HIT Standards Committee
Draft
Summary of the August 26, 2015, Virtual Meeting

ATTENDANCE (see below)

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator for Health Information Technology (ONC), welcomed participants to the meeting of the Health Information Technology Standards Committee (HITSC). She reminded the group that this was a Federal Advisory Committee Act (FACA) meeting with an opportunity for public comment (3-minute limit) and that a transcript will be posted on the ONC website. She called the roll and instructed members to identify themselves for the transcript before speaking.

Opening Remarks

Deputy National Coordinator and Chairperson P. Jon White said that this fall will be an exciting time at ONC. Newly appointed members are going through the clearance process. Until they have been seated, several retiring members will continue to serve. Rules are in clearance. The HIT Strategic Plan and the Interoperability Roadmap will soon be completed. He thanked everyone.

Review of Agenda

Vice Chairperson John Halamka said that the agenda items point to upcoming work for the committee. He differentiated between rules on certification and the Interoperability Standards Advisory (ISA), which is a sub-regulatory document. If stage 3 should be delayed, the industry would still need interoperability and standards, and the ISA would give that guidance to innovation.

Halamka asked whether there were corrections or additions to the summary of the June 2015 meeting, which was circulated with the meeting materials. Jamie Ferguson, who co-chaired the Semantic Standards Workgroup but could not attend the June meeting, expressed surprise to see the report of the discussion concerning the recommendations from his workgroup. One reported comment referred incorrectly to FHIR as a wrapper for LOINC. Ferguson stated that while it is true that FHIR can be used as a wrapper, FHIR can include a semantics information model and constrain the terminology system within it. Without any evidence of the testing and use of FHIR in the API model or in other architecture models, there is absolutely no way to know whether the use of the semantics standards is correct. He particularly objected to a remark attributed to Halamka to the effect that the standard should not be deemed unready just because the wrapper was not ready, saying that the remark is completely incorrect. Halamka replied that it was unfortunate that the members who did the work were not present to explain the recommendations and informed Ferguson that the format of the workgroup's presentation was very different from the presentations of other workgroups. Therefore, no action was taken, and the workgroup was told to reformulate its presentation and recommendations for a subsequent e-mail ballot. Halamka said that there had not been substantial disagreement with the content of the recommendations. He suggested amending the summary to emphasize that a

presentation was made and the next step is to put it in another format. Ferguson asked to revisit the entire presentation and resubmit the recommendations for action. Consolazio indicated that she had attempted to obtain workgroup members' comments on revised slides. Semantic Standards Workgroup Co-Chairperson Rebecca Kush reported that some members were not ready to approve the revised slides. Consolazio will work offline to reconvene the workgroup to work on revised recommendations. Halamka asked that the summary be amended to that effect. He asked whether there were additional objections. Hearing none, he declared the summary approved as amended.

> **Action Item #1: The summary of the June 2015 meeting was accepted as amended to show that Jamie Ferguson reported that incorrect information was reportedly presented during the discussion of the recommendations of the Semantic Standards Workgroup. Recommendations will be re-presented for action at a subsequent meeting.**

Precision Medicine Task Force Update

Task Force Chairperson White reported on the precision medicine initiative (PMI) and the progress of the task force. Recommendations will be presented to the HITSC for action September 22. The ONC staff charged the task force to:

- Identify opportunities for innovative collaboration around pilots and testing of standards that support HIT interoperability for precision medicine
- Recommend existing standards that are currently ready to support PMI
- Identify emerging standards and reference implementations that may require further pilot testing in order to support PMI
- Identify gaps in available data standards related to PMI

Task Force Co-Chairperson Leslie Kelly Hall reported that since its initial meeting July 17, the task force has listened to invited presentations from representatives of 10 organizations. Presenters identified the following challenges and topics:

- Patient access and return of study results
- Electronic consent
- Privacy, security, and de-identification of data
- Minimum set of EHR and clinical data needed to support scientific inquiry
- Representation of genomic and family history data in the EHR for primary care and how to implement clinical decision support, pharmacogenomics
- Use of APIs for patient access and data exchange
- Data storage and transportation

Now that the presentations have been heard, the task force will deliberate on recommendations. The recommendations will be aligned with the NIH Advisory Committee to the Director Work Group recommendations process. Following the presentation of initial recommendations September 22, the task force will work on more detailed recommendations later this winter. White said that NIH has presented a series of workshops on PMI. The timeline for recommendations is aggressive.

Discussion

David McCallie, a member of the Precision Medicine Task Force, cautioned against locking in standards prematurely, because the field of genomics is evolving rapidly. Kelly Hall referred to family health history as an early opportunity. McCallie said that HL7 standards for a full pedigree are inadequate. Dixie Baker reported that the PMI kick-off emphasized genomic data, ongoing consumer engagement, and the integration of personal health data and EHRs. In particular, personal health devices must be considered. CMS softened the requirement for stage 3 patient engagement, which may negatively affect PMI. The Institute of Medicine is working on integration of genomic data with EHRs. Baker recommended that

White and Kelly Hall contact and work with Sharon Terry, who is heavily involved in the initiative. White said that one NIH workshop focused on participants' engagement in research, and other workshops on related topics have been held.

Arien Malec referred to McCallie's comments and said that he worries about a focus on standards setting activities rather than a focus on convening activities. He referred to an article by the SMART Task Force on the use of substitutable labs. He recommended defining a process for convening providers and vendors to solve practical problems with interoperability. White requested an offline conversation with Malec. Malec agreed.

ISA Recommendations

ISA Task Force Co-Chairperson Rim Cothren showed slides and referred to an accompanying Microsoft Word document summary. The task force was asked to submit recommendations regarding revisions that ONC should consider as it creates a 2016 ISA. The recommendations were organized as follows:

Recommended Guiding Principles

1. The ISA should qualify standards based on maturity, implementation testing, adoption, preconditions/dependencies, and ability to meet goals.
2. Clear purposes and state of the world need to be defined to identify appropriate standards and specifications, but often the reverse is done (i.e., we have this standard/specification to achieve this purpose). The ISA should recommend standards and interoperability specification that are subordinate to achieving a set of real world, value-added outcomes and business functions to better achieve our state of the world in health care.
3. ISA should define what the standard is best for — innovation, tried and true use cases, and/or functionalities. For example, some standards support well established use cases, while others are used as building blocks that apply in multiple scenarios. Cross-walking between use cases and functionalities and explore the ability to tie functionality to use cases
4. To promote innovation, emerging standards should be identified as a potential replacement for current standards.
5. Standards in regulation should be identified as such.
6. Non-regulatory standards listed in ISA should be evaluated based on the potential for being on vendors' roadmaps, and potential to meet market demands to fill gaps in current capabilities or replace existing standards with alternatives that offer more precision or simpler implementation.

Recommendations Regarding ISA Purpose and Scope

- ISA guidance needs to cover a much broader health care solution (provider vs. public health vs. patient vs. organization) that crosses the full spectrum of health care needs (research, emergency medicine, DOJ, etc.)
- It is much easier to enable interoperability when you start with less optionality that increases over time and tight constraints and then loosen over time as more flexibility is needed
- ISA should reflect objectives of the Interoperability Roadmap to move us towards a learning health system
- ISA should include a description of functions and outcomes near the beginning and identify how each standard maps to a required function or outcome
- ISA scope should point to all the preconditions, dependencies needed to facilitate interoperability
- ISA should include (but identify) emerging standards as well as best available

- Interoperability orchestration patterns, functionalities, and use cases need to be layered and balanced to satisfy health care goals

Recommendations That Apply to the Entire Document: Tables that describe each standard and implementation guide should be adjusted such that:

- Standards and implementation guides are classified in term of maturity and adoptability, including emerging, pilot, and national standards classifications, along with pre-conditions and ability to meet the goals
- Standards and implementation guides are mapped to outcomes or business functions they address
- Innovation should be promoted

Potential Definitions from HHS RFI Nationwide Health Information Network: Conditions for Trusted Exchange:

- Emerging — technical standards and implementation specifications that still require additional specification and vetting by the standards development community, have not been broadly tested, have no or low adoption, and have only been implemented with a local or controlled setting
- Pilot — technical standards and implementation specifications that have reached a level of specification maturity and adoption by different entities such that some entities are using them to exchange health information either in a test mode or in a limited production mode
- National — technical standards and implementation specifications that have reached a high level of specification maturity and adoption by different entities

Maturity Model

- Should push for international, not just national, standards
- Should be considered a classification system to articulate maturity and help in the decision making process but should not preclude innovation

Outcomes and Functions

- The ISA should include a description of outcomes and clinical functions that standards and interoperability specifications must support in order to identify best available
- Should focus on functionality and outcomes rather than use cases because use cases can be too specific to meet more general functional requirements to meet additional clinical needs
- Define critical needs, desired outcomes, and evaluation criteria for projects and ensure they have traceability to national priorities
- Develop, identify, or refine use cases
- Include front-end clinical and other requirements into the use case development

Recommendations on Document Structure

- Remove section on transport standards because other federal agencies already make recommendations that need not be repeated and should not be confused
- Do not include an explicit section on security standards
- Instead, include a section on security patterns (e.g., disclosing party has adequate information before making an access control decision)

Task Force Co-Chairperson Kim Nolan continued.

Recommendations on Section I: Vocabulary/Code Set

- See the more detailed document for specific recommendations on standards and interoperability specifications; this is a summary of high-level topics
- Anytime there is an identified gap in a vocabulary, the ONC should convene a process to remediate the gap
- Consistency, sufficient constraints need to be articulated in all vocabularies
- Should clearly differentiate between standards for allergic reactions and allergens, and include both medications and food allergies
- Medication allergies should be in a separate section from vocabulary standards used for food/environmental allergies
- Specify codes for common food and environmental allergens; let market adopt others as needed
- May need to promote adoption of NPI by broader complement of care team
- Should consider having a separate role identifier similar to the one in the Health Exchange specification about the role attributes; there is a SNOMED-CT value set for a subject's role in the care setting that is in use
- Start collecting discrete structured data on sexual orientation and gender identity following The Fenway Institute's approach
- Concepts of sex and gender identity need to be broadened, more widely adopted in health care; recommend The Fenway Institute report as a foundation
- The vocabularies for sexual orientation should be updated to reference more modern language (i.e. transsexual is outdated and imprecise); use The Fenway Institute report as a foundation for defining appropriate capture of structured data
- There is not a best available standard for industry and occupation; International Classification of Functioning, Disability and Health is very complex, pushed away in other SDOs; do not rush towards this standard
- ONC should convene stakeholders to discuss and agree on a value set for industry and occupation and be maintained by an SDO
- ONC should convene a task force for a smaller value set of language codes for issues with preferred language that may impact care decisions, analytics
- Code on Dental Procedures and Nomenclature is proprietary; ONC should convene an industry initiative to create an open vocabulary
- The purpose of declaring race and ethnicity needs to be explicit, as the OMB standard may be suitable for some purposes but inadequate for precision medicine and directing therapy or clinical decisions
- Need to capture other qualifiers of a tobacco user often found in other survey instruments: severity of dependency, quit attempts, lifetime exposure etc.; include e-cigarettes not currently captured in SNOMED-CT
- Note a specific question regarding immunizations from HITSC later in presentation

Recommendations on Section II: Content/Structure

- HL7 Clinical Document Architecture (CDA®), Release 2.0, is considered an emerging standard, and there should be consideration to updates in standards and the hardship on both the clinicians and the vendors
- Should consider C-CDA Release 2.1 and its attempt to remain compatible with Release 1.1
- ONC should convene stakeholders (SDOs, states, CDC, vendors, etc.) to identify to reconcile variability in public health reporting
- Several standards in this section are emerging standards, evolution is in progress, not mature enough for best available

- While FHIR includes both content and services, it is probably best described in Section IV
- NCPDP Formulary and Benefits v3.0 does not meet goals of getting real-time patient benefit information to the point of care; recommend monitoring Real Time Prescription Benefit Inquiry Standard
- Advise caution in including all message transactions within the NCPDP SCRIPT Standard as workflows, system capabilities not well vetted
- Genomics are emerging standards best pushed by market demands rather than by regulations; concerned about large undertaking, niche use
- ONC should investigate more generalized survey instruments such as the IHE Retrieve Form for Data Capture Profile, Structure Data Capture
- Need clarity on the objectives for exchanging images versus radiology reports to assess best-available standard
- The task force felt that exchanging the diagnostic imaging report was critical and should be considered more strongly
- ONC should convene a stakeholder group to address computable patient consent; there exist standards but without clear implementation guidance
- There remains concern about the use of DS4P; ONC should convene federal agencies and clinicians to define a consistent understanding of allowed exchange

Cothren continued with Recommendations on Section III: Transport, saying that although transport is vital, the task force recommends that this section be eliminated, because it provides little additional value not already addressed by Section IV: Services.

Recommendations on Section IV: Services

- Include Data Access Framework as an emerging, harmonized approach for clinical querying, along with addressing metadata needs
- Consider separating patient matching from queries for health information; patient matching has broader use than query exchange
- Consider grouping intra- and inter-domain patient matching and intra- and inter-domain query exchange
- Include more complete authorization standards (e.g., IHE XUA, IUA, etc.); ensure authorization standards are compatible across disparate networks
- Include FHIR as emerging
- ONC should convene stakeholders to discuss the requirements for image transport before proceeding with a best available standard
- DICOM is one standard to consider for images at rest; however there should be consideration for exchange of images across organizations along with exchange of the textual reports for diagnostic images
- Exchanging the diagnostic imaging report is critical and should be considered more strongly; note use of MDM today; the task force has insufficient experience on whether more recent DICOM standards PS3.20 DICOM Supplement 155, XDS-I might be more appropriate; further engagement with radiology industry recommended
- All listed standards for resource location are emerging
- ONC should convene a stakeholder group to explore use of FHIR for resource location if Argonaut Project does not add it to near-term sprints
- ONC should convene a workgroup to address need for publish/subscribe

Recommendations on Security

- There must be sound policy considerations before any technology solution can be implemented
- Recommend against a section that calls out low-level security standards
- Instead, recommend a section on best available security patterns used in health care and recommended for implementation
- The highest level goal for all security standards is that they maintain interoperability as a key capability

Questions Posed in ISA Question 5-18: Should specific HL7 message types be listed? Or would they be applicable to other purposes as well? If so, which ones and why?

- ISA should call out a specific message and HL7 version number.
- Also need to reference specific implementation guides whenever available

Importance and Use of the ISA

- The ISA provides industry guidance on a spectrum of recommended standards and implementation guides
- To become more effective, the ISA must:
    - Identify a maturity model and the maturity of standards listed
    - Discuss national outcomes and common functional requirements
    - Relate best available standards to clear, real-world outcome goals and functional requirements
    - Recognize implementation guidance that enables interoperability (tighter vs. looser constraints)
    - Recognize common vocabularies whenever possible
    - Curate emerging standards as they become ready for implementation
    - Include broader stakeholder functional representation
    - Work with industry to remediate all identified gaps with standards
    - Promote Innovation

What additional information about the standards and implementation specifications would be helpful to represent in the ISA?

- Include not only best available, but emerging standards that warrant attention and need stakeholder input (refer to Guiding Principle #1)
- Ensure good separation between standards and implementation guidance, and include implementation guidance whenever possible

Are there suggestions for additional characteristics for best available, or the process in which they are determined? If so, what are they?

- Refer to maturity model and outcomes and functionality discussion earlier

What are the recommendations to better address immunizations code set and terminology standards within ISA?

- HL7 Standard Code Set CVX — Clinical Vaccines Administered is the recommended code set to identify the immunization and promote interoperability in both historical immunization and in administered immunizations
- NDC codes could be used on local systems at the time of administration for inventory management, packaging, lot numbers, etc., but should not be the code system used for interoperability as the NDC codes are not maintained and curated and can be repurposed over time making NDC less than ideal for interoperability.

Should security standards be represented in ISA? If so, how should they be represented?

- The ISA should reference other organizations that make recommendations on security standards when possible rather than reproduce that work and create ambiguity
- The ISA should include a section on security patterns prevalent in or specific to health care

How does ONC ensure ISA is relevant for intended stakeholders?

- Relate standards to real-world, value-added outcomes, clinical processes, and business functions to ensure they address real world requirements

What are the top priorities for ISA in 2016?

- Adjust organization as recommended, include implementation guidance
- Characterize best available standards in terms of maturity, testing, adoption, preconditions and dependencies, and ability to meet goals
- Identify a set of real-world, value-added outcomes and business functions to which standards are subordinate
- Do not rush to identify standards if a best available is not evident, but do not stifle innovation by requiring full maturity in all cases

What are the top priorities for ISA in future (post 2016) releases?

- Continuously update maturity and adjust outcomes and functions as necessary
- Expand to include information on adoption/commitment to emerging standards, vendor roadmaps
- Broaden to include the full spectrum of health care needs
- Refer to Guiding Principles, ISA Scope and Purpose, and Document Structure (slides 6-8)

Nolan noted an inconsistency in slide 21 and the Word document with regard to calling out a HL7 version number. She suggested that commenters help to resolve the inconsistency.

Discussion

McCallie acknowledged the excellent work by the task force. He strongly approved of the guiding principle on standards being subservient to expected outcomes. He wondered when the ISA would take on a regulatory function. Cothren responded that the task force understood that certification rules and ISAs are decoupled. The ISA is a forward looking document, not a step in progression to a regulation. Nolan said that perhaps that statement should be added to the principles. McCallie went on to say that the function of an ISA is not clear. It is not a good idea to imply that a standard should be referenced in an ISA before it becomes an official standard. Regarding FHIR, he expects that innovation around resources will be much more rapid than getting in the ISA will allow. Steve Posnack, ONC, explained that an ISA is a transparency mechanism and a coordination mechanism. It is related to the Interoperability Roadmap. An ISA reference is not precursory to regulation, but it is an opportunity for additional vetting. McCallie cautioned again about locking standards into regulations. He wondered how standards in development should be shared with others for discussion. Posnack said that he would not make prejudgments about ways in which that discussion could occur.

Kelly Hall referred to the lack of consumer feedback received in the public comments and volunteered to give advice on including consumers. She observed that patients were not listed in the recommendations for convening stakeholder groups. There are standards to support consumer input. Regarding maturity, she said that consumer devices should be considered. Cothren responded that consumers should have been included in the list of stakeholders. He acknowledged that the task force

did not discuss ways to increase consumer feedback. He agreed that it would be appropriate to draw on standards to support consumers and said that learnings from other industries can be applied.

Stan Huff observed that the ISA may be a place to come up with something new. It is a starting point. The ISA will not get to interoperability. For interoperability, it is probably obvious that implementation guidances, implementation models, value sets, and other more specific guidance are required for truly interoperable software. Legislators and others must get the message that this will take hard work. Unrealistic time frames should not be expected. Halamka noted a need for core data sets and core vocabularies.

Jamie Ferguson referred to the end of the Word document regarding SDOs and standards maturity. He asked that the criteria and factors used to measure the proposed standards be more fully described. He referred to a letter from the Federal Trade Commission to ONC regarding the effects of the ISA in which it recommended that ONC allow both standardized and non-standardized approaches to better achieve interoperability. He said that he supported that comment.

Malec said that as a member of the task force, he believes that the preconditions for interoperability should be listed. The ISA should define that for which it is solving and subsets of data and vocabulary. He agreed with Huff's comments. The enumeration of standards and vocabularies in the recommendations demonstrates that the industry does not lack standards. Interoperability is not just picking a standard.

Halamka agreed with all commenters that the recommendations were remarkably well done.

ONC Updates

Posnack reported that in 2011, the committee made recommendations on code sets for quality measures. Where an exclusive standard was not identified, transition vocabularies were noted. CMS now wants updated recommendations. Therefore, a short-term task force similar to the one in 2011 will be convened to determine which, if any, of the transitional terminologies should be eliminated and when. There are 26 clinical domains to consider. Recommendations are due later this year. Members interested in being appointed to the task force should notify Consolazio. The staff has already contacted a few individuals. Members of the public may volunteer at the ONC FACA web site.

Halamka reminded members that the September meeting will be a virtual one. The terms of several committee positions are ending this year. The public can apply for membership on the committee and task forces at the ONC FACA web site.

Public Comment:

Afton Wagner, HIMSS, wrote the following:

> Consistent with its role as a leading subject matter expert in security, HIMSS commented on the ONC ISA document during the public comment period, stating that the document should contain a list of security standards in a separate section and we provided a candidate list of standards. We are supportive of the final Task Force recommendation in this regard — that the ISA document should discuss explicitly the need to leverage security standards to facilitate interoperability — and then point to external resources, such as NIST, who publishes lists that are curated and maintained in a timely manner.
>
> During the Task Force discussions, the point has been made that "purpose of use" is a very important constraining factor for security standards that can be leveraged in terms of permission constraints, providing context to requests for information resources and supporting security system enforcement of policy. We agree that security standards in use in health care should be constrained by "purpose of use" and work should continue in this area.

We also concur with the Task Force assertion that Security standards are very important but there need to be sound and clearly articulated information sharing policies that are promulgated and agreed upon so that optimal technology solutions can be leveraged.

We thank the Task Force and previous Work Groups for the time and energy they have contributed to making the ISA document a valuable resource for the health care industry."

Gary Dickinson, CentriHealth, gary.dickinson@ehr-standards.com, wrote the following:

Start with Guiding Principles (Slide 6, Item 3): "3) ISA should define what the standard is best for — innovation, tried and true use cases, and/or functionalities… Cross-walking between use cases and functionalities and explore the ability to tie functionality to use cases." Then consider Outcomes and Functions (Slide 12, Bullets 1-2): "1) The ISA should include a description of outcomes and clinical functions that standards and interoperability specifications must support in order to identify best available. 2) Should focus on functionality…." ISO/HL7 EHR/PHR

Also note need for "functional requirements" in Summary (Slide 22, Bullets 2.2-2.3): "[2.2] Discuss national outcomes and common functional requirements. [2.3] Relate best-available standards to clear, real-world outcome goals and functional requirements." ISO/HL7 10781 and ISO/HL7 16527 are primarily focused on EHR/PHR functional requirements.

Eric Heflin wrote the following:

On the Task Force, I specifically mentioned and recommended to the ONC that they specific solicit feedback from consumers and consumer representatives. See the bottom of the ISA slide 5, which is the bottom of physical slide 37 (Which has the recommendation documented).

Regarding the comment of the SDO maturity assessment, SDOs such as the IHE, transparently publish the standards maturity assessment process. Factors include adoption by multiple organizations, rate of change of the standard under consideration, success in testing at test events, and similar criteria.

Final comment was the Use Case-driven approaches are critical. Otherwise, it is impossible to determine if a given standard is appropriate, sufficient, or insufficient.

Closing

White thanked everyone again. He said that the world is changing, and he is excited. Halamka hoped that future work will be productive without drama.

SUMMARY OF ACTION ITEMS:

Action Item #1: The summary of the June 2015 meeting was accepted as amended to show that Jamie Ferguson reported that incorrect information was reportedly presented during the discussion of the recommendations of the Semantic Standards Workgroup. Recommendations will be re-presented for action at a subsequent meeting.

Meeting Materials:

- Agenda
- Summary of June 2015 meeting
- Meeting presentation slides and reports

Meeting Attendance								
Name	08/26/15	06/24/15	05/20/15	04/22/15	03/18/15	01/27/15	12/10/14	11/18/14
Andrew Wiesenthal	X	–	X	X	X	X	X	–
Anne Castro	_	X	X	–	X	X	X	X
Anne LeMaistre	X	X	X	X	X	X	X	X
Arien Malec	X	X	X	X	X	X	X	X
Charles H. Romine	_	_	X	X	X	X	_	_
Christopher Ross	_	X	X	X	X	X	–	_
David McCallie, Jr.	X	X	X	X	X	X	X	X
Dixie B. Baker	X	X	X	X	X	X	X	X
Elizabeth Johnson	_	X	_	X	X	X	X	X
Eric Rose	X	–	X	X	X	X	X	X
Floyd Eisenberg	X	X	X	_	X	X	X	X
James Ferguson	X	–	X	X	X	X	X	–
John Halamka	X	X	X	X	X	X	X	X
John F. Derr	_	X	–	X	X	X	X	X
Jon White	–	X	X	X	X	X	X	–
Keith J. Figlioli	X	X	X	–	X	_	X	_
Kim Nolen	X	X	X	X	X	X	X	X
Leslie Kelly Hall	X	X	X	X	X	X	X	X

Name	08/26/15	06/24/15	05/20/15	04/22/15	03/18/15	01/27/15	12/10/14	11/18/14
Lisa Gallagher	X	X	X	X	X	X	X	X
Lorraine Doo	_	X	_	X	X	X	X	X
Nancy J. Orvis	–	X	_	X	X	X	–	–
Rebecca D. Kush	X	–	X	–	–	X	–	X
Stanley M. Huff	X	X	X	_	X	X	X	X
Steve Brown	_	X	_	X	–	_	X	_
Wes Rishel	–	X	X	X	X	X	X	X
Total Attendees	**15**	**20**	**20**	**20**	**23**	**23**	**21**	**17**