are, what do we mean by control? Um, because some people feel that control means that if I have a contract with you that says that you can only do these things, that constitutes control. Other people feel that, no, that doesn't constitute control because you can't stop them from bad behavior. Um, and so, you know, and so you get into this, you know – and I think that the last, when we were considering another issue, the accounting of disclosures issue you know, we came up with this, uh, concept of within my compliance control. And so, you know, that's yet another way of looking at this. Do I actually have some ability within even a compliance framework to be able to control what that agent who is acting on my behalf can do. So we don't have a clear and crisp way of looking at that. I think we're getting closer but we still don't and we still struggle with it.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Yeah.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

To me, this falls into the category of “wicked problems.” There’s a lot of complexities and variation, uh, not only based on perspective but perhaps based on life experiences, a whole variety of things that go into this. And that’s part of the challenge is there’s no silver bullet answer, or rather it’s probably some kind of an incremental bit by bit progression unless there’s some forcing function of some kind that gets us further down the road.

So with those perspectives, and Kevin, you may provide additional guidance here, but, you know, one of the main things, so we can revisit our recommendations, with regard to this question about we’ve sort of concluded that we didn’t need other policies or there weren’t other reasonable policies beyond the existing HIPAA regulations to, uh, to guide this. And in fact we were, if I recall, fairly silent about this topic in our recommendations with our rationale for that being that, you know, there wasn’t more to say there. Uh, is that still how we feel? Are there – do we want to add anything related to data protection, business associates, HIPAA, to our recommendations? Or do we still sort of say, even given the Privacy and Security Tiger Team feedback – in fact to me it kind of reinforces it, where we were, which is there’s not a lot more we can get done using existing policy levers to improve this. And so you have to live within those boundaries. Or is there something smarter that we can say?

**Kevin Larsen – Office of the National Coordinator**

This is Kevin. The recommendation, which I think is later in the presentation, essentially said that that the group felt that the rules under HIPAA were, uh, were adequate and sufficient to cover the data transmission privacy and security issues that would be met by data intermediaries, uh, being involved in quality measurement and reporting.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Then I’m just not sure what else we would say.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

I would personally – this is Brendan Mullen again from the ACC – I would still sort of stand by that recommendation. Um, I would love to be able to recommend that these policy levers should perhaps be revisited, but I think that’s probably outside of our domain to encourage Congress to, you know, look at that. I’m pretty realistic on that front. Um, and, you know, I would be leery again saying that the policies are insufficient by definition than – or in most people’s interpretation means that data use is thus insecure and thus the risk of losing data is greater than the benefit of using data.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Right. So you’re arguing for a value framework as opposed to an entirely risk-based framework.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Right.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

It makes a lot of sense. Well, one thing we can do as we go through these next five or six slides is ask ourselves the question if there’s any place in here where we want to insert that concept. Uh, maybe that’s the way we sort of imbed that into the recommendations. So why don’t we go ahead to the Roes and Recommendations for Data Intermediaries slide. So these next slides are just the – what we took forward to the Policy Committee some months ago, and as you’ll remember we had sort of short and long term recommendations for each of these topics. The first one is getting data in for measure calculation. And a lot of what we touched on – just to remind those of you who haven’t looked at them in a while, which included me until yesterday – uh, you know, a lot of what we struggled with was, was the sort of issue about both scale, uh, how these things made sense to the consumers of quality measures, and, uh, we also spent a lot of time on the issues of what were the levers and what is certification and so on, and how we created sort of glide paths around that. And so we had both the short and the long term recommendations here, and I’ll pause a minute and give people time to kind of read through those and think about anything that might have evolved, and also is there a need or a place that’s appropriate to insert this idea of value tradeoff of risk versus benefit for the patients.

**Kevin Larsen – Office of the National Coordinator**

And this is Kevin, I'll just had an additional kind of piece of context. Some part of this is about how will the new regulations around, uh, the use of clinical data registries for PQRS, and the goal of aligning PQRS with meaningful use. How will these data intermediary rules kind of impact those registries and that ability for them to align. And this, through this committee, discussed that and said that the registries would need to use the measures and standards and certification that already exists for the meaningful use context. But that's part of the reason that some of this has that particular character.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

My only thought about this one is that in long term in the second sentence we say data intermediaries – I can't say the word – will also accept proprietary data formats. Then we go on to say that they have proprietary formats. So I wonder if that first "will" really should be a "may," which is kind of trivial wordsmithing. Any other thoughts or comments about this one?

**Micky Tripathi – Massachusetts eHealth Collaborative**

This is Micky so just on the first thing, um – and again, maybe it's just me who's struggling with the DI concept still, so what's different, how is a data intermediary different than a certified EHR modules for CQMs?

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Well, I think that's partly where we kind of – I mean, we struggled a lot with this conversation and kind of landed a little bit on the – because it's got to play in the world of the rest of the infrastructure it ended up looking a whole lot like, but the question is, you can have certified technology but the data intermediaries obviously – well, I shouldn't say obviously – the data intermediary I think we conceptualize as an entity or organization that was using, uh, technology that fit into that framework to accomplish this end. But we always ended up coming back to in order for it to work in the ecosystem it couldn't fall too much outside the, uh, rules, if you will, of how the ecosystem worked.

**Kevin Larsen – Office of the National Coordinator**

Micky, this is Kevin. I would say that that question wasn't clear at the beginning of the workgroup's activity, but the workgroup had a consensus at the end that the data intermediary was a module of cert essentially, of certified technology, that the certification standards and rules applied to that data intermediary in the same way, but that was not a foregone conclusion when the group started.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right, right. Not to bring all of the pathologies of our Tiger Team discussion to this one, but going back to what you had said earlier, Kevin, about the PQRS, it just seems to me that on their own, a data intermediary, that the only sort of legal standing or regulatory standing or standings they have from a regulatory or statutory perspective would be under the PQRS authority, right? If it's Meaningful Use in their cert, well then they're just an EHR module. And they may do different things –

**Kevin Larsen – Office of the National Coordinator**

Correct, so for Meaningful Use 2 that's very clear. As this group and others give a recommendation for Meaningful Use 3, I think that's where we're looking for your input about is it the same – does the same rule that applies for 2, is that, uh, a recommendation for 3 as well?

**Kelly Cronin – Office of the National Coordinator**

Yeah, this is Kelly Cronin from ONC. I think we might also be mindful of the fact that these could be QEs as well, so whatever is, you know, set in regulation about the qualified entities from ACA 10-332, or whatever Congress might evolve, because they are considering to update some of those roles and they are considering, you know, things around the value equation I think because of the lack of business case for some QEs, so I think that these entities hypothetically will be playing multiple roles as an intermediary. They'd be doing multi-payer claims and clinical data, aggregation, measurement calculation, measurement reporting, performance back to providers, and clearly be multi-payer. And I think so far these slides haven't really addressed sort of the multi-payer perspective per se. But the way that the physician fee schedule is finalized and specified, sort of the PQRS, you know, qualification process for qualified registry, and even the RR5 process early in the year, it was really in that multi-payer construct.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. I guess sort of, I guess then sort of, and if form has to follow function, you know, it just feels a little bit like maybe we may be approaching this the wrong way, that we've been focused on form and everyone – and then we keep thinking that, oh, and this function will be a part of this, and that function will be a part of it, but, you know, really, it's hard to define – I'm having a hard time defining the form without really understanding what the function is. And, in particular, how it relates directly to what the Federal Government either in its governmental role or in its business role as the owner of, you know, two very large businesses, Medicare and Medicaid what their interests are and what their goals are, and specifically what their authority would be.

**Kevin Larsen – Office of the National Coordinator**

Yeah, so this is Kevin, I can take a stab at some of the primary functions that we – that have been clearly articulated. So there is the function that's already in Meaningful Use 2 certification, which is to import, calculate and report quality measures on behalf of a provider. Um, so that's already a certified possibility, and many of you are certified and are doing that function. Another function is the qualified entity function that Kelly mentioned, which is to really receive claims data on behalf of CMS and other payers, to do multi-payer aggregated measurement and feedback to providers so then currency is bidirectional flow. And I think the third one that we see on the horizon is a need to combine clinical and, um – clinical data from EHRs as well as claims data in these new hybrid measures that will contain both clinical and claims data. And, uh, likely some of these data intermediaries would serve that integrative and calculation function in that middle space. So I think if you think of those three primary forms as the places that we're talking about, or those two primary functions, there are many other functions they also serve but those three functions are the main ones we're talking about now.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right, okay. That's helpful. I wonder, Marc, if we want to have a slide up front that sort of defines that?

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Probably a good idea. We just had the recommendations here, not all the framing slides.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

But a fair point, out of context all this gets very confusing.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

So am I remembering this correctly based on this conversation? I recollect that we thought of sort of a Meaningful Use or an EMR module and what was required to get certified as such was the starting point for an intermediary. It was not the ending point. So that was sort of your necessary condition to get qualified in there, but then to the broader set of goals that Kevin just articulated, then you would be well outside the sort of specifications or even the contemplation of a Meaningful Use, and you could grow outside of that to respond to customers and scientific needs and so forth. Does that – am I articulating that correctly as others understand it in the context of this conversation now?

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

I think so.

**Kevin Larsen – Office of the National Coordinator**

This is Kevin, framing the discussion again, there was a core set of functions that were part of Meaningful Use, and then a wide variety of other functions that a data intermediary likely might serve – being a health information exchange, being a dashboard or a reporting solution – um, that we didn't tackle. We said for the purposes of the Quality Measures Workgroup Subgroup this is really around the data flows to and from provider organizations and payers around quality measurement and reporting.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Which was part of the challenge. You know, we sort of had this narrow charge but in a broader context. So let me come back here and ask, are there – this a good discussion to get us both realigned and make sure we're not leaving something – with the framing slides included here, are there any changes we want to make to this specific recommendation? And I haven't heard any, I think we're all just getting ourselves kind of back up to speed.

**Alan Silver – Improving Healthcare for the Common Good (IPRO)**

I agree with your wordsmith recommendation, this is Alan Silver from IPRO.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Okay.

**Alan Silver – Improving Healthcare for the Common Good (IPRO)**

About all I can add to this at the moment.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Well, we'll go on, and we can come back, of course, and you all have access to this deck if you want to ponder it, we can come back to it at the end to make sure. But let's move on to the next one, which is Ensure Quality of Data Transferred and Storage. And you know, this is really sort of in my mind sort of a chain of custody question. Um, and not repudiation kind of question. And nothing here I think related to the Privacy and Security Tiger Team recommendations. And as I remember, these were a little less controversial, perhaps, than some others. All right. Again, we can come back. So let's move on to the next one, Execute Patient/Provider Attribution Logic. This really just got at the question of, uh, I think transparency to both participants and consumers of the data.

**Kevin Larsen – Office of the National Coordinator**

And this is Kevin, a little kind of context again. This recommendation was in part to inform the PQRS rule, that's why it refers to the 2014 EHR certification. I think transmittal letter language could go beyond this and say what do you recommend for the Meaningful Use 3 timeframe that might be the same or might be different as this – than this.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

And correct me if I'm wrong, Kevin, but I believe too the other input to that would be that ONC has an active project to revisit, uh, patient matching, but not necessarily provider attribution, right?

**Kevin Larsen – Office of the National Coordinator**

Correct.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

They relate a little bit. And I think in terms of, you know, longer term, it seems we've left the door open here and maybe we weren't explicit, saying that in the longer term, stage three, that intermediaries could do something different. We thought there should be flexibility that they could do something differently than might be specified in stage three but that it would have to be publicly disclosed and transparent to essentially all participants – the providers, the public, and the federal stakeholders in the high tech program. So to me we are saying it is possible that they would deviate from what was subsequently specified, but it would have to be, uh, disclosed, if you will. So I guess we're implying it could be different.

Okay, let's move on to the next one, which is Calculate Meaningful e-Clinical Quality Measures from EHR Data that Providers use for Meaningful Use Credit, which of course is the operational thing here. And, uh, just reviewing, in the short term we said it's got to be measures that are out there, hard to come up with something else. Uh, longer term we said that there should be a core set of measures, and I think the rationale there being some kind of comparability, uh, but that intermediaries would be encouraged to have proprietary measures and that providers would receive credit for reporting on those measures and that some review of those measures was appropriate. And it wasn't just anything that somebody came up with.

**Kevin Larsen – Office of the National Coordinator**

This is Kevin, this is in part bringing in these qualified clinical data registries. This language was specifically crafted around that use case.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

I'm still struggling, looking for any place where we can insert this idea of value versus risk. Because we're kind of silent on it I'm not – we'll see here if there's any other place where it comes up, but I'm not there yet. So we'll move on to the next one, which is further long term suggestions on the calculation. And we were explicitly suggesting some criteria that might be used to help evaluate those measures. And we said specification should be similar to other measures, that they're outcomes-focused, that they address one of the National Quality domains that are high priority. I've always struggled with this one, but we had the notion of they should use multi-source data. I'm not sure why we made that a criteria, but I know we talked a lot about that, so I won't raise it again. [Laughs] And that of course we want these measures to be able to apply across all of the programs including PQRS and so on.

**Micky Tripathi – Massachusetts eHealth Collaborative**

So – this is Micky – so this is a recommendation that's really focused at those within CMS who are creating measures that a data intermediary would be required to calculate on behalf of CMS?

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

I actually thought of this slightly differently, Micky. I thought of this as the criteria that somebody at CMS or elsewhere might use in evaluating the measures that a data intermediary came up with.

**Kevin Larsen – Office of the National Coordinator**

Yeah, Marc, this is Kevin. I agree with your interpretation. This was really to help inform this kind of innovation pathway and how to bring in groups that have done clinical data registry measurement and which of their measures should count and which shouldn't.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay, but at the end of the day it's whatever the source of the innovation is, whether it's from in the bowels of CMS or it bubbles up from the data intermediary, at the end its direction – it's a recommendation to CMS about what they should approve – what guidelines they should use for approving something.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Correct.

**Kevin Larsen – Office of the National Coordinator**

Right.

**Micky Tripathi – Massachusetts eHealth Collaborative**

What I'm getting at is it's not saying that a data intermediary is not allowed to have innovative measures that it just thinks are innovative and they don't really care about what anyone thinks.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Right, right, it would have to at least meet some minimal criteria.

**Kevin Larsen – Office of the National Coordinator**

For the purposes of CMS, uh, programs.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right, exactly.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Isn't this pretty close to how it's been articulated in the proposed rule?

**Kevin Larsen – Office of the National Coordinator**

It is. As you remember the team from PQRS was actively involved here, and I think you'll recognize a lot of this language in the proposed rule.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Yep.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

So our discussion actually does matter is what you mean.

**Kevin Larsen – Office of the National Coordinator**

Exactly.

**Alan Silver – Improving Healthcare for the Common Good (IPRO)**

Separate from adding the value proposition in the preamble slot, do you see this as a place where you may want to put it in since you were struggling with where you could ascribe that? It seems to me to capture that concept.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

So something that might say that it should have some potential benefit to patients that would outweigh risks of use of their data or something?

**Alan Silver – Improving Healthcare for the Common Good (IPRO)**

Yes, I'm just trying to be responsive to your concern about where can we put that in here, and this addresses what should be considered in the future and gets into innovation measures and multi-sources and value-based purchasing and all this stuff.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Yeah, although it doesn't really – this is about the mea... And maybe one of the challenges here is we sort of chunked up the process into these recommendations, and so this is the recommendation about the measure, not about the data, and the data is where the concerned about – yeah, so maybe, what do you guys think about that? That maybe here's a place where you'd say something about a criteria to consider would be that the value outweighs the risk to the, uh, any privacy risk, and the, outweighs the costs of the data capture to be able to generate the measure, or something like that.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

I think criteria like that – even though of course I was just championing the whole idea of value versus risk – I think it's difficult when you pose a criteria like that, because other than being – when you apply it to specific measures in innovation, because I don't know how I would evaluate that –

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Yeah.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

And I don't know how a regulator would. And any time that I can't think concretely about something like that, it worries me that it could be abused on either side.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

I agree, I agree. Let's table that for the moment and we can come back at the end for a minute if we want to. The next slide, if we go to it, really talks about, uh, reporting to the public, to HHS – since we're talking about it in the scope of Meaningful Use program – and to providers. And so for the public we said in the short term it didn't have to be, uh, publicly reported, but in the long term, if they were going to count for the Meaningful Use program, that they would need to be publicly reported to HHS. That we would follow the current model and that that would continue. And then for providers, we thought that the whole reason for doing this is to have providers be able to improve their care, and so it was important for them to be able to see it. And then we wanted to push that envelope a little bit in the long term to include benchmarking data, so that providers could get a better idea where they're performing in relationship to their peers, good, bad or indifferent. This feels a little bit "motherhood and apple pie" to me. I'm not sure that there'd be much we'd want to change here. Okay.

And then the last slide in this desk is just reviewing again the things that the Policy Committee asked when we initially presented these back in July. The first two well, the first one, more stringent requirements for accountability and payment, and the next one, was really getting at this same issue, I think, about the BA agreements and whether we were covered there or not, which we kind of beat to death. And then what rules should apply to data collected or created that are not in the EHR in terms of – when they say “what rules” I guess my assumption was that this really related back to the reporting back to providers. We were saying, uh, that data and performance data back to providers was appropriate, but not necessarily to the public or HHS. I'm not sure if there was more that we wanted to say there.

**Kevin Larsen – Office of the National Coordinator**

This is Kevin, I think one of the questions or concerns was not just the aggregated reporting to the providers but what happens to the granular data.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Right.

**Kevin Larsen – Office of the National Coordinator**

So I think one of the specific questions was, let's say that a data intermediary like a registry captures patient reported outcome, standardized instruments, at a granular scale what are the rules governing how that data flows? Does it automatically flow back to the provider at the granular level? Are there rules in that space?

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

You know, when we talked about that before, you know, I think this gets back to the same basic issue, though, of what the permissions the patient provided and what the business associate agreements come down to, because if the intermediary collected data, for example, from the patients directly, what – it comes down to what rights do they have to share it back to the providers?

**Kevin Larsen – Office of the National Coordinator**

Right.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

So I hate to keep pushing things on to that, but to me, that's the framework that answers that question, and the rules will be different. And I think it gets back a little bit to the Policy and Security Tiger Team concerns that, you know, BAs may be asymmetric, they may be because, you know, if you're the intermediary, maybe you've got access to data but you don't necessarily have the rights to share it back. A good example of that being CMS. And, Kelly, you may want to help us with this. But CMS can make data available to various entities that they could use in quality measures, but that doesn't give you permission to share that data back to the providers – to the individual providers.

**Kelly Cronin – Office of the National Coordinator**

Yeah, I mean, if you're a qualified entity you can, but, yeah, if you're operating under other authorities, yeah, not necessarily, with the Privacy Act.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

And even I think qualified entities there's restrictions on which providers and whatever you can get it back on.

**Kelly Cronin – Office of the National Coordinator**

Right.

**Kevin Larsen – Office of the National Coordinator**

This is Kevin. I think another use case that people were thinking about here is if you apply some complex logic to data that's entirely supplied from the EHR, therefore you're creating essentially a new resource. Should there be something that governs what that new resource is that it's fully from an original place?

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Yeah, so a predictive model, for example, that gives you a risk score or something like that?

**Kevin Larsen – Office of the National Coordinator**

Exactly.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. So, this is Micky, I guess I'm struggling a little bit about why we would try to have any sort of regulatory or statutory reach over things like that? It seems to me, you know, for those kinds of things, providers will have choices of data intermediaries, and if they're unhappy with the way a particular data intermediary handles those kinds of things, they can go to one that allows them a little bit tighter control.

**Kevin Larsen – Office of the National Coordinator**

Yeah, I think I'll try to channel Farzad, who raised these concerns. I think his – he was trying to look out for the –

**Micky Tripathi – Massachusetts eHealth Collaborative**

Who is Farzad?

**Kevin Larsen – Office of the National Coordinator**

He was looking out for the small provider who's dealing with a large data intermediary, and not feeling like they have much business leverage. And so is there a place for regulation to support that asymmetrical relationship?

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Yep, that's my read as well.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah, I mean, yeah. So, I'll try to fall for the edge case, but then, you know, damage the market overall. If we think that there are going to be lots of these, and they're not geographically bound I guess I don't know why we wouldn't assume that there's going to be competition out there. And if it becomes a problem, then try to come in later.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

This is Brendan. I would strongly second Micky's position of, you know, prescribing minimum requirements and then allowing lots of room for innovation and growth and evolution. And number two, I might comment that at least in our experiences the smallest providers are the ones that are least likely to have these concerns, because the last thing they want is to be required to, for example, reintegrate a data stream from the ACC back into their EMR, because their vendor is going to charge them for that, they don't want the data, they're not going to use it, and so you have to be very careful if you do that it's the little guys that we've found are least likely to be worried about stuff like that.

**Kelly Cronin – Office of the National Coordinator**

This might not be the time to raise this issue and it might be out of scope from the charge, but I think one of the things we probably missed over the last many months is, you know, the conversation about what's the most scalable data architecture and if it's not bound by geography how do you actually get to multi-source data, multi-payer claims plus clinical and potentially other sources on an efficient sort of doable level to support not only the Medicare and Medicaid referring needs but you know, other commercial payers?

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

I think that's a good point. I know at the ACC that is an ongoing thing and we're spending a lot of money and a huge amount of technology capacity to try to figure that out. And you know, we certainly haven't seen a simple solution. One of the things that sometimes frustrates us, you know, for example, when working with our good friends at Medicare and so forth, is that we're supposed to use our data to support all these things and be incredibly transparent, and of course the rules for accessing Medicare data and for using it to do the things that Medicare wants us to do is incredibly restricted and complicated. I mean, if there was one, the source of data, that could be made easier to integrate with the clinical data that we're pulling, I would suggest that that is something that Medicare needs to look at itself to handle, as opposed to sort of putting that burden on us to figure out and then keeping locked up the one asset that would probably be most valuable to all of us.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

And while I agree with you – which is one of the reasons I raised them as an example – it seems a little out of scope for what we say here, I think.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Yeah. Sorry, Kevin, you don't have to put that one in the notes.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

So my kind of takeaway here is that I'm not hearing a lot of suggestions for changes to this -- this being the recommendations that we made in July, even putting our BA Privacy and Security Tiger Team thoughts hat on, other than a little bit of wordsmithing and the addition of making sure that we've included some of these thoughts in the framing, that we didn't see a place to translate them into recommendations, or changes in our recommendations. I know it's hard as a group here going through and people are thinking about things, so let me suggest that if folks want to go back to any of these and revisit them and discuss it a little bit more, uh, you know, sing out the thing you'd like to go back to and, uh, we can revisit that. But it kind of feels to me like we're – you know, there wasn't a lot more to be said about these, which is good, we did good work the first time around. Is there any of these that anybody on the call would like to revisit, either from the workgroup or from ONC?

Kevin, anything else you would like to add? I know we've got some more time so I don't want to rush this, but on the other hand...

**Kevin Larsen – Office of the National Coordinator**

So one other item that Quality Measures Workgroup is working on to bring to the transmittal letter and the Policy Committee that I think this group could potentially give some thoughts on is, and we discussed it a little bit, it's the innovation pathway, and the framework around the innovation pathway has been talked at the Policy Committee for a number of years. The idea there is that the current measure development pipeline is fairly small and we're not getting where we want to be collectively as fast or as creatively as we'd like. And so they're looking at what could be an alternative way that measures that have been used or created in the field, uh, not as part of federal contracts, could enter into the Meaningful Use program in an innovation pathway. So we have a recommendation or you have a recommendation around that in this list and I'm wondering if you have any additional thoughts that you could give to the Quality Measures Workgroup around that innovation pathway, recommendations for how to support that through policy, and that could be the EHR incentive program policy, it could be a certification policy.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Uh, this is Brendan, you know, to me, taking off the ACC hat and trying to think about decent public policy objectively, that's a hard question to answer without having further constraints put on by what they're hoping to achieve by innovation, right? So I think there are a lot of new measures that are going to be developed in increasingly niche and specified areas that could have tremendous impact for specialists in certain small groups of patients or smaller groups of patients in some of the measures up to date. And I think it could be scientifically important, it could be important from a quality improvement standpoint. I don't think it's going to meaningfully affect quality at large for the country, nor do I think it's going to affect sort of the value or the cost competition. So if innovation just means more and being able to follow the science, I think you pursue that path one way. If innovation means, you know, we're going to seriously start wrestling with cost versus resource versus quality and outcomes tradeoffs by doing economically integrated measures that's another definition of innovation that has a different sort of public policy domain. I find it really hard to offer an objective view on that without some further definition of what innovation in their mind means.

**Kevin Larsen – Office of the National Coordinator**

This is Kevin, I can give you a little bit more framing then. The Quality Measures Workgroup has discussed a couple of key domains that are still pretty empty in the national quality strategy. And so one of those domains is in patient centered care, kind of patient reported outcomes measures. Uh, and another of those domains, as you touched on, is efficiency measurements. Um, and then the third domain is care coordination. And so those three domains, our current processes for creating measures has not gotten us measures in a very timely way – not just in the special niche areas but overall across the federal space for standardized measurement. And an additional pain point that has been articulated is that the measures continue to feel like they've been not created with an EHR context, or speaking EHR natively, and so part of the goal of this innovation path has been to get measures that come out of EHR workflows and EHR data sources, and are fundamentally architected to fit EHRs rather than starting with claims and retrofitted to EHRs. So those would be four constraints: native EHR, care coordination, patient reported outcomes, and efficiency.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

That's kind of like telling my kids, "You should learn to speak European fluently." [Laughter]

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Yes. Other thoughts?

**Kelly Cronin – Office of the National Coordinator**

Marc, this is Kelly. A couple of other thoughts just going back to the need to focus on requirements for accountability and payment. I know we had a really good discussion several months ago about the different levels of responsibility, sort of at the provider level, at the intermediary level, at the Health IT vendor level, and then maybe at the government level. And I wonder if we think in the end, you know, in drafting a transmittal level, whether we've articulated all those levels of accountability. Because it's important for certification to play a certain role and the vendors to, you know, ensure that they're meeting the standards and logic and whatever is being required through the certification process, or the CMS qualification project as a registry. But at the same time there's the responsibility for data capture and data transformation at a provider level and you know, sort of, I feel like since there are these different levels, do we feel like we've adequately described them so that everyone's clear on their specific piece of this?

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

That's a good question, Kelly, and I think, actually, as you were talking, the thought that went through my mind is what you just said actually helped clarify to me, anyway, some of the struggles we had in thinking through this in that in some ways I think we concluded that the – sort of the quality measures are sort of between the providers and the, uh, stakeholders, like CMS or whatever other payers. And the data intermediaries really are intermediaries who have to sort of conform in the middle. Um, and so, in some ways they weren't in the picture of that levels of accountability, that their accountability was to one of the other existing parties in the ecosystem, which is sort of a strange way of putting it, I guess, but it sort of – when you were talking about the levels of accountability, it sort of struck me that one of the reasons that we couldn't sort of clearly nail an accountability for the intermediaries is that their accountability is to their stakeholders, the providers, and only indirectly to these other stake... Does this make sense to people or am I smoking something today?

**Steve Ornstein – Medical University of South Carolina:**

Both could be true. [Laughter]

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Thanks, Steve.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

But I think that captures it from our point of view as functioning as an intermediary, that, you know, we try to respond to both sides of that, and by definition, that defines our accountabilities. ß

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

But thinking directly about Kelly's question, you know, I think in some ways we largely said the accountability is as defined by the Meaningful Use program, because that was sort of our frame, and things have to fit into that accountability. Would others agree with that, or do you think there is more that we need to, uh, cover in terms of the layers or levels of accountability?

**Kelly Cronin – Office of the National Coordinator**

I think maybe – we know we're sort of in a messy period in terms of certification not being the perfect instrument, and we not having anywhere close to semantic interoperability. You know, we have to rely a certain amount on practices or various stock clinicians across settings of care to do the appropriate data capture, data transformation. And then the vendors try to do their magic trying to deal with very different data architectures and trying to get all this stuff to be, you know, reported out in a QRD format that's going to be ending up yielding reliable data. But given that we're just sort of in a messy environment right now I think it's helpful to just not push this all one or two parties but that the responsibilities are clearly articulated across these different levels.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

I'm just thinking about, Kelly, what that would look like. So what we have said is the accountabilities are what they are in Meaningful Use. Can you kind of help us think through an example of what other accountabilities we might consider adding?

**Kelly Cronin – Office of the National Coordinator**

I mean, it may be, you know, clarification of the providers participating, or that we recommend that there just be clear expectations if you're participating in PQRS, or in Meaningful Use, that you know, if you're using certified EHR technology, uh, there is an expectation that that technology will have the capability to report ECQMs in the appropriate format, but that you know, there's also, uh, perhaps an expectation that the data necessary to, you know, compute those measures is being captured as a part of your care delivery process, or as a part of your practice and the integrity of that data is, you know, a shared responsibility between you and your vendor. Um, I don't know how exactly to get at this, but I'm just thinking of, you know, like the challenges around documenting the outcome of a diabetic's foot exam, or Kevin, you know the examples better than I do. There's some difficult things that aren't systematically captured in the appropriate way and that's not something that certification necessarily addresses in a detailed way.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right, this is Micky, but your reporting requirements do. So again, just taking my example, my contractual relationship to the Meaningful Use participant is what binds all that together, so, you know, to the extent that they are ultimately responsible for what I report I am contractually required to you know, to do what they need done, and for both of us together, I'm contractually bound to them to represent to CMS everything, you know, in the fully accurate way that's required for Meaningful Use reporting.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

I kind of like this idea. I don't know if it becomes a recommendation, because I don't know if it can become policy or if it's actually just part of the discussion that we need to be having between intermediaries, government and providers, but you can have a fully certified EMR and then choose to still use Dragon for all your dictation, and it doesn't matter that it's fully certified and it's all structured we can't do what we need to do. And what we find is that, you know, there are a fair amount of physicians that still think that that is our problem as opposed to them needing to take advantage of those technologies if they want to be able to participate in these programs. And I think that to me sounds like the shared accountability issue. And it does raise some questions. I mean, so, you know, the result of that diabetic foot exam are in that note, they're not structured. I mean, I will report what's structured, and that is one version of the truth that accurately reflects the underlying data. And then the physician could say, "No, it's all documented here," and that would reflect another version of the truth that is all documented. And recognizing that, you know, the expectation that the government sets needs to be in line with what is technologically possible for intermediaries, and what those intermediaries require of the doctors, that the doctors are willing to meet the intermediaries halfway ensuring that that quality is a reasonable representation of the care they're providing. To me that's pretty compelling. I don't know how you articulate that in a way other than trying to just talk about that publicly, that this is a shared responsibility.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Well, I think we did try to address in the recommendations when we talked about data capture, we did talk about, uh, sort of the accountability for the data, that essentially the providers had to assert this was good data and whatnot, for the purpose. But I think that where we tried to get at this particular issue.

**Micky Tripathi – Massachusetts eHealth Collaborative**

This is Micky, and I'm going to have to drop off in a second. But just in response to that contract, that comment, I mean, it seems to me that that still flows back to the responsibility being on the provider at the end of the day. I mean, if they're – if we're their agent and reporting on their behalf, but they're responsible at the end of the day for what we report, and the fact that there is a data gap, then it flows back to them to, you know to figure out –

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

To figure out whatever, right?

**Micky Tripathi – Massachusetts eHealth Collaborative**

What is the reporting that is going to make sense. If they feel that what we're going to report isn't an accurate representation of what's in their system. You know, if we have a customer who we don't get this information and we're always reporting back zero denominators and next week I'm going to be meeting with them and I'm going to say, "I think you should drop the measure because you cannot get that data to us, so it doesn't make any sense for us to carry the measure anymore."

**Kelly Cronin – Office of the National Coordinator**

Yeah, I think it does seem like that. Maybe it's not sort of a policy per se that clarifies this, but it's just a shared understanding we need to make sure that everybody has, and if it can be reinforced through an expression in rule making or in other outreach, or certainly in contractual arrangements between the provider and the intermediary but I guess for the purposes of just communicating the recommendations it would be helpful to maybe just point this out.

**Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Where here's a component where actually rule and regulatory does come into play. Because as the data submission vendor under PQRS, you know, CMS requires us to warrant that we are accurately reporting the care that's being delivered, right? And we are accurately reporting it as far as we can get at structured data. But, you know, we routinely report that only 15 percent of patients have a lipid panel for cardiologists. I don't believe that that's accurate at all. Um, but it is accurate in terms of what's structured and technically fulfills every component of how that particular measure is constructed. And it makes us nervous because we're warranting that, but we know down well under certain auditing conditions, under certain judgments, that you could come to a different conclusion. And that's – that's where this kind of concept that you're putting forward then hits a regulatory or a legal requirement that can make us very uncomfortable at some point, even though we're trying to do absolutely the right thing as per all these different stakeholders.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Right. So, Kelly, do you think we kind of captured your question and at least gave it some reasonable thought?

**Kelly Cronin – Office of the National Coordinator**

Yes, absolutely.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Any other topics or questions before we, uh, solicit some public input if there is any? Kevin, anything else you'd like to throw out?

**Kevin Larsen – Office of the National Coordinator**

Just thank you to this group. Marc and I talked last night and we've been talking with the chairs of the Quality Measures Workgroup. We do not plan to have more scheduled meetings of the Data Intermediary Tiger Team unless there is new charge from the Quality Measures Workgroup or the Policy Committee. So we thank you for your service and for now we will uh, make this a dormant taskforce, but we may – the Policy Committee may call on you again in the future if you're willing to serve again.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

I want to add my personal thanks to everybody for diving into this very murky and challenging area. As always, I learn a lot from everybody, and sure appreciate that. So with that, operator, if we could open the lines and see if there are any public comments that we can enjoy?

**Public Comment**

**Operator**

If you'd like to make a public comment and you're listening via your computer speakers, please dial 1-877-705-2976 and press \*1. Or if you're listening via your telephone you may press \*1 at this time to be entered into the queue. We have no calls at this time.

**Marc Overhage – Chief Medical Informatics Officer – Siemens Healthcare**

Thank you, operator, and thanks to everybody for their time today. I hope our colleagues at ONC have enough to go forward with to the Policy Committee so they can complete their recommendations and I hope everybody has a wonderful holiday season. Thank you.