

Clinical Quality Workgroup
Draft Transcript
May 7, 2012

Roll Call

Operator

All lines are now bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good afternoon everyone, this is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Standards Committee, Clinical Quality Workgroup. This is a public call and there will be time for public comment at the end. The call is also being transcribed, so please be sure to identify yourself before speaking. I will now go through roll call and at the end, ask any staff members to also identify themselves. Jim Walker? Karen Kmetik?

Karen Kmetik – Vice President - American Medical Association

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks Karen. David Baker? Keith Boone? Ann Castro? Christopher Chute? Jason Colquitt?

Jason Colquitt – Executive Director of Research Services - Greenway Medical Technologies

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks Jason. John Derr?

John Derr – Golden Living, LLC

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks John. Bob Dolin? Floyd Eisenberg? Rosemary Kennedy? David Lansky? Brian Levy? Robert McClure?

Robert McClure – Chief Medical Officer - Apelon, Inc.

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks Robert. Galen Murdock? Gene Nelson?

Gene Nelson – Dartmouth University

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Gene. Eva Powell? Philip Renner?

Philip Renner – Kaiser Permanente

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Philip. Eric Rose?

Eric Rose – Intelligent Medical Objects

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Eric. Danny Rosenthal? Joachim Roski? Randy Woodward? Kate Goodrich? Kim Schwartz? And is there any staff on the line that can identify themselves?

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

This is Jacob Reider from Office of the National Coordinator.

MacKenzie Robertson – Office of the National Coordinator

Thanks Jacob.

Dana Womack – Office of the National Coordinator - Contractor

And Dana Womack, Office of the National Coordinator Contractor.

MacKenzie Robertson – Office of the National Coordinator

Thanks Dana. Okay Karen, I'll turn it over to you.

Karen Kmetik – Vice President – American Medical Association

Thanks very much MacKenzie and welcome everyone. Thanks so much for being available here, late in the day on a Monday. Jim Walker unfortunately could not join us today and Jim really is the expert in so much of this, so, I will do my best and will look to all of you to help guide me. If we look at the agenda for today, I think we all recognize that over the past couple of weeks we have divided our workgroup into two Tiger Teams. One Tiger Team has been working with Jim on recommendations around value sets in particular. Another group has been talking with me about recommendations regarding characteristics of optimal measures for EHR and so what we're here to do today is to review with everyone on the workgroup now, the recommendations that have come forward from the first Tiger Team that Jim has led, and they are a bit further along than our Tiger Team. They've got them in some nice recommendation format here. So, we want to go through those with everyone, get any additional comments and see actually if we're ready to approve those, or we could also go do email pooling on those and then to update everyone where we are with the second Tiger Team. Does anyone have anything to add to the agenda?

Keith Boone – GE Healthcare

This is Keith Boone, they finally let me in.

Karen Kmetik – Vice President – American Medical Association

Hi Keith, welcome. All right then, I am moving along to slide 2, and again, that's just to recap the timeline for the essential components or value sets Tiger Team, where we are and we're all striving to have our report into the Standards Committee by May 24, that's the outside deadline for all of us. So, let me turn to slide 3, and this outlines the scope of recommendations, again, this is concentrating on the first Tiger Team essential components, the value sets. So that team is reporting out that what was in their scope was a value set infrastructure to support Meaningful Use Stage 2, that includes the validation of vocabulary codes, the hosting, the delivery of the value sets, the standards for value sets and the transferring standard for serving value sets and this Tiger Team is saying that they considered outside of their scope, something for longer term talking; discoverability, harmonization, maintenance, verification, schematics, validity and the governance content management and versioning control, which of course will be important. But this was how I believe that Tiger Team is recommending what they felt was in-scope and out-of-scope. Does anyone want to comment on this, in particular from the Tiger Team or ONC staff, are we good? Okay. So lets move into the recommendations of the team on slide 4, and I think we need to just go through these and get everyone's reactions.

So, recommendation 1 is, and I won't read the whole slide, you have them, but in summary, to establish the NLM as a single authority for the validation of value sets using stage 2 to have NLM serve as the source for the value sets, to publish updates and to interact with value set stewards to keep them up-to-date, that ONC should coordinate with other agencies as well, as seek NLM to host these value sets and I know there was some discussion about what does it mean when we say NLM will provide validation, and I think their dot point is an attempt to describe that, that NLM would cross-check the accuracy of the value sets by comparing value set codes and descriptors against source vocabularies, suggest edits for the value set stewards, etc. So, let me stop there and see if there are any questions, comments about this recommendation one.

Eric Rose – Intelligent Medical Objects

Hi, this is Eric Rose, I cannot see the slide, so I don't know if this is addressed, but, was there any discussion of expressing value sets in terms of high level concept in ontology and all its descendants, you know, as high level SNOMED CT concept rather than just a list of all the potential codes because the maintenance issues are less with the former.

Keith Boone – GE Healthcare

This is Keith. In the slide deck that we have, and in the discussions that we had, we didn't get into representation of the value set definition, only of the value set expansion. Thank you.

Robert McClure – Chief Medical Officer – Apelon, Inc.

Hi, this is Rob McClure. A couple of comments on this; first off, this is a wonderful set of material, looks like they did a really good job. The one area that I think aligns with this bullet is something that I don't have a real succinct way of discussing, but, it aligns with cross-checking accuracy and that is, I think the importance of establishing a process where a curation and validation process can be accomplished, understanding that the measure developers for value sets that are associated with quality measures, are often going to be less, I'll say the final arbiters, but, it would be helpful if the NLM, or whoever is charged with eventually curating this process, would also be expected to validate the value sets in the context of use. And by that I mean, kind of take them a little bit outside of just the measure developer and standards . . . the standard terminologies that are used. So, that's one thing. And that aligns to some extent with what Jeff just talked about.

The other thing, and I've had some emails that I've sent out, but I haven't really gotten much response on this, is that in our work that we've been doing, we've had some concerns about the situation when you have multiple terminologies that are in play; you know, right now with MU 2, we have preferred terminology but we also have some transitional terminologies and it's common that, particularly with quality measures that are being retooled, there's an attempt to allow for, not only the primary terminology, but use of the transitional terminologies and the fact is that you can't very often have consistency in meaning when you use more than one terminology. In other words, the sense of meaning from when one uses, let's say, preferred terminology like SNOMED and then attempt to line up, I would say exactly, using another terminology is very difficult and so, I think it would be valuable for this group to in some way address the fact that, at least acknowledge that the use of multiple terminologies will not often lead to equivalent measure assessment, and that's it for me.

Karen Kmetik – Vice President – American Medical Association

Thanks Rob. I think your first comment about validating certainly rings true to me, and that seems to be maybe something that we could add to this recommendation, asking Ellen to think about that. In terms of the transition sets, everything you say of course is true, I guess I'm just not sure if that's a recommendation for NLM or that's a recommendation for ONC and CMS.

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

Rob, this is Jacob, I would ask what's the alternative; because I agree with Karen spot on, but what's the alternative. You have stuff that's in use now, and my sense is that the proposed transition sets are an attempt to reflect the fact that maybe, you know, ICD is in use today and SNOMED CT will be in use tomorrow and therefore one would use ICD or allow the use of ICD, even though it can't really do one-to-

one granular mapping where it needs to, so, semantics are going to be different. But, what's the alternative, do you just push them right to the endpoint now or do you have nothing transitional or is there something better?

Robert McClure – Chief Medical Officer – Apelon, Inc.

I think there is a transition it's a little more complicated, but it speaks to the facts that you're outlining, and that is that in some situations, not often, but in some situations, the existing, and that's I think transitional terminologies currently are in play because, as you mentioned, that they're used right now. I mean, it's not that I think the intent is to allow for these things to continue forever, but the fact is, in some situations, these are the terminologies that are currently in play. So, there are, you know, for quality measures that exist now, often times may actually utilize those terminologies. And so, in a way, and I'm not suggesting we would use this phrase, but in a way, those terminologies in the case of existing quality measures, are really the preferred terminology, if the intent of the quality measure is to say the same.

Now, what we've also found is that many times those terminologies are used by abstractors to in a sense, begin the process; and then they go in and review the content of the record and capture much more detailed nuances that, in fact, align perhaps with SNOMED and so that if in a future state where more detail is captured with SNOMED, it's possible that the SNOMED concepts could actually capture the abstraction process more accurately and that's great. So in those cases, this is a really good example of when the measure has originally defined, actually had let's say ICD-9 in it, and you might find concepts that align with that, but when you talk to the measure stewards, they say, well yeah, that's kind of what we were getting at, but when we go and select patients rationally subsetting those patients even more specifically, and we're left with a situation where one set of, let's say transitional terminology, may align with the set of concepts that were used for the original measure, they don't actually align with what the measure stewards really want to have happen.

And so, I think that's one example, there are some other examples with slightly different use case scenarios, there are a few, and I . . . for example, right around billing, when you're looking for patients who are actually having a billing event, then it's . . . even though it's a transitional terminology, it may be the best terminology to be identified for that particular piece of information. So, what I think I'm saying is that we would say that there's a set of concepts that are usually associated with preferred terminology and that that's really all that's the target, and that anything else is only of value if the measure stewards say that the quality measure can be met using that other terminology; so, even though it's a possibility, that's what a transitional terminology means. It would be up to the measure stewards to say, yes, that value set works or no it doesn't. Right now, in our experience, it's a little unclear based on current guidance from the ONC, as to whether all of them are equally valid, and I think what we need to do is get help from the measure stewards to say when they are not equally valid.

Karen Kmetik – Vice President – American Medical Association

So that description, I do understand Rob, and I do agree that that's something that measure stewards speaking as one could take on. I think in terms of though NLMs role, I would think it would be to represent all value sets that are deemed for specific purposes, clearly label them as such, validate them and such, but I'm not sure that NLM could do much more.

Robert McClure – Chief Medical Officer – Apelon, Inc.

Yeah, just to be clear, I know that this recommendation was kind of simple as to establishing NLM; this is more an issue that I'm not sure where to stick it, but it's an issue that speaks to the recommendations that ONC is providing and then whoever, and I am certainly in agreement that NLM is the correct initial choice, but whoever then has that role of the overall steward for this process, this is some of the information they would need to take into consideration.

Karen Kmetik – Vice President – American Medical Association

Um hmm, yeah, I agree, um hmm. Any other points on or related to recommendation one?

Eric Rose – Intelligent Medical Objects

This is Eric Rose, once more. I wonder whether, keeping in mind that the NLM has very limited resources, whether it might be appropriate if a terminology creator, the SDO, takes it upon itself to say, these are the value sets for one or more high level conditions or procedures or concepts of any kind, to at least give whoever is anointed to define value sets the option to accept a terminology creator's definition. So, in other words, if . . . I doubt that it would happen, but if LOINC or ICD-9 CM or whatever declared, you know, here's . . . we've made some value sets, it would be good to use them because nobody knows their terminology better than the ones who created it.

Karen Kmetik – Vice President – American Medical Association

Yeah, I could see that another way too, saying that while those who create the vocabulary certainly have knowledge of their structure and their design, when one is creating the quality measure, one also has a certain belief of the types of patients you're trying to identify, the types of procedures, the things that are meant to represent the measure which represents the evidence and I would think he'd want those two to consult, but I don't know that he'd want the . . .

M

Who?

Karen Kmetik – Vice President – American Medical Association

. . . you know, the vocabulary owner to be defining value sets, it's just coming at it from a different direction. Anyone else feel . . . have a comment on that point? All right . . .

Robert McClure – Chief Medical Officer – Apelon, Inc.

Actually, this is Rob, I would agree that this is, to some extent in my mind captured by that second bullet and that whoever is responsible, NLM, would need to interact with all those stakeholders. Jacob's absolutely right that in many cases, particularly the complex terminologies, the SDO is more knowledgeable than anyone else about what its true meaning is and what its intended use is and those are both important. So, they should certainly be responsible for interacting with all of the stakeholders, it gets back to my original point about the fact that in doing this, as important as the measure developers are in terms of defining the intended need, this needs to be externally validated with use and that uses both, you know, people who capture data about patients, but also the developers of the terminology.

Karen Kmetik – Vice President – American Medical Association

Thank you. I think we can definitely note those few points and see what other channels we can communicate those to ONC. I'm noting that now. Moving to recommendation 2 if we could; so this, I think, is just speaking to the urgency, so ONC should expedite the recommendations of both the implication workgroup and the vocabulary task force related to establishment of this publicly available value set repository. Any comments on recommendation 2? All right, recommendation 3 is that the value set repository established by NLM should build upon the IHE sharing value set profile and incorporate CTS2 methods for managing vocabularies referenced by value sets. This one is a little out of my league, so I'm looking to all of you to see is this something you agree with, does anyone have comment?

Robert McClure – Chief Medical Officer – Apelon, Inc.

So, I'll start; there're probably a couple of us. So the one issue with this, and I believe it's a good recommendation, but it's a starting point, is that this gets to the comment previously about the ability to establish what we call an expression that will allow for a concept to be selected in all of its descendants, perhaps mine and others. The existing IHE sharing value set profile doesn't support that. I think, as there's interest in trying to extend it to support that, that would be very important because being able to describe value sets as an expression is a critical part, I think, of creating something that's really useful.

Karen Kmetik – Vice President – American Medical Association

So it sounds Rob, like you're emphasizing the words "build upon," that it doesn't get us all the way there yet, we need to build on it.

Robert McClure – Chief Medical Officer – Apelon, Inc.

That's exactly right.

Karen Kmetik – Vice President – American Medical Association

Other comments on this?

Keith Boone – GE Healthcare

This is Keith. As I said earlier, the SVS profile represents the value set expansion as opposed to the value set definition, umm, and yes, I agree with Rob that there should be some capabilities to show what the value set definition is subsequently, but I think this is a good first start.

Karen Kmetik – Vice President – American Medical Association

Thank you. Okay. Recommendation 4 speaks to establishing a web service for both human and machine readable consumption of the value sets with some considerations there to provide output in commonly used formats and to support the creation of web-based views based on the measures and value set names, etcetera. This is a little bit around some of those formats we'd like to see it in once it's established. Comments on 4? Okay. Great, I think we've got support for the recommendations, a few notes to enter in another communication vehicle. Slide 6, I think, is just a visual representation of what we've been talking about. Anyone have a comment/reaction to slide 6? Slide 7 then is an attempt to represent some of the roles of the quality measure stewards who would also be developing value sets, consensus organization, NLM. I'm wondering if here is where we want to add anything?

Robert McClure – Chief Medical Officer – Apelon, Inc.

I think that middle swim lane, or consensus organization perhaps is where, if any of . . . this is the first place in my quick review of the material, where I see something that's somewhat separate, you know, in terms of the sort of things that I was mentioning with the being either NLM or someone else is responsible for bringing together views on this content as a consensus process, so I don't know if the consensus organization was mentioned elsewhere and I missed it, or what that organization is responsible for, but if its intent is to take this material, make sure that it does vet this with the appropriate stakeholders and perhaps make modifications or suggest the changes to it in order to be able to kind of create the most valuable value sets that are needed for the quality measures and then those get sent off to NLM for the NLM to do the kind of technical process. Then, that makes sense.

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

Yeah Rob, this is Jacob. I'm not sure necessarily even that these swim lanes are serial, and that's not the breakfast cereal, and they may actually go, you know, things may bounce back and forth. I could see a measure set developer developing something and bouncing it to NLM and NLM making recommendations and then perhaps the consensus would say . . . would provide a service that would validate that a set of objective experts agree that this value set represents the semantics that the measure developer intended. But, it's not as much of a quality check so much as a semantics check; much like the quality measures themselves are reviewed by a consensus org, such as NQS. So, I think that was the intent of this slide, if others disagree, speak up, but I think that was what I remember from this part of the conversation.

Robert McClure – Chief Medical Officer – Apelon, Inc.

That sounds like that aligns very well with my concerns and so, it would, I think, meet that need well.

Karen Kmetik – Vice President – American Medical Association

Thank you for that. Then I'm moving on to slides 8 and 9, which I think are really just meant as a sort of potential look at what information might be in a repository, just an example provided there. Any comments on that?

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

Do people like what they see? Is this helpful when you close your eyes and now you can think about this a little bit more concretely. Does it align with what people would expect it to look like or is it vastly different in some way?

Robert McClure – Chief Medical Officer – Apelon, Inc.

Jacob, this is Rob McClure, it aligns with what I imagined reasonably well, I think.

Danny Rosenthal – Director of Healthcare Intelligence - INOVA Health System

This is Danny, ditto that.

Karen Kmetik – Vice President – American Medical Association

It does help to see it. Well then my question is, it sounds like we are all very supportive of the recommendations. I guess I'll ask ONC staff, are we seeking a formal approval from the workgroup or do we need to have a quorum and therefore we need to do it by email? How shall we proceed?

MacKenzie Robertson – Office of the National Coordinator

You don't need to have, this is MacKenzie, you don't need to have a formal quorum of the workgroup, so, whatever you decide today, you can obviously, when you know, fill in Jim behind the scenes, but it doesn't have to be a formal vote or anything like that.

Karen Kmetik – Vice President – American Medical Association

Then I guess I would summarize it that those on the workgroup today are supportive of the recommendations of the Tiger Team regarding value sets. Does anyone disagree with that statement? Okay, then that's what we will relay to Jim and the others. Moving on . . .

Eric Rose – Intelligent Medical Objects

This is Eric. I certainly don't have any disagreement with the recommendations. I wanted to just, one additional thing for the Tiger Team to consider which is, what happens when there's a legitimate deficiency in a published value set and do we need an escape valve that will allow healthcare provider organizations to modify the value set when it's necessary to do so because the published value set has either slipped out of date or it has an omission, or what have you. I think it's more likely that it'll slip out of date, because new codes get added all the time to source terminologies. Or at least that there should be some allowance for, if you do that in good faith, it doesn't necessarily invalidate your status as a meaningful user or something.

Keith Boone – GE Healthcare

So, this is Keith. One of the things that the essential components workgroup declared out of scope was governance and what you bring up, is an issue of governance and specifically an issue of governance and specifically an issue of governance as it's related to the Meaningful Use rules and ONC. And in that context, I think we could look at that in further work in the workgroup, but, it was something that was not in the original scope.

Eric Rose – Intelligent Medical Objects

So maybe its feedback that should be directed to the Health IT Policy Committee or some entity that, "hey, there is a potential risk here" that we might box provider organization, EHs or EPs into acting irrationally in order to comply.

Karen Kmetik – Vice President – American Medical Association

Yeah, Eric, I think your points are well made and I think we're saying we'll refer that back for more longer term discussion, it comes under governance and I think it also comes under versioning, how to set up the system to hear about unintended consequences, that type of thing.

Eric Rose – Intelligent Medical Objects

Okay, thanks.

Karen Kmetik – Vice President – American Medical Association

Um hmm.

Keith Boone – GE Healthcare

This is Keith. I'd actually like to expand upon that point. I think with the publication of value sets, one of the things that ONC should also consider is a way to keep track of, and publically make available, the issues, ... reports, etcetera, that folks might have with the use and questions about, for example, the use of values so that it's easy for organizations to see what's going on and what other people have encountered and see what the status of any issues that were raised were.

Karen Kmetik – Vice President – American Medical Association

I think that's a good recommendation for ONC, yes. Anything else? Okay, moving on then to slide 10, this is mostly by way of an update for those who are not on this second Tiger Team, but of course, welcome comments from the team; to let you know that we've been thinking about what are attributes that we would be looking for in measures that are re-tooled. We also talked about that word, which I'll get to in a minute, or created newly for EHRs. And so, when we think about our scope, on slide 11, we wanted to look at the measures and EHR specifications from the standpoint of a technical lens. So, out of our scope was whether it's a measure that we want or not; so, we're making an assumption that other processes have occurred such that we have measures before us that are those that are important, matter relevant and we're trying to figure out what are the criteria we would apply to make sure they are EHR-ready, if you will and that they're also leveraging the EHRs. So, we're looking at this in terms of all types of measures that likely will be those that come forward in hopefully the near future.

Slide 12 has our time frame, which is, as I said, a little behind the other Tiger Team and with apologies to the team, while I have some of you on the phone, we didn't get the recommendations out to you on Friday, trying to do that by mid-week so they'll be in a form that you can react to. We have the same deadline in terms of going to the Standards Committee by May 24. Slide 13 I think is really redundant. Slide 14 begins to outline the different criteria that we've been trying to define and then think about how would we apply the criteria. Right now we have it grouped under usability, feasibility, accuracy and standard terminology. On the next slide 15, the definitions we're looking at in terms of usability have to do with are the data available now or could they be available with reasonable workflow changes. So here we're thinking of it from the perspective of, the practice sites either entering or acquiring the data. We're also trying to avoid redundancy in data capture, unless there's an obvious reason why you might want to, if you're prompting clinical decision support, care coordination, etcetera. But, that's how we're thinking about usability.

I will go through one more and then I'll pause. Feasibility we're thinking more from the standpoint of the EHR, does the functionality support the quality measure exists or could exist with reasonable stretch, and then we talk about EHR-enabled, which is a little fuzzier, but is the measure and the accompanying specification enabled by the electronic format. Are we really leveraging the EHR capability? Let me just stop there in terms of the framework we're looking at and definitions and see if there are any initial comments. All right, let me move forward. We're also looking at accuracy, which has many components that we talked about. The data could be captured correctly, but are we also querying it correctly. Are there any errors in the actual entry of the data, what is our knowledge about whether the source is accurate and we do want to make sure though that we're not making a lot of assumptions about how the collection actually happens, but, perhaps a value should be provided on ways to do that.

When we think about standard terminology, I think this relates to what we've just been talking about. We would apply criteria when we look at a measure through this technical lens, does . . . is the measure specification using the standard terminology so that we can eventually get to some comparison. This relates to what Rob you brought up, I think on this call, about transitional sets being used. And then, so what we're trying to do is look at these criteria, in our discussions and in our most recent as well, we were thinking about well would we apply them differently or would we have different thresholds depending on

the type of measure, whether it's process, clinical outcome, patient-reported outcome, delta measure; and I think where we are now is that they're really the same regardless of the type of measure, there may be some nuances as we look at the information against the criteria, but they pretty much stand for the different types of measures and one thing that I know I'm thinking about how to turn into the recommendations for the Tiger Team to think about is, how do you then interpret the results.

So, whether you do a feasibility study at practice sites, whether you do some dummy data sets that you share with vendors, you do surveys; whatever is the method by which you're getting information about this measure and the EHR specification, and then you apply that so it's binding to our criteria, how you make that some interpretations of whether something is ready or not for a stage of Meaningful Use. So, let me stop there, particularly to see if the Tiger Team members want to comment and then welcome any thoughts from others, as we continue on this journey.

Robert McClure – Chief Medical Officer – Apelon, Inc.

This is Rob. I think that that does seem to align reasonably well with some other material we just saw from the other Tiger Team, so, I have nothing really else to offer, unless we think that it does dovetail in for some of the spots that were highlighted, so that's good to see.

Karen Kmetik – Vice President – American Medical Association

Yeah, I do think this is one where we're all going to need to look at the recommendations as we try to frame them up in the next couple of days for you all and that's where I think it'll make it a little more real. We've had great, great discussions, a lot of information filtering through. This is a tough one, I think this is a tough one; how to structure it in a set of recommendations. All right, well stay tuned, more to come on that in the days and weeks ahead. I will now see if we have any public comments.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Operator, can you please open the lines for public comment.

Caitlin Collins – Altarum Institute

Yes. If you are on the phone and would like to make a public comment, please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any questions at this time.

Karen Kmetik – Vice President – American Medical Association

Thank you. Any final comments from anyone on the call? Well, I thank you all very, very much. Hats off to Tiger Team for seeing it through to a set of recommendations and we'll get somewhere similar with second Tiger Team soon. Thanks everyone.

M

Thank you, good bye.

W

Thank you.

M

Thank you.