NATIONAL QUALITY FORUM

Moderator: Patient Safety and HIT
January 26, 2016
3:00 p.m. ET

OPERATOR: This is conference #: 12539574.

Operator: Welcome everyone. The Webcast is about to begin. Please note, today's call is being recorded, please standby.

Andrew Lyzenga: Hi, everyone, this is Andrew Lyzenga from NQF, thank you for joining us for the post comment call for the – our HIT Safety report. We would welcome – we welcome all of you and thank you for joining us today, you know, we're joining from a pretty snowy D.C. here, but managed to make it into the office.

Today, we are going to just provide a bit of a summary of the comments we received, hopefully, all of our committee members have had a – we received the documents themselves and have a chance to take a look through those, and we'll give you kind of a summary of the – some of the highlights or overarching teams we got, you know, from those comments.

Try to have a little bit of discussion from our committee on that and then talks about a few specific issues that we thought might be worth having you weigh in on and of course, you can as your – our committee members call out any other issues that you'd like to discuss as specifically as well.

So with that – I will turn it over to Ann Phillips just for a quick roll call to see who we've got here on the call.

Ann Phillips: Hello everybody. I'm going to go ahead and go see the committee really quickly and see who's here. (Elisabeth Belmont)?

(Elisabeth Belmont): Present.

Ann Phillips: Hardeep Singh?

Hardeep Singh: I'm here, thanks.

Ann Philips: (Jason Edelman)? Gregory Alexander? Gerard Castro?

Gerard Castro: I'm here.

Ann Phillips: David Classen?

David Classen: I'm here.

Ann Phillips: (Linda DeMetropolis)?

(Linda DeMetropolis): I'm here.

Ann Philips: (Lisa Freedman)?

(Lisa Freedman): I'm here.

Female: (Linda), you may want to turn down your volume on your computer.

Ann Philips: Tejal Gandhi? Andrea Gelzer? Kevin Haynes?

Kevin Haynes: Here.

Ann Philips: Laura Hermann Lankford?

Laura Hermann Lankford: Here.

Ann Phillips: (George Herbsac)?

(George Herbsac): Here.

Ann Phillips: (Jason Jones)?

(Jason Jones): Here.

Ann Philips: (Nena Conorlik Kennik)?

(Nena Conorlik Kennik): Here, thank you.

Ann Phillips: (William Norella)?

(William Norella): Here.

Ann Philips: Dena Mendelsohn? James Russell?

James Russell: I'm here.

Ann Phillips: Eric Schneider? Mark Segal?

Mark Segal: Here.

Ann Phillips: Karen Paul Zimmer?

Karen Paul Zimmer: Oh, present.

Ann Phillips: All right. Thank you.

Andrew Lyzenga: Great and thanks everyone. So again, I'll just start out by going over some of the high level themes, summary of some the things we heard through our comments. The number of comments on clinic – and I should say at the beginning there was a pretty consistent support across the board for the recommendations as a whole, you know, in general people, I think were supportive of the committees recommendations and findings.

A few sort of differences here and there which we'll try to talk about, but overall, you know, generally, people are very supportive of the report and recommendation and so I just to say out at the outside.

So a few specific topics where we got comments, the clinical decisions support topic area, a few folks suggested that the measures related to CDS where little bit too narrowly focused on alerts and then sort of taken to consideration of broader sort of sphere of clinical decision support.

There was some concern around the ability to very precisely define and measure the appropriateness or effectiveness of alerts. It was noted that training and education and measurement of user competency can play an important role in ensuring that clinicians are using (PDF) as intended.

With the respect to the system interoperability, there were so bit a concern that the concepts there were not quite specific and often may not provide actionable information. Some commenters suggested that measurement of interoperability is likely to require more consistency in terminology and more of a shared understanding across parties of what data can, should and is being exchanged.

Patient engagement, some commenters noted there is a good deal of variability in patient for those across vendor, systems, settings and that there maybe some need for standardization if you want to get comparable data on whether portals are effective and facilitating patient engagement.

It's also noted that some portals limited in terms of there content and navigability and there is a need for greater transparency to get where we want to be with greater patient engagement.

With respect to data entry burden some commenters noted that – wanted to point out that data entry requirements are affected by factors other than just HIT systems themselves and the usability of those systems including a regulatory and certification requirements and other external factors.

It was also noted that any measurement of HIT safety related to data entry burden but also related to any particular issue shouldn't add to that data entry burden without, you know, sufficient justification and or, you know, and assurance that they are adding value and contributing to the improved patient safety.

With the respect to user center designed, some commenters noted that again that usability is not only a property of HIT systems but it's affected by a lot of external factors, workflow, organizational requirements, the same kinds of regulatory factors. A number of commenters suggested that testing of system

usability should extend across the HIT life cycle and wanted to know, particularly when upgrades or fixes are implemented.

With the respect to information sharing, commenters agreed that organization should have access to lessons learned related to patient safety risk. Some commenters noted that differences in configuration and interfaces or across organizations, may limit the ability to learn from public they reported safety issues and particular issues that come up around patient safety and related to systems may not be directly applicable to every user of those system even if they are the same systems and maybe configured or implemented in ways that limits the ability to take those learning and apply them.

A few other comments of note, a number of commenters, you know, pointed out that a lot of these areas will be difficult to measure, and there's going to be a lot of challenges sort of actualizing these measures putting them specific, you know, specifying the measures, building them out into full measures which is certainly the case.

The challenge going forward as noted by some commenters will be to take this concept that are at this time just very, you know, general comments and or concepts rather sort of recommendations to set the priorities for future measure development and, you know, for the developers in the future to provide enough granular detail to allow organizations to apply them consistently and in a standardized way.

A few commenters suggested that in general there maybe too much of a focus on system components and single actors rather than on those broader cultural aspect to safety.

With that just wanted to sort of open it up to see if there were any particular remarks from our committee members on any of those particular issues or any other issues, general thoughts about issues, general thoughts about the comments we received. Is there any feedback from the committee at this point? Thoughts on the comment?

(Bill Marle): Well this, this is (Bill Marle), and I did review the comments, I mean I thought they were – as a group, you know, very reasoned and unthoughtful.

One comment that I would react to is about – there was a comment about the clinical decision support and, you know, a critic that we were too narrowly focused on alerts to the, you know, to exclusion of other forms of decision support and I don't know if we – I don't remember explicitly addressing this in our discussions but if it's not in the reported, you know, sort like could be that just as we talked about.

You know, whether the organizations are monitoring their alert, override rate, whether they're looking at there accept – you know, with their alert acceptance rate as, you know, rough measures of the utility of there alerts as a group.

You know, they could also, you know, use a similar approach when looking at orders sets, so I think the safer guides outline, you know, order sets for your top 10 diagnosis and, you know, if those are not being utilized in a high proportionate cases where they're relevant, there's probably a reason for that so that might be something that we could add and also maybe, you know, the frequency of review and updating of those order sets against, you know, the latest evidence in the clinical literature.

Andrew Lyzenga: Great, thank you. Any other thoughts on that or would other committee members agree that we could potentially extend the, or you know, add some language in the report saying that these comment – concepts could potentially be extended to order set?

(Mark Hughes): Andrew, this is (Mark Hughes), just a quick question. The summary of the comments that you were scrolling through?

Andrew Lyzenga: Yes.

(Mark Hughes): With that sent out to us, I'll guess, I saw that the Excel Spreadsheet but I don't know …

Andrew Lyzenga: Yes and – no I apologize, that was not the sent out to you, but I can – we can certainly circulate that to the committee, that was just a sort of brief summary in the comments for the purposes of this call and I should note that the comments are also going to be get a bit more thorough summary in a report

itself. We'll be adding a section related about the comments received where we'll sort of again summarize the over arching themes and some of the specific points that were raised by the commenters. We just had not been able to incorporate that.

(Mark Hughes): That's fine, I just thought maybe I've missed it. One just comment on the comments and their usefulness given the nature of this report is, I think your plan which I think is a great one to rather than responding to each comment in the text. You know, I think you've done the nice job of making traditions changes, but because we're identifying concepts and hopefully this will be a resource for measure developers.

I think it will be particularly important and useful for them to be able to have access to, you know, pretty detailed summaries of the comments receive. I think that that becomes really important data from the report for the use of measure developers.

Andrew Lyzenga: Yes, absolutely and I should also say that will – in addition to that, the summary in the report, I believe the plan is to include the comments as an appendix as well in the report.

(Mark Hughes): Right. That's what I was thinking that I think that'll be just really valuable. And I think we will make the commenters actually feel very positive about the contributions they made.

Andrew Lyzenga: OK, all right. Any other thoughts about that comments as whole or any specific issue? Any comments that, any of our committee members wanted to call out and respond to or …

Hardeep Singh: Sir Andrew, this is Hardeep. You know, I think there was a comment about ISO standards. I just want to give David Classen a little bit of time to just update the group on what he's doing with AAMI, David, you got a maybe …

Andrew Lyzenga: Yes sure.

Hardeep Singh: … have a minute, yes.

David Classen: I'm here, thanks for Hardeep.

Hardeep Singh: Yes.

David Classen: So the American Association of Medical Instrumentation has previously developed safety standards for medical devices. And have used the ISO framework for quality management systems and risk management systems. And they have now just start the initiative to do the same things for HIT systems, allowing the development of ISO standards for quality management systems and the risk management systems. And that committee has been formed at the AAMI and anybody is interested and go to the AAMI website and joined that effort. And then effort will probably be in producing new (anti)-standards in this area within the next probably 15 to 18 months.

Andrew Lyzenga: Great, that's helpful. Thank you. Any other thoughts, comments or question?

Hardeep Singh: I think I saw – I heard a comment about measure developers. I think this is not only just good for measure developers, but I mean for researchers in the field to try to study where to be make headway to prioritize. I mean we're pretty in a small grant on, you know, measurement and it's so important to try to at least have some reference document and saying, you know, here is something really important that you should and in, you know, try to study.

So, I would say it's beyond just set of measure developers. There's so much work to be done in this area.

Andrew Lyzenga: Yes, absolutely. Thanks, Hardeep. Any other thoughts before we move on?

All right, so, to a few specific issues that we thought might be worth sort of calling out for the committee's consideration, I'll just kind of move forward here. One commenter suggested changing the term level in our framework. We have the three levels, two categories and actually we had a bit of discussion before we joined this call with the co-chairs and have the suggestion of calling it rather than levels call them domains which I think makes a lot of sense.

Are there any objections from our committee members to rephrasing or renaming the categories in the framework as domains rather than levels?

(Mark Hughes): Yes, this is (Mark). I made that comments or a comment I think others had as well and I think that certainly addresses my issue and just to get I'm sure you'll get it and I think where we're referencing, you know, the work, I think by Hardeep and I mean, and to David and others on that, obviously we're not going to change it there but it's where we've adopted and I guess it's sort of our framework.

Andrew Lyzenga: Thanks, (Mark). Any other thoughts or objections to that proposal? All right. Hearing none, we'll move on.

Just want to note that that and this came up a few times I think that there were some measures that are overlapping with other sort of existing initiatives or programs including meaningful years, there's a measure or, not exact – I'm not sure if it's even a measure specifically around medication right reconciliation as part of meaningful use.

I think that we had intended to, you know, we have sort of – a number of our committee members had noted that overlap previously and saw that as a good thing being that there was some alignment between some of the areas that were being sort of incentivize through meaningful use and potential measure concepts now that could be developed around HIT safety that it would be sort of desirable that there could be some overlapping that meaningful use could potentially be used as a kind of vehicle and should there be measures as part of it, meaningful use, you know, those can serve to meet the recommendations from this committee in any particular area.

So again our proposal at staff was to note these comments in the report, but to retain the recommendations as currently presented. Are there any objections to that approach or thought?

(Mark Hughes): Hey Andrew, this is (Mark). One quick suggestion, is to make a general point that in some cases, either currently or sort of again through independent efforts measures maybe developed that aligned with the measure concepts identifying this report and that the intention, you know, is there for, it would

be then not to redo or duplicate those, but to sort of identify those as part of there kind armamentarium of relevant HIT safety measures.

It kind of acknowledge that that there maybe existing measures that already tracked and that's part of the universe that we're focusing on.

Andrew Lyzenga: OK, and that sounds reasonable.

(Mark Hughes): But that wouldn't call changing any of the actual measure recommendation.

Andrew Lyzenga: All right. OK, answers up.

(Bill Marle): Andrew, this is (Bill) again, I would support that in my – I would say this to the extent of the report that comes out of our committee can call out where there is overlap or alignment, you know. Have you think its overlap or alignment is sort of a semantic issue that calling it out where the exist, I think, would be helpful.

Andrew Lyzenga: OK. We can see what I can do about that, thank you. Any other thoughts on that – in that subject?

Move on. Here's the few – there are some folks who took a look through the full reporting including me dependencies and that full longer lift of measure concepts that we had considered throughout the project then thought that maybe some of those that were not included as part of our final sort of set of concepts within those key measurement areas maybe ought to be (pulled) backup.

We could, you know, bring those in if our committee agrees that it's worth sort of pulling those into these boxes, you know, with the potential measure concepts with, you know, whichever section they would be relevant within or again we can note it in the comment section and retain the report as currently presented.

Any thoughts on that? Anybody who feels strongly that those measures should in fact be sort of made, you know, pulled into the body of the report.

Hardeep Singh: Andrew, this is Hardeep again, safer guide mention is already there in the CBS section correct? I don't have it in front of me right now.

Male: It is.

Hardeep Singh: So I'm pretty sure it is and if it is, you know, I am pretty sure the first two are already are in there?

Andrew Lyzenga: Yes, I thought so too, those are part of the safer guides you said?

Hardeep Singh: Yes.

Andrew Lyzenga: OK.

Hardeep Singh: In some form or the other.

Andrew Lyzenga: Yes, that's again an instance where we have some overlap or alignment however you want to put it, so we can again call that out more specifically.

Any other thoughts or comments if we hear none, we'll make a note that some of those measures are included in the safer guides and again note them in the comment section and leave it at that.

All right, hearing none, I'll move on.

A couple suggestions, when, you know, suggestion for an additional measure concept somebody suggested doing recommending some measurement around data provenance, saying that the, you know, it's important that organizations have accessibility to made that metadata that describes where data came from, particularly obtain through external system, so that could get – sort of add some ability to ensure interoperability or ensure the integrity of data that is coming from an external systems or even from say patient portals if patients are able to make additions or to their records and that kind of thing.

Again, if we will at least note these in the comment sections. One other recommendations, is that we add call out to some interoperability specifically within the framework as a separate category within lay of level two, we had sort of conceived of system interoperability as being part of data availability

within the framework. Again, we would sort of respond to the commenters that these issues are already represented from our point of view in the report as part of the framework and the measurement area is well noting there, their comments in the section of their report, but does anybody think that those are important enough to add specifically into the report itself.

Specific measure counts – concept around data provenance or any additional specific framework category related to system interoperability?

Karen Paul Zimmer: Hi, this is (Karen). I'm just looking at the levels. It's an interesting point. I almost under organizational planning preparation and governance. If there be – should be some reference to interoperability in there?

(Off-mike)

Andrew Lyzenga: We could, does that make sense to others, I mean I think we'd actually thought of it is part again data availability, more than the organizational planning preparation, but that – we could also call it out under that section potentially.

Hardeep, I know you had a lot to do with the sort of the ground work for this framework, any thoughts on where system interoperability fits best in your view?

Hardeep Singh: What, you know, it spans the whole – all the three domains and, you know, it's all overlapping, and so I think …

Andrew Lyzenga: Right.

Hardeep Singh: I don't think it belongs only in level two, I think it's actually – well or domain two for that matter. I think it – that's spans all three and I don't know whether it's worthwhile, putting it into one bucket.

Karen Paul Zimmer: Hardeep, and actually that's what I – going to still keep where we had it, but I meant in addition to.

Andrew Lyzenga: Got you.

Karen Paul Zimmer: In some reference because planning preparation that's a lot of the infrastructure that also deals with data interoperability.

Andrew Lyzenga: Yes.

(Bill Marle): This is (Bill Marle), I would support having something about data provenance and it's for two reasons, one is it's come up in the, you know, in (inaudible) partnership for health patients safety, it's come up in the context of copy and paste and information from the medical record and I think it we'll also become increasingly important with health information exchanges for information to be clearly, you know, labeled with its source, so that that can be, you know, kind of taken into account by the clinicians who is interpreting it.

(James Russell): Well, this is (Jim), I actually would probably say, if I'm taking this from the clinician end-point that it may be nice to feel to find that information but for the most part, I just don't know it's outside information coming from somewhere and I'm going deal with it especially we start getting again the HIEs with consolidating data and then someone grabbing that data from a consolidated data source. It's going to really hard to track the provenance and then also the ability to explain the provenance in a meaningful way.

(George Herbsac): This is (George). I guess my only – I mean I would love to have the provenance, it's feels a little bit like a phase three or four meaningful use measure where trying to push the field to do something that they can't do right now, and I don't know if it's measures is the – is a top priority to do that and think about it really is asking I guess clinicians to enter metadata when they scan something into the record and otherwise it's pretty straight forward to know what system it came from, you know, came from your lab, it came from this, it came from that. The hard one is when you get a document from another doctor's office where an ancillary, the patient brings in or something then it requires the clinician to I guess type the information in a coded fashion and I'm not sure we're ready for that.

(Off-mike)

Andrew Lyzenga: All right. Well the way, the sort what I'm hearing and I think maybe is that you should note it, again as part of the comments, call it out specifically that was something that was raised as a potential measure concept, but not necessarily added to our formal recommendations at this time. Is everybody comfortable with that?

Male: Yes.

Female: Yes.

Andrew Lyzenga: OK.

Hardeep Singh: Yes.

Andrew Lyzenga: All right. So, I'd wanted to do sort it just also call out the issue of shared responsibility as well, we got a number of comments that were supportive in general of that idea. And, you know, I know that was sort of a theme that was – that cut through throughout our deliberations and the report and can sometimes be something of a sensitive issue. I didn't really see a lot of strong push back on that notion in itself maybe some thoughts on how, you know, it should be sort of implemented and practice carefully.

But I wanted to see if there were any comments from the committee or thoughts on that issue in particular or responses back to the comments in any issue related to share of responsibility or information sharing.

(Mark Hughes): I'm sorry, the shared responsibility, is that relate to the licensure issues, and the software license or?

Andrew Lyzenga: I guess, yes. And some they – we had proposed some concepts, I guess it was termed information sharing in the report …

(Mark Hughes): Right.

Andrew Lyzenga: … that was around – around sort of measuring, you know, the nature of contracts between provider.

(Mark Hughes): Right, yes. So, Andrew, I had a comment on that. I appreciated the one change you made, I think, from the committee to some committee members, but I think particularly the proposed concept around, you know, licenses and hardware purchase agreement permit shared learning.

Again, I understand the intent, but thinking about this is a measure, I'm just – I'm both uncomfortable and skeptical with NQF measures that would require evaluation of contract provisions. You know, I mean there's the issue of who will do this evaluation, you know, you got to have lawyers basically, you know, for viewing the contract to determine what they permit or don't permit. So, this, you know, aside from the conceptual issue which I don't want to rehash here, I think there is an issue in terms of just the practically of having a safety or quality measure that's framed, you know, sort of for this particular domain.

Female: I don't believe that it would require a lawyer to review the agreement. Business people on a regular basis review contracts on – contract should be written in a manner that one can easily discern whether such information can be shared or not, in cases where it was ambiguous then I agree it might require a like overview.

Hardeep Singh: And, you know – this is Hardeep. I would add that, you know, I think what we're saying is, this is a potential area or maybe a – well it is a concept. We're not saying this is a measure, we're definitely not saying this is NQF measure. All I think we're trying to say in – the spirit is shared responsibility as measurable. And here's how you could potentially measure it in the future. We're not saying this is the measure you would use, but I think if I was to put in a grant as a researcher because that's what we like to do. We like to explore and figure out what things we can find out to make things better, what would I – where would I even start in terms of defining or measuring shared responsibility. I have – OK, well, that's what they mean when they say that shared responsibility could be measurable.

So that's what I think the spirit of the document was to suppose to do and I mean, maybe we could sort of tweak the language (Mark) as you suggest, I don't know, but I think some amount of, you know, in terms of license and

purchasing, we need to sort of refer to it because it's not – I mean, we just cannot blindside it.

Male: And just maybe to echo and compound on what (Mark) said, I think the one thing is if the commentary piece of the whole thing is actually I think pretty fair and balanced. The system we got down to the proposed concept measures became – it seemed like it became very explicit and maybe we need to like you just said, Hardeep to kind of put this as aspirational or at least frame that in a away that they don't come off as very explicit.

Andrew Lyzenga: Maybe it's worth adding a note just to overall maybe in the overall overarching themes or somewhere else about the intention of this report as Hardeep just said very well, I think that it is – the intent is to identify general areas where – that we think are measurable and important to measure related to HIT safety not that we are proposing these the safety measures and certainly as you said not NQF-endorsed measures. But that these are areas that we think are worth pursuing for future measure development. We could add a note specifically in that section maybe around some concerns that committee members had about the practicality of this particular area, but I think base on the comments maybe worth calling that out somewhere else in the report to just around what our intentions were.

Hardeep Singh: Well, you know, Andrew, I was thinking – this is Hardeep again. I was thinking, I think this should be in the executive summary and introduction.

Andrew Lyzenga: OK.

Hardeep Singh: Make it very clear. And also say that, you know, there is some things that are fairly measurable right now. Some of these concepts could be operationalize within the next year or two for instance or maybe even sooner. But there are some that are going to need a lot more rigorous sort of evaluation, sort of research, try to figure out what's right. We don't even know whether we have the data for some of these things. We're talking about provenance earlier. I mean, I can just imagine.

And so, you could say, you know, some of these will take time to develop. So that the report should be used as a guiding sort of, you know, sort of like a foundation to stimulate further work in measurement in this area.

Andrew Lyzenga: Yes, it sounds great. Does that sound reasonable to our other committee members?

Ann Phillips: Yes, I think that is a great approach.

Male: Sure.

(Bill Marle): You know, this is (Bill) and I would argue to keep the concept in the report and I, you know, I short of, I see (Mark's) point about how that would be difficult to operationalize as a publicly reported quality measure. But if you look at the, you know, the level of an individual hospital that might be, you know, evaluating three competing bids for, you know, pick your application, it would be completely measurable in the context of that procurement.

So, you know, I think we should, you know, explicitly say that these measurement concepts might be applied by different parties for different purposes. And that's one way that I could see that measure being put into practice pretty easily by any provider.

Andrew Lyzenga: OK, great. All right, that's very helpful. So we will make some changes to the language or the report to reflect those thoughts.

Hardeep Singh: Andrew, you know, (Bill's) comment made me think about one more thing and it's been awhile since I read this personally, so I may have missed it. I think we need to revisit this as you might know, perhaps the folks on this call, there has been a bunch of papers and op eds against measurement recently.

So, I think the other thing is to try to clarify and what we're trying to do is to provide sort of a robust foundation for measurement for multiple purposes which includes just improvement in care, improvement in safety, not just things like, you know, pay for performance, penalties, public reporting which is what people are, you know, which is what has burned out a lot of people.

So, maybe it will be a nice sort of exercise in tweaking the language, but we probably can communicate – and there was a lot of pushback by several people on the burden issue of, you know, so it would be a good time to sort of reflect back and make that language clear.

Andrew Lyzenga: Sure. OK.

Female: Hardeep, this is (Inaudible), sorry I've been on for almost – I didn't jump in until now. But I agree with that and, you know, I don't know if it would be helpful that the report from NQSF that came down – came out in December about the needs, you know, for certain key things to advance patient safety both measurement and optimizing HIT where in there – where in those recommendation, so it just might be something useful to reference in terms of, you know, this is what our true goal is.

Andrew Lyzenga: Yes.

(Mark Hughes): And Andrew on the burden piece and I think I can't remember where it is but I was reviewing this morning, you added a sense, a really good sense about through the business case for measurement.

Andrew Lyzenga: Yes.

(Mark Hughes): And I think there is that it would be worth sort of having that at two levels, one is there's the general need for business case for measurement, as you indicated but that I think the point that folks are just been making that in evaluating the use – the development and use of particular measures, in a sense it's almost like you need a measure – you need a business case both for measurement and for the individual measure that …

Andrew Lyzenga: Yes.

(Mark Hughes): … that's considering the cause and the benefit of the development of the measure, which in some cases, but not all cases could be a data collection burden for, you know, for providers or vendors or other stakeholders. But anyway you do it, you know, focusing on one measure, there is still an

opportunity cost relative to other, you know, other things not done, so just at both global and individual measure level.

Andrew Lyzenga: OK, great, that's helpful. Now, I would encourage everybody if, you know, we haven't had a change yet to take a look over the report again and we would very much welcome any other thoughts comments or suggestions that you have for us to make change to the report or additions or any kind of enhancements that you think would be appropriate. We do have a very short timeline to turn this around within our sort of contractual agreement under this project. So, I might ask you if possible that you would get any comments or request for additions or edits to us by the end of this week to get them in.

So, apologies for that short turnaround and also for not providing you the report in advance of hosting for comment earlier as well, for the same kinds of reasons, it's a very tight timeline under our contract here, but we were hoping that you would, you know, would take a look at the report during the comment period, give us any thoughts and suggestions and many of you did and we very much appreciate that. The time that you took to read through it, give us some specific thoughts and comments.

Again, would just encourage any of you to give us any additional comments or thoughts you have on the report. Changes you've like to have made. But we would ask that you get them to us by the end of this week if you have any additional request.

(Jason Edelman): Andrew, this is (Jason Edelman). It's just a …

Andrew Lyzenga: Hi, (Jason).

(Jason Edelman): Hi Andrew. It's just a – it's just a small thing but in the reports, it mentioned the, you know, the measure that I submitted was I guess under review at the time that this draft was written. But now it’s I believe fully endorsed as the first, you know, health I.T. safety measure that's endorsed by NQF and so, I don't know if you just want to update, update it to reflect that.

Andrew Lyzenga: Sure. We can do that.

(Jason Edelman): Yeah.

Andrew Lyzenga: Congratulations as well on that.

(Jason Edelman): Thanks, thank you.

Andrew Lyzenga: Any other thought overall on the, you know, report in general on comments received? We would welcome any additional thoughts you have or questions at this point.

So we'll be working over there next week again to revise the report as suggested here to summarize the comments received and then make any change of those that we've discussed on this call, and are aiming to have the report posted, the final report posted by February 12th.

Again, a pretty short turnaround there and we've got our own sort of internal processes that we have to go through in terms of our publications and internal review. So we really do need any additional edits or thoughts by the end of the week, but we'll try to turn those around as quickly as possible. But that's our timeline moving forward and then at that point, we will close the project out and your work here will be done.

So again, any final thoughts? So, I think, we can otherwise end this call early and let you guys have your time back.

(Elisabeth Belmont): Andrew, this is (Elisabeth) and I just want to thank Hardeep as co-chair and all the members of the committee for the excellent work they did on such a short timeframe as well as to recognized the work of you and Ann and (Jason) and your other staff.

Hardeep Singh: Yes. I'm going to second that, it's been great working with this committee. I think we've actually put a very strong document together as you can, you know, see from the edits.

One thing, yes, Andrew, you can sort of speak to that even now or later, is do we have some formal plans to disseminate this in some way? I know we got pretty good letters from EHRA and (EMA), they're going to be our partners in

disseminating this type of an effort but is there anything else that either we could do or you could, you're planning to do?

Andrew Lyzenga: No. I don't know if we have any specific plans. Certainly, we would like to disseminate this as much as we can and we'll be kind of working with our communications out here to think through some ways so we can do that and we would most certainly, welcome any input from you or any of other our committee members on how we can do that. Any opportunities we could have to publicize this work or disseminate it further or, you know, highlighting any of the work that you all do would very much, again, welcome that and be very happy to take part in.

Hardeep Singh: So, I was going to say, there's couple of people who actually is more than just (EMA) and EHRA, there's plenty of organizations that have, you know, sort of submitted comments, AHIMA, there's several others. I'm wondering if we could reach out to them as well to make sure we get through their membership. And I think, I'm sure people on this group can send you some more information on their network, it would be good to sort of get the word out and disseminate this broadly.

Andrew Lyzenga: That would be great.

(Elisabeth Belmont): And Andrew, I'm happy to help with that as well and I have some thoughts and can follow up with you.

Andrew Lyzenga: Perfect. That'll be great. And please anybody else who has any additional thoughts or suggestions on that or anything else, and you can feel free to follow up with us here as well.

All right. Well, if no other comments or questions, thank you all again. We will let you go early. And we will follow up with more information about – let you know about any changes we've made to the report and we'll be posting that final report soon. So do, again, if you have any other additional thoughts or comments, let us know by the end of this week and we'll do what we can do to incorporate them.

So thanks again everybody and enjoy the rest of your afternoon.

Hardeep Singh: Thank you.

Male: Thank you.

(Elisabeth Belmont): Thank you, Andrew.

Male: Thank you, Andrew.

Female: Thank you.

Andrew Lyzenga: Thank you so much. Bye-bye.

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

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