

**Information Exchange Workgroup  
Subgroup #2: Care Coordination & Patient/Family Engagement  
Draft Transcript  
July 20, 2012**

**Presentation**

**Operator**

Thank you, all lines are now bridged.

**MacKenzie Robertson – Office of the National Coordinator**

Thank you. Good afternoon, everyone, on 5 o'clock on Friday. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Information Exchange Workgroup Subgroup #2 on Care Coordination and Patient and Family Engagement. This is a public call. There'll be time for public comment at the end and the call is also being transcribed, so please make sure you identify yourself before speaking.

I'll now do the subgroup roll call. Larry Garber?

**Lawrence Garber – Reliant Medical Group**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Larry. Jeff Donnell?

**Jeff Donnell – No More Clipboard – President**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Jeff, and Peter DeVault?

**Peter DeVault – Epic Systems – Director of Interoperability**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Peter. Are there any other workgroup members on the line?

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Micky Tripathi.

**MacKenzie Robertson – Office of the National Coordinator**

Hey, Micky, thank you. And is there any staff on the line?

**Seth Foldy – Centers for Disease Control and Prevention**

Seth Foldy in ... workgroup.

**MacKenzie Robertson – Office of the National Coordinator**

Oh, great, thanks, Seth.

**James Daniel – Office of the National Coordinator**

James Daniel from ONC.

**Michelle Nelson – Office of the National Coordinator**

Michelle Nelson from ONC.

**Tari Owi – Office of the National Coordinator**

Tari Owi, ONC.

**Kory Mertz – Office of the National Coordinator**

Kory Mertz, ONC.

**MacKenzie Robertson – Office of the National Coordinator**

All right. I will turn it back over to Larry and Jeff.

**Lawrence Garber – Reliant Medical Group**

Sure.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks.

**Lawrence Garber – Reliant Medical Group**

So, Jeff, do you want me to pick this up here?

**Jeff Donnell – No More Clipboards – President**

That would be great since I'm, since I'm driving. I've printed out all of the materials, but, you know, I'm going to try to also drive safely here.

**Lawrence Garber – Reliant Medical Group**

Good, good call, here. It's easier because I can actually see the, the slides popping up. So as, as you know, we've been tasked to work specifically on longitudinal coordination of care and patient engagement, ah, and making recommendations for Stage 3 to bring to the IE Workgroup meeting on Wednesday. Is that right, Micky?

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Yes, that's right.

**Lawrence Garber – Reliant Medical Group**

Okay, so, we've been trying to come up with a framework for that, so I think if we could go to the, the next slide.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

And, and just, you know, we, we sort of just need, you know, initial thoughts, initial perspectives, and we have, we have a, a long time to refine, but you know, as far as, as far as you could get is great, because that gives us a good starting place in a lot of this to get the, as much early course guidance from the broader workgroup as we can.

**Lawrence Garber – Reliant Medical Group**

Excellent, and so we've got so Jeff and I are, are co-chairing this, and so we've, you know, we're going to certainly be juggling this around and hopefully not the steering wheel as Jeff is driving right now. We do have, ah, Peter DeVault has volunteered to be on this, as well as Jonah Frohlich and Arien Malec. Are, are Jonah and Arien on the call?

**MacKenzie Robertson – Office of the National Coordinator**

This is MacKenzie. I don't see them as logged in.

### **Lawrence Garber – Reliant Medical Group**

Okay, all right. Next slide please. So, there, on the slide we really have, we talked about three different areas, but in a way from my perspective there are, there're really sort of two areas that we're, we're talking about. Um, one is sort of patient driven communication, which is really the, both the, the communication to the patients and their family and also from the patients and their family back to the providers and care teams, and that, that can have a whole slew of functionality. Um, you know some of them are, ah, you know, the, the, the view download transmit, ah, that we've talked about, um, and it can be directly to patients or it can be their, um, their devices, home devices. Um, some of this can be educational. Some of it can be self-management. Some of it is secure messaging, so there's a lot, a lot, ah, tied in with that.

And then the other is, is really the care coordination piece, um, between the care, among the care team, um, and that, that involves both transitions of care, um, as well as, ah, extreme transitions of care, where you're actually talking about, um, you know, data portability from one EHR to another. And that can be both within, ah, a single practice when you're buying a new EHR to replace an old one, ah, or it's really a patient moving from one primary care physician or care team to another.

Those are probably the similar kinds of problems. And then, and then in terms of the transitions, those are typically when a patient is, is moving from one setting to another of care, but there's also, there's also care coordination that takes place with patients not actually moving at all, so that, um, you know, that there are the care teams that are working. Patients aren't actually moving necessarily. They may very well still be sitting at home, but you've got the primary care physician and home health agencies and, um, and specialists all trying to coordinate their care even if the patient is not actually doing transitions through those. So, um, so it's, so in my mind it's almost lumped into two categories.

I don't know, Micky, does that feel comfortable with lumping the data portability into transitions, or do you think that, that really should stand out separately?

### **Peter DeVault – Epic Systems – Director of Interoperability**

This is Peter. I think I might have even suggested something like that earlier, so yes, I'm fine with that.

### **Arien Malec – RelayHealth**

This is, this is Arien and I think there's actually three sub-categories for care coordination or care transitions. One, as you said, is the, is the care transitions patient, patient moving from one care setting to another and back, um, and that there are the typical cases there would be, ah, close loop referral, admit/discharge and the various flavors of admit, admit/discharge from ambulatory or from long-term care. There's the, there's the data affordability piece of it. That does, I think it's a little ..., but, but has some of the same issues, so it probably does belong there.

And then the third piece, and you kind of alluded on it, is in a heterogeneous IT environment where there is a virtual care team who is providing, ah, providing or coordinating care for the patient, and I would put into a list of actors, ah, not just primary care and specialty, ah, but also care navigators and you said, you know, home health as well. I'd also put in there care navigator, or care coordinator, nurse educators, etc., where's there's a virtual care team that's organized around a ideally organized around a single or singular view of the patient and the distinction between that and the first is that in the transition I can get away with sending a snapshot of the patient to you, and then receiving a snapshot of the patient back to you. Um, in the virtual care team, I may need to have central access to, um, the plan of care and the active med list, problem list, allergy list etc., um, as, as a longitudinal concept.

### **Lawrence Garber – Reliant Medical Group**

Agreed.

**Arien Malec – RelayHealth**

And then, and then maybe a fourth one is emergent care or unexpected care, um, which is, you know, a lot of the HIE problem domain has been centered around, historically centered around the emergent care model. I think it's now getting much more focused on transitions and coordinated care. In the emergent care, I haven't had access to this patient, um, or haven't cared for this patient, but know that he or she has been seen and has had encounters and you can get access to the latest information.

**Peter DeVault – Epic Systems – Director of Interoperability**

So Arien that, that last bit is, ah, what I usually consider the query response model. Are you seeing that differently?

**Arien Malec – RelayHealth**

Um, well, I guess I'm focused on the, I'm focused on the clinical need first, and then the enablement second, but I would agree that generally the way you enable emergent care is in a, is in a query response model.

**Peter DeVault – Epic Systems – Director of Interoperability**

Yes.

**Lawrence Garber – Reliant Medical Group**

Excellent, so let's go to the next slide, and I think we'll all on the same page of that, right, Arien, that's well put. So, we're trying to come up with sort of a strategy of how to think about what, what we might want to see for the Stage 3. And we thought that it made sense first to start with what's already been established for Stage 1 and Stage 2 and to see how these may relate to, to Stage 3, um, whether, ah, whether things should be dropped, added, expanded, you know, bars raised, and then move onto other, you know, other additional criteria that, that may not, um, you know, had been in, in and thought of in Stages 1 and 2, or, or addressed in Stages 1 and 2. Does that sound a like a fair approach to everyone?

**M**

Yes.

**M**

Yep, sure does.

**Lawrence Garber – Reliant Medical Group**

Let's see, what's, what do we have for the next slide? Now we thought that there're essentially some guiding principles as we, as we think about each of these, whether they're existing objectives or whether they're new ones. And so there's some general meaningful use criteria that are being shown on this slide for those that are driving in the car, that are out there as guiding principles and then there are a few specific to our, to our work group. So, the general ones being, you know, to support, you know, new and emerging or, or rehashed old models of care, you know, that are team-based outcome oriented population management, you know, patient centered medical home, ACO kind of stuff. Also it addressed, you know, national priorities that are out there, you know, like a million hearts, that are, are broadly applicable, you know, to, you know, the fact that we've got eligible professionals, we've got hospitals. We've got the patients, you know, throughout and their specific needs, and, you know, applicable geographically across the country, not just in Boston.

And then also, you know, to promote, to promote advancement to move things forward, from, from where they had been, especially if the market forces by themselves, they're not going to make that happen. Um, and, and then also try to be realistic and achievable, ah, try to work where there are mature standards or are rapidly evolving, um, you know, standards, ah, that are hoped to be widely adopted by 2016. Um, actually, is it, is it in 2016 starts in October of 2015. Is that right?

**Arien Malec – RelayHealth**

That's normally when the fiscal year for hospitals starts.

**Lawrence Garber – Reliant Medical Group**

Right, okay, so there's plenty of time.

**Arien Malec – RelayHealth**

Are we, sorry, that's actually news to me. Or it took us three years to go from Stage 1 to Stage 2 and the timeline even still is uncomfortable. Are we thinking we're going to go two years from Stage 2 to Stage 3?

**Lawrence Garber – Reliant Medical Group**

Micky, do you have your finger on that pulse?

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

I think that's the current schedule, but I think some of this was done, you know, the table that was in the end, the preamble of the NPRM.

**Arien Malec – RelayHealth**

And, and my reflection on what it took to get to stage, to get the really pretty modest expansions between Stage 1 and Stage 2 with better, ah, better standard support, I think of Stage 2 as Stage 1 with better standard support in many ways. Um, three years wasn't enough, although it's going to have to be, um, and there's a, there's a tension between the timeline and the ambition. And this is a, this is a, so if we think of Stage 2 as Stage 1 for real with better standards support and better information—

**Lawrence Garber – Reliant Medical Group**

Then we need a Stage 4.

**Arien Malec – RelayHealth**

This is, this is a, this is a big leap over, this is a big leap over Stage 2.

**Michelle Nelson – Office of the National Coordinator**

So this is Michelle of ONC. So part of it, so Paul put together the general meaningful use criteria, Paul Tang, um, to just kind of start to think about those things and make sure that what we do for Stage 3 is feasible, and we aren't having lost vehicles that we may not be able to have, um, standards ready for. Um, that's part of the reason why he put those together to kind of help ground the Meaningful Use Workgroup. And there has been a lot of talk around the timeline and where we'll land. And a lot of that can't really be solidified until we find out when the Stage 2 final rule will be published. Um, so there is a little bit of uncertainty out there, um, and I think once that's published, we'll have a better idea of, you know, timelines and deeds and, you know, where we can actually go with Stage 3.

**Arien Malec – RelayHealth**

Right, and, and so I do think we ought to have a recommendation or point of view of the IE Workgroup as this, in this intersection between ambition and timeline, what the right, what the right staging, if you will, is.

**M**

Right, and I agree with you. I think that makes sense to keep as a, you know, sort of a perhaps a second overarching recommendation or another over-arching recommendation aside from the specifics, so we may even want to consider, you know, sort of a two-step, um, sort of set of recommendations if we want to ultimately divide them into, you know, a 3A and a 3B or something like that if we really ... some are more easily, some of them are easy to accomplish, um, versus others.

**Lawrence Garber – Reliant Medical Group**

All right, so this is what we think could be achieved by, you know, by the fall of 2015, and if we have a little bit more time, this is what we'd to also see achieved.

**M**

Yes.

**Lawrence Garber – Reliant Medical Group**

All right that makes good sense. The, the other, um, the other criteria that we, um, talked about adding to the list, um, the, the one I threw out there is, you know, is the hassle free health information exchange sort of making it easy. Um, what are the things that we can do to automate the processes, so that it fits more stream, you know, more streamlined fashion into health care, so that it's less of a hassle for providers. It's less of a hassle for patients.

Um, and, and I guess, that, that, Micky, I guess you had consolidated our gains there. What, what specifically were you—

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Yes, that was, um, you remember in our IE Workgroup we had, um, I think it was the last meeting or the one before, we were just talking about first principles, um, and you know, how should we think about that. And if you remember, we had sort of thought about, you know, as an overall strategy, do we want to think about, you know, consolidate our gains versus, you know, sprint to the summit, you know, sort of an ACO, you know, new model to care kind of approach; and I think where we ended up at that time was, you know, sort of a let's think more about, you know, consolidate our gains with a couple of other aspects, one of which was the ones you had, ah, Larry about, you know, make HIE easy. And then, the other was, um, the advancing query for continuity of care, which was, you know, really thinking about that, that, that use case, enabling that use case, an easy kind of use case and being able to query out sort of information for an un, unsolicited patient visit. Um, and administrative ... was the other part of that, um, you know, sort of the, the, um, one or two dimensions beyond, the, um, consolidating of gains kind of approach.

**Lawrence Garber – Reliant Medical Group**

So that, does that feel right, um, as sort of our, our general criteria as, as we think about new, um, you know, our new set of, um, objectives?

**Peter DeVault – Epic Systems – Director of Interoperability**

This is Peter. I, I still am in agreement with that.

**M**

Yes, agreed.

**Lawrence Garber – Reliant Medical Group**

Okay, next the slide, please. So our, our, the timeline, well, the short-term timeline is that next Wednesday we have to present our suggestions, ah, which were part of, ah, there's a, ah, separate group, ah, who's working, who's working on clinical decision support, quality reporting, administrative simplification, ah, e-prescribing, and public health. Um, and Micky, they'll all have their stuff done as well by next Wednesday, is that the, is that the plan?

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Ah, well, yes, I don't think so, I mean, the um, we went off, um, ah, the public side and the quality measure ones we're sort of playing more of a liaison role with existing sub workgroups of the Meaningful Use Workgroup. So we're going to be sort of more a slave to their schedule on that and I don't, I haven't seen anything suggesting that we're going to be meeting before the Wednesday ... meeting. Um, Amy might have one for the public health one perhaps on Wednesday if I'm not mistaken. Um, so, and then we're still trying to identify a chair for other ones, so it maybe just, just you guys on, ah, on this Wednesday.

**Lawrence Garber – Reliant Medical Group**

Okay, we'll be presenting to the larger group on Wednesday.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Yes.

**Lawrence Garber – Reliant Medical Group**

Okay, and then—

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

That, that meeting I think is only a hour, so that's, um, even if we had a higher ambition, the reality is that might be all we can accomplish anyway.

**Lawrence Garber – Reliant Medical Group**

Okay, and actually, you know, I think the, oh, okay, so on this slide, it also has sort of how this evolves to, you know, into September, um, you know, where hopefully that we'll be hearing exactly for real what Stage 2 is going to be. And then we have to, sort of, reconcile that with where, with the direction that we've been going, um, and then October, you're, you're hoping that we'll have this all finalized for our Stage 3 recommendations.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Yes, so it's early October is the, um, the HIT policy committee ... focus, and then our final recommendation.

**Lawrence Garber – Reliant Medical Group**

And then you hope to—and then the RFC goes out in November.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Yep.

**Michelle Nelson – Office of the National Coordinator**

That's the hope.

**Lawrence Garber – Reliant Medical Group**

As I said before, it's good to dream. You know, so on the next slide, it's got the more details of, of what our work group, you know, our timelines are, and, you know, as so we talked about this coming Wednesday, um, is we'll talk to the larger group about the things that we've been thinking about, um, and then August 1<sup>st</sup>, , I guess Micky is presenting to the Policy Committee our, you know, our initial, ah, our initial thoughts, and, ah, and then we, we get some rehashing through, um, through August and September. And are these dates, are these dates already in our calendars?

**Michelle Nelson – Office of the National Coordinator**

Yes.

**Lawrence Garber – Reliant Medical Group**

Excellent.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Yes, so you know I think overall, the, you know, there's a bunch of dates here, a bunch of meetings. I guess, the overall takeaway from this is, you know, we have, we actually have some time to have sort of a, you know, a thoughtful deliberative ... here, um, and, ah, if, you know just, we'll have the intervention of the, um, of the final rule coming up that'll, you know, have us doing a little bit of, you know, realignment based on that. But I think we know, you know, pretty much most of that anyway, um, and, ah, and the exercise right now, as I said, you know, for the August HIT Policy Committee meeting is really just to, here we are, um, you know, to get some initials speared, um, from them, but, , we do have, you know, a number of opportunities for meetings after that to, ah, to spend a little more time on, you know, anything that we come up with.

**Lawrence Garber – Reliant Medical Group**

So, so in order to at least get as much of our thinking done by this coming Wednesday, we, we do have, you know, another half hour or so today, um, and we've also, we're setting up a call, ah, Arien, I think you might missed this talking about this, that we're, we're going to connect again on this coming Monday, ah, from 10:30 to noon eastern time. Is that, are you able to make that?

**Arien Malec – RelayHealth**

That would be 7:30 to 9:00?

**Lawrence Garber – Reliant Medical Group**

On Pacific, that's correct.

**Arien Malec – RelayHealth**

Yes, I, I, I can do that.

**Lawrence Garber – Reliant Medical Group** Awesome, so that will be this coming Monday, and I think MacKenzie or someone was going to be sending out a, ah, an invite to that.

**MacKenzie Robertson – Office of the National Coordinator**

Hello, yes, this is MacKenzie. You'll be receiving an appointment from Altarum, um, today at some point.

**Lawrence Garber – Reliant Medical Group**

Excellent. Thank you for doing that. So, um, at this point, I'd, we have a spreadsheet that, um, has been so kindly put together for us to help give us guide-, guidance, and is that something, that, , you guys can present?

**W**

Yes, the Excel document?

**Lawrence Garber – Reliant Medical Group**

Yes.

**W**

Yes, I'll put that up right now.

**Lawrence Garber – Reliant Medical Group**

Excellent, thank you.

**Michelle Nelson – Office of the National Coordinator**

So while Altarum is putting up the document, um, this is Michelle, I just want to say, um, for the public that may be listening, if you could use the ID numbers that are in column C, rather than the row number when you're referring to it, it will make it easier for those people that are listening in, they typically PDF them.

**Lawrence Garber – Reliant Medical Group**

The SGRP numbers.

**Michelle Nelson – Office of the National Coordinator**

Yes.

**Lawrence Garber – Reliant Medical Group**

Okay. And what does SGRP stand for?

**Michelle Nelson – Office of the National Coordinator**

This is my nomenclature, subgroup #2 and ... 01.

**Lawrence Garber – Reliant Medical Group**

Okay, got it, all right.

**Michelle Nelson – Office of the National Coordinator**

It doesn't need to make sense to everyone.

**Lawrence Garber – Reliant Medical Group**

Well, actually not this one. Um, this one is, is for when we start dreaming, um, the one that's being presented here. There should be a, um, ah, an Excel spreadsheet.

**Peter DeVault – Epic Systems – Director of Interoperability**

The candidate suggestions there, or the, no, Stage 3 planning it think it's called.

**Lawrence Garber – Reliant Medical Group**

Yes, IE, IEWG Stage 3 planning, that's right. The, the one that's up here is, you know—

**W**

We're putting it up right now, give us just sec.

**Lawrence Garber – Reliant Medical Group**

Yes, I take some drugs and then write things down, so.

**M**

Yes, um, so I would actually recommend, um, and this may just be me liking things that I said in which case I apologize, um, that if we ground things in clinical scenarios and the clinical outcomes that need to be achieved, and then map, um, those outcomes to capabilities, um, that that might be a good way of organizing our thoughts.

**Lawrence Garber – Reliant Medical Group**

Ah, yes, I think that is, that's sort—that's sort of a use case approach.

**M**

Right.

**Lawrence Garber – Reliant Medical Group**

Which, I mean, that's a, that is reasonable to do. That basically today we would just be sort of schmoozing and, you know, sort of thinking about visions and then try to nail that down more at the next meeting. Um, I'd be okay with that. How is the rest of the gang?

**Jeff Donnell – No More Clipboards – President**

This is Jeff. I support that, that concept.

**Lawrence Garber – Reliant Medical Group**

Okay. Well, let's do it. So, um, do you want to, do you want to throw out, you know, some potential use cases there, Arien or?

**Arien Malec – RelayHealth**

Um, well, I, I, um, I do think the coordinated care team and the emergent care, I think we've got trans-, there's a, so maybe there's—we've got transitions already in Stage 2. There's a, what more do we need to support transition and, and, and, um, we've kind of got transitions 1.0, ah, in many ways, ah, in, in Stage 2, so what's the 2.0 version. And, and I suggest, a closed loop would be, one of those cases, and there may be some others as well.

## **M**

Arien, one way that I think of what we did in Stage 2 is, um, covering, um, of course, or beginning to cover plans' transitions of care, and where need to expand is both as you suggest closing the loop on some of those planned transitions, but also moving into the unplanned transition.

### **Arien Malec – RelayHealth**

Yes, so unplanned is what I was referring to.

### **Michelle Nelson – Office of the National Coordinator**

So, so this is Michelle. I just want to interject and say that the Meaningful Use Workgroup has already done a lot of work around these things.

### **Arien Malec – RelayHealth**

Okay.

### **Michelle Nelson – Office of the National Coordinator**

So I'm not sure, I mean, if you, if you just want to vet your ideas and get them out on paper today, I just want to make sure that, you know, when it comes down to it, that you're not kind of doing duplicative work.

### **Arien Malec – RelayHealth**

Thank you for that. If there is a reference to what the Meaningful Use Workgroup has done, um, in setting the policy goals, um, I think that would be, that would be an incredibly useful starting point.

### **Michelle Nelson – Office of the National Coordinator**

Okay. So, so just to take a quick step back, so actually, the Meaningful Use Workgroup has, um, subgroups focused on both patient and family engagement and care coordination, and they actually both met today. Um, care coordination has met a number of times and they, they've, they're still working to, um, solidify their ideas.

Um, so actually in the Excel document that you were sent out, we put a column in there, and it's actually column J, and we, we hid it, because we wanted, we weren't sure if you would prefer to have your own ideas first, or to bounce off of their ideas. Um, but I will say that even, this was done before today's two meetings and a lot has already have changed. So, um, we will send out a revised document, um, and I have to revise it anyway, so I'm happy to revise this and send it out to the group, um, at some point this weekend. But if you wanted to see where they initially were if you have your own Excel document, you would just have to unhide column J, so I'm sorry to be confusing, but we didn't want to take away from your ideas as well.

### **Jeff Donnell – No More Clipboards – President**

So, Michelle, is that—

### **Peter DeVault – Epic Systems – Director of Interoperability**

I'm a little bit, go ahead.

### **Jeff Donnell – No More Clipboards – President**

Micky, is that a set of use cases that they, that they have, or?

**Michelle Nelson – Office of the National Coordinator**

Well, so, so actually the care coordination group started with use cases. They actually did do that same process, and, and it is in a Power Point, um, you know, all those documents are public, and I'm happy to go back and share. And actually today, we used, I mean I can go back and put together all of what they've done, and now that, you all tell me what's easier. They, they have now moved to the Excel document, you know, going back from this is a Stage 1, this is Stage 2, and now what should we do to Stage 3. But we can certainly share what they're done within, you know, related to use cases, because that's a better starting point.

**Lawrence Garber – Reliant Medical Group**

But, you know, I mean, some of the stuff is really good, actually. I hadn't, I hadn't unhidden J, J until you had mentioned in one of your emails. You know, so for instance, in the patient engagement, I'm sorry, SGRP 204, ah.

**Michelle Nelson – Office of the National Coordinator**

You can just say 204.

**Lawrence Garber – Reliant Medical Group**

Oh, okay, right and, and, 204, in the, you know, sort of the patient engagement, ah, talking about the view download, transmit, talk about provide patients with the ability to self-report information, such as family history, observations of daily living caregiver status enroll, list of care team members, functional status, um, you know, so those, those are pretty good. You know, the observations of daily living, I'm not sure if that that specifically includes, you know, home monitoring devices, but, you know, I think that that sounds pretty, you know, pretty good. Systems should provide the ability to provide hyperlinks to online resources for education, um, provide patients with the ability to send relevant updated information to the care team, you know, across settings and providers. The ability of providers to actually review and accept these updates, um, create, oops, so it's saying I need to expand it.

**Peter DeVault – Epic Systems – Director of Interoperability**

So I, I don't have, ah, column J in front of me and I don't doubt that there is excellent work already done that we should use to inform what we do, but the point is for us to also make recommendations to them, correct, so we shouldn't be necessarily constrained to what their thinking has already been.

**Lawrence Garber – Reliant Medical Group**

True.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Well, I think also it, this is Micky, you know, they've, they've made point recommendations lined up against each of the initial objectives, um, which I, you know, I think in the beginning we have, we were sort of on the path of thinking that that's not how we want to approach the problem. Everyone is ... sort of a more of a use case cut, but you know, column J just has, you know, line by line against each of the objectives.

**Peter DeVault – Epic Systems – Director of Interoperability**

Right.

**Lawrence Garber – Reliant Medical Group**

Well, so, Arien, the direction you were going was your, you know, I think since we don't have their documents, you know, their presentation or whatnot, I mean we could, we could, could talk about the different, you know, the care coordination, the planned and unplanned transitions of care, the communication to patients, the communication from patients is sort of go in, is that sort of the universe, um, do you guys see that as the universe and then we can drill down into, you know, use cases for each for each of those?

**Arien Malec – RelayHealth**

That's was the direction that I was going.

**Lawrence Garber – Reliant Medical Group**

Well, why don't we try that and then, you know, it would be nice if we, if we could get, you know, access to that presentation or get that sent around some stuff for us to look at over the weekend, and then, you know, we can see if we can come up with, you know, on Monday?

And I guess my other question is, there is the possibility to also have a meeting on Tuesday, if we so desire, you know, to, to pull in another hour or so on. Do you guys want to do that as well, or willing to do that in case, you know, this takes more than an hour and a half on Monday?

I think the time slot that was available was 2:00 through 5:00, ah, I can look that up. Yes, 2:00 through 5:00 is eastern time is potentially available on Monday if we wanted to grab, or Tuesday, if we wanted to grab an extra hour.

**Peter DeVault – Epic Systems – Director of Interoperability**

None of that works for, or, well, I do have 3:00 to 4:00 or 3:00 to 5:00, actually, that I could move around.

**Lawrence Garber – Reliant Medical Group**

What time is that?

**Peter DeVault – Epic Systems – Director of Interoperability**

It's like 3:00 to 5:00 eastern I'm doing the ...

**Lawrence Garber – Reliant Medical Group**

Okay, you do the math, okay. And how, how is somewhere in the 3:00 to 5:00 is there an hour that looks good for you, anybody else?

**Jeff Donnell – No More Clipboards – President**

This is Jeff. I can do, ah, I can do 4:00 to 5:00 eastern that day.

**Lawrence Garber – Reliant Medical Group**

Well, that works for me, too.

**M**

What day and time are we talking about?

**Lawrence Garber – Reliant Medical Group**

So, so we're talking Tuesdays, ah, this coming Tuesday, the 24<sup>th</sup> from 4:00 to 5:00 eastern, so that would be 3:00 to 4:00 out in Wisconsin land.

**M**

Yes, I can do that, so that's in supplement to Monday's meeting, right?

**Lawrence Garber – Reliant Medical Group**

Exactly, and we could always, are we allowed to, you know, at the end of Monday's meeting say, no, we've got it all done, let's cancel Tuesday?

**MacKenzie Robertson – Office of the National Coordinator**

You sure are. This is MacKenzie.

**Lawrence Garber – Reliant Medical Group**

Okay.

**MacKenzie Robertson – Office of the National Coordinator**

We will not force you to call in.

**Lawrence Garber – Reliant Medical Group**

Perfect, thank you, you know. We don't pay a fine for doing it. Ah, so all right, so, yes, if you could also send out an invite for that, I saw the Monday one came across, so.

**MacKenzie Robertson – Office of the National Coordinator**

Sure, we'll have Altarum send that out shortly.

**Lawrence Garber – Reliant Medical Group**

Awesome, thank you.

So let's talk about the care coordination then, because, you know, I think the transitions of care, you know, plan, actually, let me take that back. Let's start with, let's grounding ourselves sort of where, where we have been here with the transitions of care. You know, that's, you know, that is fairly well defined, certainly for the planned stuff and it's laid out there right now as a push model; and I think if we then talk about how we evolve into an unplanned support for the unplanned transitions of care, then that may provide, provide some foundation for how care coordination is handled.

**Arien Malec – RelayHealth**

Yes, so I was suggesting there was two directions we can, we can go and and, ah, I think both could be valuable. One is enhancing the support for plan transitions, and that could include, um, deepening the data that's supported in the plan transition, ah, deepening, broadening the types of transitions that we're that we're looking at. So for example, there's been some really good work on long-term care, um, and transitions to and from long-term care, ah, that have been going through, ah, for example the S&I framework. And then supporting, you know, the current support is kind of a one-way transition, ah, so supporting more closed loop transition all in the rubric of planned transitions, um, as enhancements or potential enhancements for plan transitions, as well as looking at supporting unplanned transitions.

**Lawrence Garber – Reliant Medical Group**

Yes, I, so I co-chair that S&I framework sub-workgroup and so I, from a long term post-acute care and so I do, you know, clearly see that that is the case. Um, that there, as we expand it to look at the other types of transitions, you know, I mean there are literally over 100 different types of transitions, you know, from, from SNFs to home health, from hospitals to SNFs, from SNFs to extended care to, you know, there's just lots of different permutations of that. And, um, we were able to break it down really into five general data sets, um, so that, and, and they do sort of go around this closed loop approach. You know, if you're sending someone for a specifically for a test or a procedure, um, and then that patient is coming back from that test or procedure. So you're sending them enough information to be able to do that test or procedure safely, um, and then they're giving you the results back, so those are two different data sets.

Second is you're sending someone, ah, for a referral, to, it's sort of a shared care. You know, you're still maintaining the ownership of this patient, but now you're adding someone to care for that patient, like a consultant, you know, some specialist or for that matter, a visit to the emergency room, where you're, which is just a different level of intensity. What you're really asking for, you know, you're not, you're not necessarily relinquishing care of that patient, but you're asking for their opinions on that patient, um, so you're giving them enough information, so that they can do an appropriate evaluation. And then when they send that patient back to you, ah, there's a data set that represents the consult note or the ER note, um, about what was what they discovered, what they think ought to be done, what their recommendations are.

And then there's the, and then the fifth type is the, the true transfer of care, you know, where someone is being transferred now into an inpatient facility from, from outpatient, or they're being transferred from that hospital to a SNF, or they're being transferred from a SNF to a home health agency, or they're being transferred from a PCP to another PCP. Those are, you know, more complete transitions, and those require a much broader data set.

And, and we found that pretty much you can, plus or minus some tweaking, you can really generalize into those five data sets. And, and one of the things that we're realizing, and we went down to the nitty gritty details of the data elements that you need, ah, for that broadest transfer of care that includes the long-term post-acute care and we came up, it's about 300 data elements, whereas the CCD is only specifying about 175 data elements. And so, um, you know, and we are going through the standards process with S&I and then into HL-7, um, to try to more clearly define those. And some of it's that there aren't on a sections or elements in the CDA, but some of it is that there are buckets to put them in, but the definitions aren't constrained enough to let everyone know that, you know, they've got congestive heart failure. You need to tell us what their objection for action is. They're on Coumadin, you need to tell us what their last few doses were and what their few INRs are, so, you know, so those kinds of constraints need to be built, and that's sort of the stuff that's happening.

**Arien Malec – RelayHealth**

That's pretty fantastic. I think from a Standards Committee perspective, if we have the right, if the IE Workgroup can help define the right, ah, outcomes and objectives, and then we've already done a lot of the work of noting the standards gaps, then we can help prioritize the standards work to be done in order to support the policy objective to be focusing on, um, the first part of that, which is the high level, um, or the high priority policy objectives better coordinated plan transitions.

**Lawrence Garber – Reliant Medical Group**

Right, and to include your long term post-acute care community.

**Arien Malec – RelayHealth**

Correct, as well as, as well as, you know, better support for ambulatory or acute, acute ambulatory.

**Lawrence Garber – Reliant Medical Group**

Right.

**Arien Malec – RelayHealth**

Um, as well as closed loop ambulatory to ambulatory.

**Lawrence Garber – Reliant Medical Group**

So, um, that, that, that, and that still can be the, the push approach that we're currently using. It doesn't necessarily require any new, um, you know, consent models. It doesn't necessarily include any new, you know, needs for master patient indices or anything like that. Um, you know, that, that's—it's really just an extension of the direction of the things that have been currently going.

Um, on the other hand, the unplanned, ah, is, is really, you know, opens up a lot of different options. Um, you know, and so, you know, an unplanned can be many different things. I mean one is, you know, they show up in the emergency department, you know, brought in by ambulance, and they don't have to be naked or unconscious, but they, they basically have come in there. And, um, you know, and you need to be able to access information that's out there, but there's also, you know, there are, you know, direct referrals to specialists, you know, in, in, with some health plans or some states, you know, you can go see your gynecologist without any referral. You can go to see a dermatologist without any referral and, um, and they need to be able to, ah, in those scenarios pull in information. Um, there's also the scenarios where someone's been referred to a cardiologist, but now the cardiologist is seeing them three months later, six months later. You know, there's no new referral for those follow-ups. Yet they need to be able to find out what new is going on, so those are, those are similar kinds of, you know, unplanned use cases, um, that need to be met.

**Arien Malec – RelayHealth**

Yes, I totally agree.

**Lawrence Garber – Reliant Medical Group**

Are there other kind of unplans that we can think of?

**Arien Malec – RelayHealth**

They all feel the same, you know, it's it's, ah, ah, there's all kinds of I just show up.

**Lawrence Garber – Reliant Medical Group**

Yes, now I can tell you, you know, just to let you know the model, I mean, we talked about the query model. Um, what, what I've done with the health information exchange I've got up here in Massachusetts, um, where we use a, essentially it's a subscription model, where we, where we have a master patient index and we push subscriptions to, ah, wherever the patient has, ah, authorized. So for instance, they can authorize to, you know, I want wherever I go as long as I show up there for care, I authorize them to have my records. And so we monitor registrations, so when the patient registers in the emergency department, if they've done that authorization that says, you know, wherever I go, we, we push the authorization to that emergency department, ah, while we put, we add that to the authorizations for the patient to all the other places, um, so that all—you know, the primary care offices, the specialists all push their information out to the emergency department because they've registered there, and that's now fits into their authorization model. Um, and if, um, so it's really, a, a, it's a subscription model, where we're updating authorizations and pushing them to new places.

**Arien Malec – RelayHealth**

So you're listening, this sounds similar to what ... does. You're listening on the ADT feeds.

**Lawrence Garber – Reliant Medical Group**

Exactly.

**Arien Malec – RelayHealth**

And then based on the, based on, ah, a, a patient match, you're then, you're then pushing, ah, the information to that setting of care.

**Lawrence Garber – Reliant Medical Group**

That's exactly right.

**Arien Malec – RelayHealth**

Yep.

**Peter DeVault – Epic Systems – Director of Interoperability**

So that's a, it's a, a really interesting model obviously, although it certain required, certainly requires many more moving parts than just the EHRs and PHRs, which we kind of stuck to so far and ....

**Lawrence Garber – Reliant Medical Group**

Right, right and that's, that's one of the things, you know, that clearly requires a master patient index, um, you know, because, so that you know that the authorization that they gave when they were at the PCP, you know, applies to that same patient when they've shown up in the emergency department.

**Arien Malec – RelayHealth**

Well, I don't know if any, I don't know of any models that don't require that capabil—don't require a master patient index or, ah, a, or registry of where the patient is out—there are some, there are some, um, there are some use cases where there's a large enough central organization with a unified HIT system that where you're—you don't need to do that, but those, those don't seem like the ones that we should be organizing around. We should be organizing around the much more typical, ah, multiple HIT systems, multiple settings of care, and I don't know of any of those models that don't rely on some kind of central patient index, and central record locator.

**Peter DeVault – Epic Systems – Director of Interoperability**

Actually, Arien, I'd like to challenge that a bit.

**Arien Malec – RelayHealth**

Sure.

**Peter DeVault – Epic Systems – Director of Interoperability**

So, we've got about 125 organizations around the country who, ah, communicate with each other and their neighbors without any kind of central infrastructure and they just simply do that by patient demographic.

**Arien Malec – RelayHealth**

Yes, so, so, Peter, and what I'm, I'm, I'm, um, what I'm—that's what I was saying where I know of models where there's a large enough organization that you can go one place and ask.

**Peter DeVault – Epic Systems – Director of Interoperability**

Nope, sorry, that's, that's actually not what's going on, so let's just take Madison where I happen be sitting right now as an example. There's four health care organizations and a patient shows up at one and they'll query the other three. You don't have to query the world. You can be intelligent about where you're querying or query the place—

**Arien Malec – RelayHealth**

Sure, but, but that model doesn't, doesn't, that model does not work if there are 100 and, that—I don't know that we should be building a model that scales to three or four, ah,—

**Lawrence Garber – Reliant Medical Group**

Well, there is, I mean, there's another, I mean, assuming that the patient is conscious, you know, it's rare that you're dealing with someone who—

**Arien Malec – RelayHealth**

Exactly.

**Lawrence Garber – Reliant Medical Group**

Is unable to give consent and give an idea of where they've been.

**Arien Malec – RelayHealth**

Sure.

**Lawrence Garber – Reliant Medical Group**

So there is, you know, there is sort of this intermediate, um, you know, not quite show me the universe of everything that's possible—that's appropriate for this patient, but let me get some information on this patient, which, you know, which can be, di—directed queries, you know, until, ask the patient, you know, where have you been and what do we do right now, we call that place, or we fax them a signed consent, and then they fax us back information. And so there is this same kind of intermediate model that we could do.

**Arien Malec – RelayHealth**

That's right.

**Lawrence Garber – Reliant Medical Group**

Where we, you know, direct a message with an authorization tied to it, you know, for a release, and, you know, that, that EHR can do, do matching and, um, you know, and, and send back the information if, but there is some standards that needs to be set. So one is, you know, definitions about what data elements are required for patient matching, and also some standards about the authorization and what the content should be, so that it can be machine computable when it is received by an EHR.

**Peter DeVault – Epic Systems – Director of Interoperability**

Well, there's also, there's also the how do I, you know, I know that I've been seen at Sunny Family Practice, but how do I tell my computer to go look up Sunny Family Practice—

**Arien Malec – RelayHealth**

By typing it in like Google, or you type in the, ah, zip code. That's why we need, you know, a directories—

**Peter DeVault – Epic Systems – Director of Interoperability**

So that's, that's where, that's where I why I was saying I don't know where it works, and how it works with that a record locator services of some kind.

**Arien Malec – RelayHealth**

So, well, ah, a directory is not the same as a record locator service. A directory is a listing of possible end points that you want to query.

**Peter DeVault – Epic Systems – Director of Interoperability**

Okay.

**Lawrence Garber – Reliant Medical Group**

They use their direct address.

**Peter DeVault – Epic Systems – Director of Interoperability**

Sure.

**Lawrence Garber – Reliant Medical Group**

Go on, Arien, that's, that's your baby.

**Arien Malec – RelayHealth**

No, no, I, I, I, don't want a marriage ..., but then there's this intermediate of Sunny Family Practice maps to, you know, what direct address, um, but, but I'm there obviously.

**Lawrence Garber – Reliant Medical Group**

Yes, I mean, so imagine that, so if we had, if we defined that, you know, here's a standard for authorizations of what, you know, what, what you're authorizing, in other words, the types of data and, you know, ah, for what purposes, and what time periods or whatever, and, um, and, and, or even, you know, what organizations, if we could then push that from using direct from the ER to the PCPs electronic health record, um, and the electronic health record could match the patient because we've defined what data elements need to be passed and, and what, what constitutes an acceptable match, um, then they can push that right back using direct. And, ah, you know, that, that doesn't require a huge leap in technology.

**Peter DeVault – Epic Systems – Director of Interoperability**

Yes.

**Lawrence Garber – Reliant Medical Group**

It just requires, ah, so you know, some standards.

**Peter DeVault – Epic Systems – Director of Interoperability**

Correct.

**Lawrence Garber – Reliant Medical Group**

And we've got, what, two years to make it happen.

**Arien Malec – RelayHealth**

And we did direct in one, so there you go.

**Peter DeVault – Epic Systems – Director of Interoperability**

That's right.

**Lawrence Garber – Reliant Medical Group**

There you go. So, Arien, this is your next project.

**Arien Malec – RelayHealth**

Excellent. I have to go quit now and—

**Lawrence Garber – Reliant Medical Group**

So that, so that, that would be a, you know, you know, that's one, you know, potential, ah, solution that we could be talking about and then is the more, you know, the, the sort of higher level more comprehensive, um, where there is a, a scatter across a, a larger population, you know, and whether it's using the rec—record lo—record locator service to direct that or whether it's, you know, centralized databases or other, you know, query options.

**Arien Malec – RelayHealth**

Right.

**Lawrence Garber – Reliant Medical Group**

Um, you know, and then are the subscription models, which are, are, you know, I actually like those a lot, too, um, you know, so that things are just constantly updated. You know, as a primary care physician, I, I, would love to, you know, I love to subscribe. I mean, that's what we do actually with a lot of our inter-patients the hospitals, is we just, we subscribe to all of our patients. We let them know, you know, these are our doctors. When, when you see, um, you know, when you register that, you know, the PCPs is one of our doctors, you know, send us a copy. And so essentially we subscribe, um, you know, to a lot of stuff, and the beauty is then when I look at my EHR for whatever reason, all the information is there. Or when I want to do, um, you know, quality analysis, show me all the people who haven't had mammograms. I, I know the ones who have had mammograms, whether or not they've been done in my organization, because I subscribe to all this information, so I can really direct myself, so—

**Peter DeVault – Epic Systems – Director of Interoperability**

Larry.

**Lawrence Garber – Reliant Medical Group**

Yes.

**Peter DeVault – Epic Systems – Director of Interoperability**

Larry, when, when you do that, do you combine the subscription with the consent in that model? That is, does by virtue of you subscribing, are you also warranting, um, or otherwise asserting that you have the consent for that subscription from the patient?

**Lawrence Garber – Reliant Medical Group**

So we've been, we've been doing that in our, our notice of of privacy, you know, that we, you know, that we've got these interfaces to those hospitals and they send us this information.

**Peter DeVault – Epic Systems – Director of Interoperability**

Got you.

**Lawrence Garber – Reliant Medical Group**

You know, so it, so, so that's kind of how it's done. Is it necessarily 100% kosher? Ah, it's unclear when they start sending us, you know, HIV results. Um, you know, and Micky is Massachusetts and, and you know, and, and, that's an area where we potentially could be getting in trouble, but that's why it'd be nicer to have, you know, more clearly defined authorization standards—

**Peter DeVault – Epic Systems – Director of Interoperability**

Right.

**Lawrence Garber – Reliant Medical Group**

And so we could handle that kind of stuff.

**Peter DeVault – Epic Systems – Director of Interoperability**

You could be in trouble, but you, you tend not to look too closely at it.

**Lawrence Garber – Reliant Medical Group**

And the reality is we've been doing this for almost 20 years, 1993, and, um, and no one has complained. In fact, the only complaints I get is when, when there's some mismatch, so the data won't come across, and, and they say, what do you mean you don't have my information.

**Peter DeVault – Epic Systems – Director of Interoperability**

That's right. So, so, what I—let me see if can replay back what I think we just discussed, um, to make sure that I'm understanding it. So when we talk about unplanned or uncoordinated transitions, um, we just noted that there are at least three ways to solve the problem, right?

**Lawrence Garber – Reliant Medical Group**

Yep.

**Peter DeVault – Epic Systems – Director of Interoperability**

There is the directory plus, ah, plus direct like, ah—

**M**

Directed queries—

**Peter DeVault – Epic Systems – Director of Interoperability**

Directed queries.

**Lawrence Garber – Reliant Medical Group**

Right.

**Peter DeVault – Epic Systems – Director of Interoperability**

There is the record locator service model, and there's a subscription model, and I think what we've, what we've said is that, um, I think Epic has some really nice use cases or proof cases for the directed query model. Um, you guys and IHI have some really nice proof cases for the subscription model. Um, there are some existing proof cases for the record locator model. Um, and what I, what I'm, what I'm thinking we're saying is we don't want to, we don't want to focus on one size fits all models, because there are, there are proof cases that, um, there are proof cases in all three models.

**Lawrence Garber – Reliant Medical Group**

Right, right, but with their, but there are some standards that would enable, um, like as I said, like the authorization—

**Peter DeVault – Epic Systems – Director of Interoperability**

That's right.

**Lawrence Garber – Reliant Medical Group**

That would enable all of these that we could, you know, that, that clearly the marketplace has not solved—

**Peter DeVault – Epic Systems – Director of Interoperability**

Yep.

**Lawrence Garber – Reliant Medical Group**

And that this is probably the right place for government to step in and, you know, or SNI framework to step in and, and help push some of these standards to facilitate this from these happening.

**Peter DeVault – Epic Systems – Director of Interoperability**

Right, or the public/private world to focus on this, this is the priority yes.

**Lawrence Garber – Reliant Medical Group**

Right.

**Peter DeVault – Epic Systems – Director of Interoperability**

And what we haven't discussed is the, the team based care model, um, but we're I think out of time, right?

**Lawrence Garber – Reliant Medical Group**

Yes, I think we're, we're close to that, but quickly I wanted to point out one, one interesting thing. You know, we had talked about the, the Epic approach versus the, what I was talking about using a direct where you, you pass the authorization. And so the interesting, the difference is, that when you're pushing the authorization, it's, it would essentially, be, be pushing my authorization as a requester, whereas the Epic model is to actually do the authorization of the sending organization. Um, in other words, I, I actually, if I want, I'm the primary care physician, querying another, um, Epic customer, I actually print out that Epic's customer's authorization and that's what the patient signs. So that's, that's a little nuance of the difference as to whose, whose authorization you're signing.

**Peter DeVault – Epic Systems – Director of Interoperability**

Yep.

**Lawrence Garber – Reliant Medical Group**

And that may be one of the things that the standards need to develop is this is an appropriate authorization template that anyone can use, you know, whether you're the sender or receiver, you can, you know, this, this is appropriate to be completed, and then you're covered.

**Peter DeVault – Epic Systems – Director of Interoperability**

So actually I think what I'm going to do, this is Peter, is, ah, is write up that approach and have it be sort of our gift to the world, because I think it's a simpler approach than, ah, many possible ones, so that the, ah, record holding organization is still in charge of what kind of authorization requirements it needs because it's got a its own state laws and its own policies and that sort of thing.

**Lawrence Garber – Reliant Medical Group**

So what you need to think about then is, is again, the, how using this, say, the direct model where we're sending direct messages, how can I make sure that I maybe I send you a message to query for your, your authorization, then I have the patient complete it and then I send it back to you, you know, maybe through direct messaging because it would be nice if we could come up with something that works with direct messaging.

**Peter DeVault – Epic Systems – Director of Interoperability**

Yep.

**Lawrence Garber – Reliant Medical Group**

So I think we're out of time then, um, I guess, let's see, do I say Mackenzie, please open the line?

**MacKenzie Robertson – Office of the National Coordinator**

Sure, sure, just so the two appointments, um, have already gone out for Monday, so everyone please make sure you check your email boxes. Um, the appointments should be in there. And operator, can you please open the lines for public comment?

## Public Comment

### Operator

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 comments at this time.

### MacKenzie Robertson – Office of the National Coordinator

Thank you.

### Lawrence Garber – Reliant Medical Group

Great, thanks a lot everybody.

### M

Thank you.

### M

Thank you, great discussion. Have a good—

### Lawrence Garber – Reliant Medical Group

Have a good weekend.

### MacKenzie Robertson – Office of the National Coordinator

Talk to you all on Monday.

### Michelle Nelson – Office of the National Coordinator

Thanks very much.

### M

Bye, everybody.

### M

Bye.