Transcript

PHARMACY INTEROPERABILITY AND EMERGING THERAPEUTICS TASK FORCE 2023 MEETING

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VIRTUAL

Speakers

Name	Organization	Role
Hans Buitendijk	**Oracle Health**	**Co-Chair**
Shelly Spiro	**Pharmacy Health Information Technology Collaborative**	**Co-Chair**
Pooja Babbrah	Point-of-Care Partners	Member
Chris Blackley	Prescryptive	Member
Shila Blend	North Dakota Health Information Network	Member
David Butler	Curatro, LLC	Member
Steven Eichner	Texas Department of State Health Services	Member
Rajesh Godavarthi	MCG Health, part of the Hearst Health network	Member
Jim Jirjis	Centers for Disease Control and Prevention	Member
Summerpal Kahlon	Rocket Health Care	Member
Steven Lane	Health Gorilla	Member
Meg Marshall	Department of Veterans Health Affairs	Member
Anna McCollister	Individual	Member
Deven McGraw	Invitae Corporation	Member
Ketan Mehta	Micro Merchant Systems	Member
Justin Neal	Noble Health Services	Member
Eliel Oliveira	Harvard Medical School & Harvard Pilgrim Health Care Institute	Member
Naresh Sundar Rajan	CyncHealth	Member
Scott Robertson	Bear Health Tech Consulting	Member
Alexis Snyder	Individual	Member
Fillipe Southerland	Yardi Systems, Inc.	Member
Christian Tadrus	Community Pharmacy Owner	Member
Sheryl Turney	Elevance Health	Member
Afton Wagner	Walgreens	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Tricia Lee Rolle	Office of the National Coordinator for Health Information Technology	ONC Program Lead

Call to Order/Roll Call (00:00:00)

Michael Berry
Good morning, everyone, and welcome to the Pharmacy Interoperability and Emerging Therapeutics Task force. On behalf of ONC, I would like to take this opportunity to thank each of the task force members for dedicating your time, expertise, and enthusiasm to develop thoughtful recommendations for this important work. This task force meeting is open to the public, and your comments are welcome in Zoom chat throughout the meeting or during the public comment period that is going to be held around 11:50 Eastern Time. I would like to begin rollcall of our task force members, so when I call your name, please let us know if you are here. I will start with our cochairs. Hans Buitendijk?

Hans Buitendijk
Good morning.

Michael Berry
Shelly Spiro?

Shelly Spiro
Good morning, everyone.

Michael Berry
Pooja Babbrah?

Pooja Babbrah
Good morning, I am here.

Michael Berry
Chris Blackley? Shila Blend? David Butler?

David Butler
Good morning.

Michael Berry
Steve Eichner?

Steven Eichner
Good morning.

Michael Berry
Raj Godavarthi?

Rajesh Godavarthi
Good morning.

Michael Berry

Jim Jirjis is not able to join us today. Summer Kahlon?

Summerpal Kahlon
Hey, good morning.

Michael Berry
Steven Lane?

Steven Lane
Good morning.

Michael Berry
Meg Marshall? Anna McCollister?

Anna McCollister
Good morning.

Michael Berry
Deven McGraw is not able to join us. Ketan Mehta? Justin Neal? Eliel Oliveira?

Eliel Oliveira
Good morning.

Michael Berry
Naresh Sundar Rajan?

Naresh Sundar Rajan
Good morning.

Michael Berry
Scott Robertson?

Scott Robertson
Good morning.

Michael Berry
Alexis Snyder?

Alexis Snyder
Good morning.

Michael Berry
Fil Southerland?

Fillipe Southerland

Good morning.

Michael Berry
Christian Tadrus?

Christian Tadrus
Good morning.

Michael Berry
Sheryl Turney?

Sheryl Turney
Good morning.

Michael Berry
Afton Wagner?

Afton Wagner
Good morning.

Michael Berry
Thank you so much, everyone, and now, please join me in welcoming Hans and Shelly for their opening remarks.

Opening Remarks (00:02:11)

Hans Buitendijk
Good morning, everybody. We really appreciate getting ourselves very close to the finish line, which will be today's focus, to get us there and finalize any edits and gaps that still might be missing so that, between now and next week, we can wrap up the document and present it to the full HITAC committee for their review. I think we are at a great point here, and I look forward to going through that today with everybody. We really appreciate everybody's feedback, comments, review, and suggestions. We are still going back and forth on a couple of them, but it looks like we should be able to close that today. Thank you very much. Shelly?

Shelly Spiro
Yes. I hope everybody liked the new format and the move away from the spreadsheet. I am really glad we were able to do that. We have lots of comments that came in. I just want to thank Hans. Hans has just done a great job with going through all the comments and trying to restructure the recommendations, so we definitely owe him a big thanks for all the hard work he has done. I also want to thank the ONC team, Mike, Tricia Lee, and Maggie, and the folks from Accel who are doing all the work for us. So, thank you very much, and I think we can get going now. We are right on schedule to move forward with the review of the draft recommendation report. I am going to turn it over to Hans to get us started.

Review of Draft Recommendation Report (00:03:57)

Hans Buitendijk
All right. Let's see. Since we are now in Google Docs, when edits are made, one can see them popping up immediately as well. Somebody from the ONC team might be able to share the screen while I am applying some edits and other thoughts there. Could you go to the top of the page? The plan is just to go from top to bottom, see where we still have open comments or highlights on what changed, make sure that we are all okay, and in the process, between Tricia Lee and myself, we are going to apply the updates, accept the comments, and make some notes in there. That is now the nice part. Unlike spreadsheets, where that could conflict, now we can actually see what we are all doing at the same time.

So, when we scroll down, we see that background has been added. Thank you, Tricia Lee. Have a look through that. We do not need to do that right now. It is really down to some fine-tuning there, but that has been added at this point. We can go down to the charge. There is an open comment that relates to Topic No. 4. Tricia Lee, do you want to give a little background here, and then we come back to it in the recommendation where we specifically talk about it, or we can wait until we get there and then address the comment that Tricia Lee made around this?

Tricia Lee Rolle
Sure, I am happy to do that. Let me expand my full comments and let folks read that while I talk. So, as you have been going through this, this fourth charge identified policy and technology needs and considerations for direct-to-consumer medication services. I have some new concerns about the term "direct-to-consumer medication services," that it could potentially invoke the negative connotations associated with direct-to-consumer advertising. I have to be careful how I say things, but there is a lot of scrutiny on manufacturers and the pharmaceutical industry on allegedly trying to bypass the physician relationship in getting individuals to request certain prescriptions, so we are not assuming that there are nefarious intentions here, but we really are just trying to describe an area where there is a lack of visibility on the prescriptions individuals are receiving.

We have talked to individuals at DiMe. I know Alexis had also suggested that we reach out to individuals there. They shared some information that there might be some more industry-acceptable terms that we can use to describe this area, and what was shared with us was that it is called virtual-first care. Let me see if I can share that with you guys. Are you still seeing my screen? Let me see if I can get the reshare to share this with you. Hold on.

Alexis Snyder
Actually, it was Anna that suggested that. I do not know why everybody always confuses Alexis…

Tricia Lee Rolle
I do not know why either, and shame on us for being so far into this process, yet still Anna-and-Alexising both of you, so, apologies for that. Okay, I am sharing my screen.

Alexis Snyder
Because we are both very well-spoken patient advocates with the letter A at the beginning of our names.

Tricia Lee Rolle
Right, right. So, I want to thank Megan Coder. I reached out to her and had a conversation with Doug Mirsky and Abby Sugg at DiMe, and they shared this concept of virtual-first care. It is medical care for individuals or a community accessed through digital interactions where possible, guided by a clinician, and integrated into a person's everyday life. In particular, there is this framework that kind of has some components that fit what we are talking about here. It kind of covers synchronous and asynchronous virtual interactions between an individual and a clinician, and it also covers the prescription medication services that an individual might receive.

So, I kind of included some notes in the document with some suggested language. I cannot make those edits on behalf of you all, but this is just a place to start thinking about if we can and should start clarifying that term "direct-to-consumer prescription services" some more by describing the fact that what we are really talking about are these virtual care interactions. So, I will leave it there, and I will go back to the document for folks to discuss it, but I wanted to share that I was having a bit of angst. I really do not want us to be putting out a document where it is perceived that we are coining a term or phrase that might have some negative association with it. So, it is kind of the last hour here, but is there an opportunity for us to better clarify that term so that we are not being confused by those that read this document and work product?

Shelly Spiro
Okay, we have several comments. Steven, then Christian, then Anna.

Steven Lane
Sorry, Tricia, what part of this do you think would have a negative connotation?

Tricia Lee Rolle
The "direct-to-consumer medication services." In the document, we have been calling it DTC. It just reads as though we are coining a new phrase to describe…

Steven Lane
That is a pretty common phrase. Direct-to-consumer advertising is something people have talked about for years. As I mentioned in the chat, the idea of virtual-first care is very popular. There are lots of digital health companies that are standing up similar services to the one that you are showing us. I do not personally see this as negative. We could perhaps flesh it out and talk about a list of "for instances," but I do not personally think it is a problem as is.

Shelly Spiro
Thanks, Steven. Christian?

Christian Tadrus
Thanks, Shelly. As a pharmacist, these connotations are hitting a little weird, too, and I think it is a tough term to describe because we are not sure what we are truly defining. This is just part of my perception of some of our recommendations, but I think it applies here, too. When I hear something like "direct-to-consumer" or, for example, some of the rationale we have landed on with product locating, some of that really comes across in the pharmacy world as bypassing the pharmacy or the pharmacist in the equation

of care. As I go back to our charge here, these recommendations are built to engage the pharmacy component of healthcare in the national healthcare IT infrastructure roadmap and really try and get consumers more directly connected to the valuable roles that pharmacists can play.

So, just the concept or topic of "direct" indicates bypass, and I am wondering if we can figure out, throughout the document, even, where we can flip that a little bit and say that there is an efficiency aspect to it, and it could be a prescription component, but it also could be more of the telehealth engagement processes that we are typically using now to engage patients. I guess what I keep coming back to is as long as we are not bypassing the role of the pharmacist in these relationships around both dispensing and provision of the services that the pharmacists provide and dial into it, then we can come up with a better term for it. That is my gut, that we are drifting a little bit to convenience and not enough towards putting the teams together in some of these recommendations.

Tricia Lee, I know this is a tough call. I do not know what the term is because it is still an evolving model, but in the end, with my regulatory hat on, the construct does not matter. The expectations of pharmacists, engagement, and oversight of these types of processes in pharmacy would be expected in any delivery mechanism that is being done. We are basically defining a method of delivery, but it still has to have the components of not bypassing the pharmacists in the process, if that is helpful.

Hans Buitendijk
Just to interject, at the same point in time as other comments come in, can you scroll to Recommendation 38 so we can look at it and consider it? That is the one where we are speaking to direct-to-consumer. That is also the only one that addresses Topic 4. So, as we are discussing what kind of changes to make, this would be the place to respond to it in the text or to make some adjustments so we can have that in mind. Recommendation 38 is the one to keep in mind as we go through this. Anna?

Anna McCollister
From my perspective, it is a relatively straightforward issue of nomenclature. I think "direct-to-consumer" is confusing, and it does seem to suggest that there does not need to be a provider involved. I was confused about it when we first started discussing this because I was not completely sure what it meant, but what we are talking about is virtual-first care. In essence, these companies and services are popping up that do the exact same thing that a physician would do, but they do it via telehealth, online, and, to some degree, asynchronous methods, and there is no in-person component.

So, there is a physician involved that is a prescriber, which is why they call it virtual-first. Sometimes, the virtual services are integrated, and again, I am one of the founding members and am on the steering committee of Impact, and what we are trying to do is come up with a set of standards and industry guidelines and criteria for assessing quality of care that helps these services integrate more seamlessly into the broader medical system, but all it is talking about is providers who prescribe things who do not have physical offices. They may have a physical office, but that is not where they see their clients and their patients. So, I do think "direct-to-consumer" is misleading, and Tricia, I think it was smart of you and helpful to raise that, but the term that everybody has landed on is "virtual-first care," so I would suggest that we use that because that is where everybody has landed.

Shelly Spiro

Pooja?

Pooja Babbrah
I put this in the chat. When I look at this recommendation, all we are doing is convening stakeholders, so I wonder if we should just call it either online pharmacy or online pharmacy services. I know Afton commented that there are some that are rogue as well, so I am kind of posing this to the group. I do not know if these pharmacies have to be certified, but maybe we could say "online certified pharmacy or pharmacy services." I agree that we need to get rid of "direct-to-consumer," but if all we are doing is convening at this point, I wonder if we are okay with just calling them out as online pharmacies, online pharmacy services, or both, since this is about convening that stakeholder.

Anna McCollister
But they are not just pharmacies. These are doctors who are doing care, and they are ordering labs, and they are following up regularly and getting counsel.

Pooja Babbrah
If we put them in as one of the stakeholders, Anna, would you be okay with that recommendation?

Hans Buitendijk
Maybe along those lines, Shelly, if I may point to what I did during the conversation, the original question included the term "direct-to-consumer," so I do not think we can really change the original question, as it was part of the charge, but if we have clarity in here that we use the term to tie back to Topic 4, as we have indicated that this is a response to that, we use both terms, "virtual care" and "telehealth providers," which includes pharmacists, and presumably, they are authorize and licensed, etc., but in the rationale, we are dropping the term "direct-to-consumer." We may describe it a little bit further, but then, in here, we describe that transition so that we are sensitive to not really propagating the term "direct-to-consumer" in its other context. Would that help?

Shelly Spiro
This is Shelly. One of the things we have to remember is what the intent is behind what ONC made as a recommendation. From a pharmacy interoperability standpoint, it will be important for whoever is dispensing the medications on the pharmacy side to be able to share information in an interoperable way. That means that "online pharmacy," "virtual pharmacy," "DTC," or whatever you want to call it is going to be interoperable and in a position to exchange information with others of the care team who are taking care of that patient. I think that is probably the biggest issue that we see with this, that the patient can help in this by giving consent to share information about their care, and it is not siloed care.

Are they using e-prescribing? Are they using the standards for exchange? Is there clinical information that they need, not only for the medications that are being dispensed, but also for assuring that those who are taking care of the patient are able to get that information from these operations? I think that is the intent, and Tricia Lee, please help me clarify this, but what is important is to get the point across that these are different, not in the mainstream of what we consider interoperability in relationship to pharmacy and pharmacists, but moreover a separate type of entity that needs to be brought into the fold.

Hans Buitendijk

From a progression perspective, we have a number of things we need to get through. Would it be okay to come back to this one later in the conversation once we have had a chance to go through everything else? And then, in the meantime, one can look at 38, and if there are suggestions on how to improve the wording or otherwise, we can come back to it after we have gone through the rest. Otherwise, we run the risk of not getting to that. Would that be acceptable?

Tricia Lee Rolle
While folks are looking at it, I will also add that perchance, 38 is too confusing to make the clarification there. Mike did inform me that we have the ability to add a clarifying footnote to the charge task, so at this point, we cannot change the charge task itself, No. 4. It has been voted on, and we would have to go back to the HITAC to do that, but we can clarify it. So, there are some options, and it is at your discretion where to put any clarifying statements.

Hans Buitendijk
Ike, go ahead, and after that, let's put this on the back burner for a moment. We will go through the rest and then come back to see, based on this, what we can adjust when we get to 38.

Steven Eichner
Hans, this is Steve. I just want to put in a footnote for when we come back. We also probably want to include patients in this space as well, just because of what happens with yet another circle or sphere of sharing patient information or information blocking that is used to control that information flow.

Hans Buitendijk
Thank you. If there are specific suggestions that you would like to have as we go through, please annotate or make a comment under 38, and then we will come back to it and see how we can improve the phrasing there, plus consider the suggestion to have a footnote as well at the top to clarify the charge. We will come back to that. Okeydoke, Shelly or Tricia Lee, anything else before we keep on going and then pick this back up?

Shelly Spiro
No, go ahead.

Hans Buitendijk
Okay. So, the first one is going to be a combination of some smaller and larger ones, but we just want to make sure, particularly from those that submitted the suggestion, that everyone is okay with it. In the additional background, there was a suggestion to include "caregiver," which makes sense, but also to use the term "patient advocate." This is the suggested updated wording. I just want to make sure with either Alexis or Christian that you are okay with that in the context of your suggestion and that we can then move to the next one and I can hit the checkmark.

Alexis Snyder
I am good.

Hans Buitendijk
Christian, does this address your…?

Christian Tadrus
Yes. I think it was more editorial in nature. I was just trying to call out that we did not really have a group of patients here reflecting on this. We had advocates. I was just trying to clarify that as a matter of who was in the room. It is probably not a significant thing, but I think "patient and caregiver advocates" looks good. That will work, thank you.

Hans Buitendijk
Okeydoke. Let's jump to the next part, recommendations. That is primarily to highlight that we have been talking about definitions of providers and pharmacists. For "provider," we specifically pulled from 42 USC 300(j)(j), and that is also referenced in the 21st Century CURES Act final rule. For the term "healthcare provider," we pulled that from a document that ONC provides on where they tied these together, so it is the literal text from an ONC document in that regard. Are there any concerns with using this? This clearly pulls out the variety, including pharmacies and pharmacists, in here that we then can use. We have "pharmacist" specifically defined, we have "pharmacy" further defined, and we have "other provider," when we use that, to indicate that we are then referencing.

Steven Lane
Hans, I just added one word there in the top paragraph, "regulatory interpretations," because they also have different interpretations just in common speech, and since we are referencing the regulatory, I think that makes sense.

Hans Buitendijk
That makes sense. Any concerns with this or the "provider" definition? I already hit the checkbox, but I can go back.

Shelly Spiro
I think it makes sense.

Hans Buitendijk
Then that is done. There was a suggestion to clarify a little bit more on the pharmacist, and there was a comment here, because it is highlighted…

Christian Tadrus
That was my addition, Hans, pulling from some regulatory language in Missouri as an example of the prescriptive authority.

Hans Buitendijk
Any further concerns or comments around that?

Shelly Spiro
I think it is a good addition.

Hans Buitendijk

Okeydoke. If there are no further concerns, then we are done with that. We will find our way back to 38 pretty rapidly at this pace, so then we will have the rest of the time to look at that. Here, there was a suggestion from Alexis to add some more about patients and caregivers and transparency. In the consumer statement around that initially, we beefed that up a little bit more to make it clear that the consumer engagement full transparency is about everything that is relevant and appropriate, but now that is shared with the consumer engagement. So, the suggestion was to not add it to bidirectional, but to make sure that consumer engagement is more clear. Alexis is okay with that, but I wanted to make sure everyone else is fine with that as well, that we keep that consumer engagement along transparency applicable to wherever needed, not just bidirectional. I am not hearing any, so we are okay there.

As a result, we made an update in full transparency. Could you scroll down a little bit further? That is where we further clarified to make that more clear, as well as that there are a couple other examples that are put in with various updates. We want to make sure that we are okay with these bullets under consumer engagement. Alexis, I believe you are okay with it. You made most of the comments there. I want to make sure we did not miss anything. Any others as well? Christian?

Christian Tadrus
Hans, I still have a little bit of heartburn if we are not putting a recommendation in there that that suggests the pharmacy can provide more relevant information regarding availability in this situation. I think that is so key in this particular arrangement to avoid assumptions and steerage issues, so I think we have to reference that the interchange has to be robust enough to give a full picture of when product may be able to be on hand and those types of things. Is that captured here?

Hans Buitendijk
Well, the intent here was just to capture the kinds of use cases we are talking about. In the recommendations, particularly R11, is where that comes back in a couple of other places, where transparency comes back in a number of places. This is the use case, so, in the recommendations, there are a couple of them that would reference both consumer engagement and bidirectional or other ones.

Christian Tadrus
Okay, then I am content with that. Thank you.

Hans Buitendijk
All right. Any other comments on consumer engagement? Christian, double-check that in the rest, but it did come up in a couple of places on transparency. If not, then I am going to start to hit the checkbox on these ones around consumer engagement, and then be able to look at the next one, where we are talking about pharmacy quality measures. There were a couple of different comments on clarifying this that came from Christian, as you can see on the right-hand side, and VBC quality measures to see whether there were any other ones that were clearly inside the recommendation.

This time, I am not sure exactly what the number was, so I am not going to list specifically. We will get to it. There are specific ones listed in the recommendations. This was just to give a flavor of the use case that we talked about. I wanted to make sure that with these updates and a summary of some of the kinds of quality measurements that are more specific to VBC versus quality measures that are relevant in a pharmacy/pharmacist setting regardless of whether it is part of a VBC context or not. I want to make sure

that these examples for that are reflective of those contexts because they are quality measures, but with a different angle to it. Pooja, you had a comment here, so I want to make sure you are still on.

Pooja Babbrah
Yes. It looks like Christian already went through and commented.

Christian Tadrus
Yes. I do have another example that we might be able to put in there.

Hans Buitendijk
While I am accepting these ones in suggestion mode, if you want to put them in, then we can come back to it once you have done that. Any concerns with the existing ones as I am hitting the checkbox? I am not hearing any, so I am going to try to remove all the markup as we go. Okay, we will come back to that once Christian had a chance to give another example in there. The next comments you are going to see are just trademarks, so do not worry about those. Those are just fewer edits. We go now to R27. In R27, there were comments made to remove some text, though not all of it, from the recommendation to the rationale, particularly that in strikethrough that is highlighted here. You might see me highlighting that around there. That text is now incorporated in this way in the text, not at the start, but in the middle, in this particular way. Plus, Fil had a comment to reference HTI-1 Recommendation 6 from HITAC, and that was included here. Here, we want to make sure we met the intent from Fil's recommendation and from the discussion last week on this.

Fillipe Southerland
No issues from my side, Hans. This looks great.

Hans Buitendijk
Okeydoke. Anything on the way we blended the text that was moved into the rationale? If not, then we are going to move along and get that other green out of the way. Next one, 38. Actually, I am going to skip that. We are going to come back to it after we have gone through the rest and after others might have had the chance to read through it and get some updates.

Shelly Spiro
Christian, you have your hand up. Is that from an old one, or do you still need to talk?

Christian Tadrus
I will lower it, sorry. That was left over.

Shelly Spiro
Let's go to Recommendation 12. Here, there are three recommendations, 12, 32, and 11, that were discussed. Twelve and 11 were discussed as part of Topic 1, where we had extensive discussions around a variety of topics on availability of data in real time to patients. In R11, there was a lot of work done by Alexis, Afton, and others to make updates to that. Twelve was listed first based on the current sequence, 11 was not until later, and 32 is somewhere in between, so they are a little bit spread out across the document based on the organization right now. So, it initially appeared that we missed out on the discussions and the detail that is provided in R11, which, if you just want to jump to it, is towards the end

where it is in play. The page numbers are not totally clear, but it is the first one in quality measures. Tricia Lee, would you scroll to that? Let's see how many pages down it is. Keep on going. I am not in display mode, so I am not seeing the page numbers in mine.

If you go a little bit further, you will see quality measures popping up, but it is well beyond this. There you go. So, that is where the main discussion was, because it really was around defining quality measures around this. So, the question became do we need to have all three, two of them, or can they be combined into one? The suggestion would be that clearly, R11 is kept as is, that it stays there, that R12, albeit shorter, is focused on a particular interoperability capability and is kept where it is, and that R32, which we will go to in a little bit, is the one that we are going to merge with R11, and we look at this text here. That has taken the key components that are in 32 that were not yet in R11 and blended in here in both the recommendation and the rationale respectively to make it fit. The references were actually all the same. So, if you can look at that a little bit further, let's go back to…

Shelly Spiro
Before you do that, Hans, can you scroll down a little bit more? I want to see what the subtopics are after the rationale. So, you included Topic 1A and Topic 2, and the other one was Topic 1B also.

Hans Buitendijk
Let's see. I did not notice that. I thought I had that. Let's check that, because that would have to be copied as well. I will make a note to make sure that that is there. Actually, look at 32. I am sitting in the wrong place here. So, I will take Topic 2B and Topic 2D. Topic 2B needs to move across, and then it will all be merged together. I am moving that around as we speak. That is going to end up there. So, you can look at that and see that, as a result, when get to 32 and 11, they are now intended to be merged, and as we go back to R12, that is intended to still stay on its own because it is not quite just about quality measures, it is more about the capability. Let's see whether that separation makes sense as a result. If you can go back to 12, we can pick it up there. If you search for R12, it will get you right to it.

Shelly Spiro
You were there, but just go up a little further. Right there, that is R12.

Hans Buitendijk
That is the one that we suggest keeping on its own. It does not have all the discussion that was put in context of the measure, but copying it over here or merging it seemed to lose out some of the discussion in R12. With that in mind, there are the updates, and I see that Steven also made an additional update as well. This is appropriate, and we can move those suggestions forward as well.

Steven Lane
It is not just the response that may be inefficient, but the entire communication.

Hans Buitendijk
Right. Any concerns? Alexis, are you good with this, as you raised the question to make sure that we did not miss the duplication or kept them apart?

Alexis Snyder

Yes.

Hans Buitendijk
Okay, I am going to mark this one. Any concerns with what Steven just put in? I am going to accept that, not having heard any other ones. All right, we will come back to the merge of 11 and 32 in a moment, but we can then look at that and make sure we got it. Here, there was also a thought to merge 13 and 14, if it is possible on the screen to show 13 and 14 mostly together. There is a suggestion from Alexis to consider merging them together if they are duplicates. It looks like they were still addressing different perspectives. My suggestion was to keep them apart, so I want to get from the task force overall if we want to keep them apart or work on them, and we can do that separately and still merge them. Any preference? Just have a look through it. While you do that, Christian, I see you have something in the chat.

Christian Tadrus
Those are the use cases. I do not have a suggestion for this. Maybe a few of those might be good examples.

Hans Buitendijk
While others are reading this one, I will see whether I can get the text and drop that into the use case nearby as a comment. Anything on 13 and 14? Summer, go ahead.

Summerpal Kahlon
Thanks, Hans. I was just reading through them, and I do think it makes sense to combine the two. The main reason is that, in 13, the recommendation is to give information about why a prescription has not been filled, which makes me lean more into communication as a conversation about why it has not been filled. Where I went back and forth in my head, and maybe others can weigh in, is it would make sense to keep it separate only if it is about automated transactions.

So, if it is a specific sort of question and response where a data element comes back as “prior auth required” or “step therapy required,” something like that, as why it has not been filled, in that scenario, it makes sense to keep it separate because it is a structured, transactional response versus an unstructured response of having a conversation about why it was not filled and that kind of thing. I do not know if that was the intent in keeping it separate, to make one transactional and one more free-form communication, but if they are both meant to be more free-form, I think we should combine them. If the distinction is that one is transactional and one is free-form, then I think it makes sense to be separate.

Hans Buitendijk
As I was reading it, my interpretation was that that came across a little bit more to still keep them apart because they are different parts, although they are very related, so we should keep them next to each other.

Summerpal Kahlon
I guess I am arguing with myself while sharing that. When I read the rationale, it says “there is an insurance issue” or “more information is needed from your provider,” so, based on the description here, I would say to combine them because it is really more about a conversation. It is pretext, so to speak. I do not know if that is the clarification and the rationale for 13 that we need to discuss if people feel like it needs to be more transactional or clear, “step therapy required,” “prior auth required,” or “nonformulary” as a standardized response. Maybe just to be clear, I think the way the two are written now, they should be combined.

Hans Buitendijk
Others? Anna?

Anna McCollister
I included these, and again, I put this in the chat, but I have not been able to really read the documents all that well because I had a retinal bleed a few weeks ago. I will be fine, but there is a temporary wealth of blood still in my vitreous. The two are distinct in my mind in the sense that the first one, R13, was based off the fact that many times, after I have waited on hold for literally hours and/or been forced to go into the pharmacy, the pharmacist can print out more specific information about what the issue is as to why the medication has not been filled, whereas the only information you can get on the app basically just says there is an insurance issue. The pharmacist actually has a structured form that they can print about what the insurance issue is. That is just not shared with me, but it could be helpful if I have to make a phone call to the insurance company or the doctor to get it clarified. For reasons I do not understand, that information is never shared through the app or the portals, and that would be a very simple thing to require.

So, if the pharmacist has some sort of structured information in their portal, that information should be shared with the patient in case there is some sort of action that needs to be taken. It literally would save me hours and hours of time just to be able to get that information. The second one is that there is no way to communicate with the pharmacist via that app. It may be related to the recommendation I had about making sure that any data that is available to the pharmacist in a structured form is also available to patients, or it may be something else, but right now, it is just one-way messaging in a coded format, so it is the only way that you can get through and provide any additional information.

For instance, there is one medication that is frequently switched; it is "generic." There is a big difference with the generic. Inevitably, they will fill the wrong one. I now know the NDC codes. There is no way for me to communicate that to the pharmacist, that they have, once again, automatically switched, against my wishes, against the caregiver's instructions, to the wrong medication, the wrong version, the wrong NDC code, the generic. I have to then wait on hold for a couple of hours, potentially, or go into the pharmacist's to stand in line and tell them, "You have once again made a mistake. You have given the wrong medication." So, that is just one example. I could think of others if I had more time. They are related, but I consider them to be distinct.

Hans Buitendijk
We have a couple others. Christian, Scott, then Alexis, and then we will see whether we can wrap it up into a split or keep them separate or combined. Christian?

Christian Tadrus
Just to follow on Alexis's comments, I understand the interest in understanding what is going on, but maybe for clarity, the processor messages that can return to the pharmacies around these delays and hiccups in processing a claim are often pretty limited, and they are determined almost entirely by the payer in terms of the free text, but they can also be fairly cryptic. The recommendation is okay to be separate in my mind, but if we want to go down this path, we may want to refine it to focus a little more on the clarity and detail of the response from the processor and/or the ultimate payer in consumer-friendly and appropriately detailed language. That has to be the infrastructure build. If that is the expectation, there has to be a lot of

work behind it to get payers to start providing more information through the pharmacy and even directly to the consumer.

Anna McCollister
Just a note that that was Anna, and not Alexis.

Christian Tadrus
I am so sorry, but I have joined the club now.

Anna McCollister
You are not alone. Everyone seems to keep doing that. I keep getting all the credit for Alexis's good ideas, and she gets blamed for the ones that are probably not as good.

Hans Buitendijk
Perhaps also from the comments that were made so far from Christian, Anna, and Summer, if 13 is more on that the information is shared and 14 is that there is now an interactive communication as follow-up because of that or otherwise, if we can make that distinction better, there is a good reason to keep them apart. If they blend together, then we can try to blend them together, but if we can make the distinction that one is about the provision of information and then you need to be able to follow up with questions, then that needs to be there. Alexis?

Alexis Snyder
I was just going to say that I am fine with keeping them separate as long as we change some of the language. There is just a lot of duplicative language about the communication process, so I think that we could probably just rewrite them both to clear that up and make the distinction better, and then I think it makes sense if you want to keep them separate, but I also did want to add, rereading Recommendation 14 and listening to what Anna was saying, there are pharmacies that do have two-way communication via an app. It is just not universal, and so, perhaps we should rewrite something that says to make this a suggested, mandatory, or universal process for pharmacies that do have apps to allow the two-way communication. I would not word it that it is not there, because it is for some.

Shelly Spiro
I have a problem with the word "require" because there is no regulatory requirement that ONC can put on pharmacies for this, so I think we should use what was just said by Alexis, that we look at it as more of a suggestion, because there is nothing in the standards, unless fill status is available, but it is still… I am worried about the word "require" from a regulatory standpoint. Tricia Lee, do you want to say something on that?

Hans Buitendijk
Based on these comments, what we can do is take a couple of folks and try to see how we can keep it more clear on what the distinction is, and then remove the duplicative aspects of it, but it is clearly understood that these are only recommendations. "Require" might be a stronger word than we can use. What I am trying to figure out is that we will not get this right now, but we make some updates after the meeting, and we let everybody know to look at that as soon as an update is out there and see whether there is any further refinement that needs to be done. I do not think it requires a follow-up meeting, but just

clarifying language that is there. I am not hearing disagreement on the essence of the multiple points, but rather if it is best organized into one or two. Is that a reasonable way to move forward? And then, I am going to particularly reach out to those that just commented today on that to make sure that it captures that. Any concerns with moving on?

Shelly Spiro
I know that David had made a suggestion related to R13 and 14. David, do you want to explain that?

David Butler
Sure, I would be glad to. If you leave it as two, that is fine, but it does seem to me that the purpose of R14 is to accomplish R13, among many other purposes, and so, I apologize for the typos in my suggestion in the box, but I would take the opening sentence of Recommendation 14 that ends with "to facilitate two-way communication between the pharmacy and the patient" and extend it to say "in order to improve patient care through greater pharmacist-patient-caregiver interaction for such needs as…", and then create a list of needs, the first of which would be R13, because that is what we are really trying to do, is improve the overall two-way communication in order to accomplish R13, which is to allow provision of specific information, as well as to allow improved assessment by the pharmacist on the patient, as well as to allow the patient to make sure they are getting their medications as quickly, safely, and conveniently as possible. So, I would think we could just extend the phrasing on R14 with that clause that I mentioned, and then add 13 and possibly several others underneath it.

Hans Buitendijk
Thank you. Let's take this with the other comments and work with it to find out if it is easier to combine it, as you indicated, or more clearly separate the two parts of sharing information and the interaction of communicating back and forth on whatever it might be, including the information shared from R13. I think that is where the part comes in. It is not clear in either one or the other direction, but it encompasses everything we just talked about. Let's work through that because that requires a little bit more wordsmithing and construction to hold it together, and we will let everybody know it has been updated to get final feedback on that.

Shelly Spiro
Hans, just a question. Are the majority of people thinking of combining it or keeping it separate? I do not know if we have come to that agreement.

Hans Buitendijk
What I was hearing was that it can be okay to be separate if it is clear and that it can be okay if combined, so I did not hear it clearly one way or the other, as long as the points are more easily understood, if that is a fair interpretation of what the discussion was.

Shelly Spiro
I can live with that.

Hans Buitendijk
Any objection from anybody on that? Can we just put two next to each other after we work them and figure out which one we are going to use? Okeydoke, let's move on to R32, a couple pages down. This is the one

that we started with R12 that had some relationship to it. The suggestion here is to combine it with R11. So, if you look at the statement made here at R32 for a moment, we then jump to R11 to make sure that the intent of 32 has been included and preserved in R11, and then we can wrap up R11 at that point as well.

Shelly Spiro
Which category is R32 under?

Hans Buitendijk
It is under specific interoperability capabilities of particular interest, and R11 is about quality measures. Let's look at that. There are two parts to the markup or highlighted text. The overall purple text is what was lifted from R32 to make sure that R11 addresses 32, and then there is a second question. There are two suggestions that were somewhat different. One is to use the term "their," "can fill their prescriptions," and that it is applicable to anyone, and the other one is to use the term "urgent" to have a subset of prescriptions that is particularly focused on that. So, we have two questions, whether the purple is reflective of 32 and whether we should use "their" or "urgent," which is a subset of prescriptions. Anna?

Anna McCollister
Sorry, I was on mute. Who defines "urgent"? The amount of time that it took for me to get access to my prescriptions to go on a two-week vacation was insane. Would any of those particular medications be considered urgent? Would I die without them that day or the next day? No, but I needed them urgently so that I could leave, even though I had started working on the process four weeks prior. I do not know what the word "urgent" actually serves because it is relative.

Hans Buitendijk
So, your suggestion would be to go with "their" because it is more inclusive of the variety that it could occur with?

Anna McCollister
Yes. If you take a medication daily and you cannot get it, it is kind of urgent. Otherwise, you would not need to take that medication.

Hans Buitendijk
With that, is there anybody that is concerned by using the term "their"? That might be the easier discussion to have. Does anybody object to using "their" instead of "urgent"?

Shelly Spiro
Christian?

Christian Tadrus
It is not necessarily an objection. With this whole recommendation being a value-based quality measure, as well as a convenience measure, as well as my comments earlier, I am still struggling to dial it in so that it does not just become the vague definition. Anybody can define "urgent," so the comments just made are as relative as "urgent" is. Who gets to decide what is urgent? So, I do not know that we have the best verbiage here, but at a higher level, I am still struggling with it even being a quality measure

recommendation because there are so many other factors to get involved in this, and many are out of control of the pharmacy. I guess I keep coming back to how it is really a communication conversation. If we are doing quality measures, we should be talking about how efficiently and appropriately the pharmacy engages with the patient, which is ultimately going to lead to better overall care. That is what I am struggling with, not necessarily the "urgent" part, just the fact that there is a quality measure on convenience. I am not sure that is an appropriate recommendation.

Hans Buitendijk
Noting that this recommendation that indicated value-based incentive structure was developed this way by the subgroup, that is where we sit right now.

Christian Tadrus
Yes. I may be an outlier, and I understand that, but you know where I stand.

Hans Buitendijk
It is going to be a little hard to make that level of change at this stage, given the discussions that have occurred. David?

David Butler
My thought on the real measure here is that we need to make this so there is a way to capture data about it and there is a way to use that data to improve all aspects of the pharmacy, whether it is the immediate prescription, something that is more delayed, something that is held up, or anything. To me, the key phrase here that is most important is that we need to make sure we need to agree on a manner that optimizes patient care and convenience. I am comfortable with that phrase, but what I am leading to is I would actually take "their/urgent" and replace it with "all prescriptions," the word "all," so they can fill all prescriptions in a manner that optimizes patient care and convenience, and that way, we have given a charge to build a system that truly monitors all aspects of the pharmacy, and ways to do that can then be built out from that.

Hans Buitendijk
Then I would almost say we should just drop both words, and then "fill prescriptions" would cover any kind.

David Butler
I thought about that, but it seems a little softer than using the word "all." We could make it "prescriptions" if we wanted it to be more succinct. I just thought we wanted to capture every aspect.

Hans Buitendijk
I am hearing, then, that it should be "their," "all," or nothing, and I am seeing in the text that "all" is fine. Does anybody object to making it "all prescriptions" to enhance that?

Unidentified Speaker
"All" is fine.

Shelly Spiro
Let's ask Pooja. She had her hand up.

Pooja Babbrah
Sorry, I could not tell if my hand was raising or not. Going back to the "urgent" discussion, I know there is some urgency used in electronic prior authorization, and I know that was defined somehow. I just do not know if there is someone on this call that may know that better, but if we do want to keep "urgent" in the document… I know when the prior authorization rules came out from, I think, CMS, there was some kind of "urgent" term defined. I apologize, I am not at my desk, so I cannot look it up right now.

David Butler
Pooja, that is why I was thinking about making sure the word "all" is in there, and I like what you said, if we could include "urgent" somewhere in the text, so that "all" includes the urgent and the routine…basically, everything.

Pooja Babbrah
Yes. So, we may want to look at prior auth, because I think that is defined in the electronic prior authorization somewhere.

Christian Tadrus
I think "all" is fine. I put in the chat that we have to remember that a pharmacy does not get to choose where patients get their meds, and it is usually payer interests and manufacturers that route patients to different pharmacies, including CMS's "shop your pharmacy every year" logic. So, if the expectation will be "all," then no pharmacy could actually active that, so we just have to clarify that it may be more of a communication that patients have access to the drugs, whether one pharmacy or another is doing it, so we really may want to **[inaudible] [01:04:23]** into transactions like med history and visibility for any given pharmacy to be able to know that if a patient is on a list of 10 drugs, they may be filling three of them, but they can see that they are getting the other seven somewhere else. That may be a thorny topic, but that is really what we are driving at. If we make it a quality measure, patients have the product in hand, and the pharmacy has a responsibility to know that or facilitate that. We are talking about communication and visibility, not the actual dispensing of the medication.

Hans Buitendijk
So, given the discussion, is this update to use "all prescriptions" and include "routine to urgent" to make sure there is no confusion around that a workable way to move forward that we can live with? Not hearing any, I am going to assume we are okay with that. Are we also okay with this as a reasonable merge of 32 into 11 as well, so we can strike 32 by just putting it in here? This then includes 32, we remove it from the top, and we accept all the changes here. Is this then acceptable? Any concerns?

Anna McCollister
Can we just take a quick additional look at 32?

Hans Buitendijk
Yes, we can go back to that. It is the purple one from here that was lifted from 32.

Shelly Spiro

If I can, Hans, just from the chat, Margaret Weiker from NCPDP states that there is an indicator. In the Script standard, there is a CMS notice of proposed rule regarding prior authorization, as it includes timeframes, so that might be the place to look for it in terms of CMS.

Hans Buitendijk
Okay. Go ahead, Alexis, and then we have to start to close this out. We have a few more to go, and we need to go back to 38 in about 10 or 15 minutes.

Alexis Snyder
I am fine with either word that gets used instead of "urgent," but for me, using the word "all" makes an assumption, which I think is what David was just talking about, that you are going to get all of them in one place, so that is why I think "their" sounds better. I am fine with it either way, but I also wanted to point out that whichever word you go with needs to be changed in the purple and the rationale as well.

Hans Buitendijk
Yes. I was just doing it in one spot to make sure we would like it. Any other comments? If not, then these are going to be accepted, and we are going to remove 32 above. Hold on, we just need to get this in the right place. This is the fun part, checking out boxes. Okeydoke, and then, I am going to remove 32. Let's move on, then, to R4. There was a comment made in here to consider merging R4 and R9. They were very similar. If you scroll down a little bit more, we are at R4 and R9. Can you scroll down? Below R9, in green, there should be markup that is combined, and effectively, it just took the two together. There you go. It is purple on yours.

That is the combined text, so I want to have the reassurance that we did not miss anything between the two, and then that would be the recommendation, one instead of two. They both talked about PPRL. One included tokenization, and the other one could have included it as well. By the time we were done blending the text, it seemed to make a lot more sense. I will give you a moment to look at it and see whether there are any concerns with that. I do not hear any. If I am going to go too fast with checking the boxes off, I will start with striking this out and keeping this one at this point in time. Last call. It looks like we can go ahead and remove that, and now we have this. Next is R24. There was a comment from Fil to reference the HITAC recommendations, in this case Nos. 4 and 6, the same as what we talked about before, but now we just include 4 and 6 in here. I believe that addresses your concern, but I just want to make sure.

Fillipe Southerland
I am also good with this one, Hans.

Hans Buitendijk
Okeydoke, we have got that. That means we are at 19. The comment on 19 was that the meaning of the rationale was not clear, so a bit of reconstructing has occurred. Alexis, you were the one who raised that, so I want to make sure that we caught it from your or anyone else's perspective. Did this do the trick, or do we need more work on this?

Alexis Snyder
Well, it makes sense now. The wording just did not make sense before to understand what the concept was.

Hans Buitendijk
All right. Anybody else? If not, then, we are going to accept that. We are almost there. That means we are just about to go to the last ones, as we get a space in here as well. That means that we got to the end, where, in R33, there was a statement here, "other outcome-focused measures," and there was a note that David was going to provide a couple examples. David, I am not sure whether you had a chance to look at that, but if you have anything you can forward, we can still put it in.

David Butler
I will be glad to do that. I thought I did forward them, but I will focus on that.

Hans Buitendijk
Okeydoke, great. As a quick note, we have a list of abbreviations here. Thank you, Steven, for fixing that one. That should be everything, but it might not be. If you find anything missing, please let us know.

Shelly Spiro
I think you have to scroll down.

Hans Buitendijk
All the way down to the bottom, sorry. I was looking at mine. If you have any other ones that were in the text that were missed, just mark them. We are going to check it out. If you find them, just put them in. So, we are going to go back to R38 first.

Shelly Spiro
Before you do that, on that R14 combination…

Hans Buitendijk
Do you mean 13 and 14?

Shelly Spiro
The one you combined that was in purple.

Hans Buitendijk
That was 11 and 32.

Shelly Spiro
Yes. Did you make sure that we had the questions and use cases combined?

Hans Buitendijk
Yes.

Shelly Spiro
Okay, I just wanted to double-check on that.

Hans Buitendijk

Okeydoke, let's see 38. There we go. This goes back virtual or telehealth and direct-to-consumer. I do not see any additional suggestions at this point in time. I think the question is about adding the footnotes, one of the two that Tricia Lee suggested to clarify the charge all the way up at the top of the document, and then, in here, using the term "direct-to-consumer," but then extending it to "virtual care or telehealth," and only referencing "virtual or telehealth" in the rationale. Would that be sufficient to make sure, in combination with the footnote above, that we are talking about the right scope, whether we think we need to have additional text in there, like the one that Tricia Lee is showing on the right? This would be the footnote that would go all the way on top. We could add it here as well, but on the top, it could provide the right context that then introduces this. So, we would still use the term "direct-to-consumer," but not "DTC," and we would effectively switch into "virtual or telehealth," making it clear that it includes pharmacists.

Christian Tadrus
Hans, is what we are trying to capture reflective of siloed or disconnected care models, where this is outside the primary care arrangement, or is it broader than that? We may want to think about that distinction.

Hans Buitendijk
Probably both, in that where this occurs, it may be because it is outside the other regular care team, and you want to have them connected. It is different in that the patient may not have seen the provider in person. I think it is a combination that was discussed here.

Christian Tadrus
I think the term could be dialed in if we really see conceptually as care other than through the final patient care arrangement, disconnected care, or where there is no provider available. If that is a distinction we can make, there is probably a better term we can find for it. If it is too muddy, then my recommendation would more…

Steven Lane
That is sort of a new distinction, care separated from the established care team. All the other terms we use, "virtual," "telehealth," etc., do not get into that question so much as the mechanism or the location where the care is provided.

Hans Buitendijk
The question also becomes where you draw the line of what the established care team is. Is there a record of that care team that is agreed to, and then, if the patient goes somewhere else, that is not part of the care team, even from the patient's perspective, they are?

Steven Lane
It is a whole new discussion we have not really gotten into.

Hans Buitendijk
Scott, go ahead.

Scott Robertson
This is Scott Robertson. Actually, keeping that in mind and using your second suggestion, rather than, say, a virtual provider who is not a member, it is whether or not the virtual provider is part of the primary care

team. So, yes, everything we have discussed has been… We have had this concept of the primary care team that we have never really actually defined, but what we are trying to do here is point out that there could be good or bad reasons or good or bad situations where I go onto some website, fill out a form, and get a prescription mailed to me, and that needs to be incorporated into everything else about that patient. The primary care provider and others need to know about it. So, if they are not part of the primary care team, if it is a virtual provider outside the normal care team, it needs to be included in that patient's overall longitudinal health record.

Hans Buitendijk
We have two in line, Alexis and Anna, and we have public comment in about 15 seconds or less, so why don't we go to public comment, then come back and try to get to a conclusion of accepting what we have here because we do not have time for a larger discussion at this point, and then we can wrap up another thing. So, we will come back after the public comment.

Public Comment (01:18:53)

Michael Berry
All right, thank you, Hans. We are going to open up our meeting for verbal public comment. If you are on Zoom and would like to make a comment, please use the hand raise function located on the Zoom toolbar at the bottom of your screen. If you happen to be just on the phone only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. Let's pause just for a moment to see if any members of the public would like to make a comment. I am not seeing any hands raised at this point, Hans, so I will turn it back to you.

Hans Buitendijk
I thought that Alexis had her hand raised, but she dropped it. Go ahead.

Alexis Snyder
I just did not want to take up too much time before the public comment. I think a lot of what I have been sitting here thinking was also just said by Scott, but I wanted to elaborate a little bit more. When someone is reading "virtual care," they can be thinking that means virtual care within your health system, whether it is your primary care or a specialist within a certain healthcare system or network, so I wonder if there is a way that we can word it not to suggest that it is outside the primary care team, because certainly, anybody you choose to see is then part of your own care team, but something that signifies that it is outside of the general healthcare system, like the way we normally receive healthcare, whether it is in person or virtual, and I do not know what that wording is, but I think it is beyond "virtual or telehealth" because, again, that could be with someone who is generally part of your care team or already in a healthcare system. Does what I am trying to say make sense?

Hans Buitendijk
Yes, that starts to sound like something like this, "beyond the traditional healthcare system," but they said it was too big. While we think about what that word is, Anna, go ahead.

Anna McCollister
Part of what I am having a hard time understanding what the issue is, first of all, is that I do not know what the primary healthcare system is anymore. I do not have a primary care provider, I have a bunch of

specialists, and most of them are at different institutions, so they are still not sharing information well, but hopefully, with the work that all of us have been doing over the years, that is changing. These are not necessarily doctors that are outside of the "healthcare system," they are just ones who are not physically located in your city that you go to their office to see. You work with them or a team. In some cases, especially for the diabetes-related ones, the people you are working with are a combination of endocrinologists, certified diabetes educators, nurses, etc., just like you would with an endocrinologist that you went to see in your hometown.

So, it is not a difference in care, except that maybe you do not have somebody taking your vital signs, it is an interest in the modality through which you get care, so the informational needs that those providers have are really no different than the informational needs of your traditional providers. It is an issue of modality, and as has been referenced a couple of times, I have an endocrinologist who is "local," but is an hour's drive away. I have not seen him in person since the pandemic began, and it is fine. It is still the same provider. He would not be considered virtual-first, but in this instance, the care that I would get from him is no different from the care that I would get if I just went to a virtual-first-care endocrinologist. I realize that for some disease areas, it probably feels a little more like a medication dispensing system, like erectile dysfunction drugs or birth control. The modality is probably a little bit different, but the care needs and care interactions are still the same.

Hans Buitendijk
Thank you. Shelly?

Shelly Spiro
I think we have to remember that this is not as if… Especially from a payer standpoint, if a patient is reaching out to a different provider, not necessarily within the same insurance type of payer model, the problem is the virtual location does not necessarily have the regulatory requirement, as with all pharmacies, to interact with other providers, and therefore, the patient has to put some requests on those providers to share their information, which I guess is consent, because it is not part of the referral process. It is something that the patients are doing on their own, going directly to that provider that is not necessarily within the same network of their current care team members.

Hans Buitendijk
I apologize for having to do this, but looking at the clock, we only have about four minutes left. Is there any way in which we can add a very short reference saying that we cannot arrive on that? Therefore, are we comfortable leaving it with the updates that are included in here, plus the footnote, or, if we cannot get to a consensus on this, do we have to drop it? In other words, it does not seem like we want to drop this, but we are unable to come up with a clearer term of what group of providers we are missing without struggling with how to reference them.

Shelly Spiro
Maybe we should say "out of the current network of providers."

Hans Buitendijk
I think that is part of it. Whose network is it? Is it the insurance network, or is it my care team? To me, they are still part of my care team. I think that is where we are struggling, so I am not sure whether we can find

a term. If somebody still has something over the next time, that would be great, but are we comfortable moving forward with this in the absence of that term?

Anna McCollister
What about saying "nontraditional care settings"?

Shelly Spiro
I think we are still missing the point that the patient is going directly to some other type of provider that is not communicating with other providers that they are usually working with from a **[inaudible] [01:26:32]** standpoint.

Hans Buitendijk
So, in that sense, I do like Anna's suggestion, because it is a group that is not the ones that we are thinking of, and beyond that, it is going to be hard because they are part of my care team. They might not be part of the insurance network, but they might not be part of the health system that I see 90% of the other team, so, in that sense, I am not sure whether "nontraditional" is the right word, nor "offsite providers." Can we work with this a little bit more offline? I know we have the deadline of next week and it needs to go to HITAC, but unless there is a better word we can go with than "nontraditional care settings," are there any concerns from others? We have something, but we are not sure whether it is accurate enough.

Shelly Spiro
Anna, can you make it short?

Anna McCollister
Yes. None of my "traditional" care providers communicate with one another, so I do not think this particular group is any different than that. If there is a communication, it is because I asked them to communicate directly or I shared the information from one to the other, so that is kind of a false distinction at this point. Secondly, insurance companies do cover these services. There is a high rate of coverage of many of these services by insurance companies, so it really is just an issue of modality and setting for care rather than other aspects. Am I going to somebody's office at some point before I do telehealth, or am I just doing it all virtually?

Hans Buitendijk
Yes, and I think this is where we are struggling. We are just running out of time right now, so I think we have to leave it with this. If somebody comes up with something that is short and can fit in here that describes that in a clear term, please forward that, but other than that, I think we have to leave it with this and recognize that this area remains as murky and challenging as it is purely because of the nature of it. It is not clearly defined.

Shelly Spiro
We are at the top of the hour, so…

Hans Buitendijk
With that in mind, there are a couple follow-ups occurring. Christian provided some in the chat, but we will pick up the use examples for the quality measure use case in that space. We are going to have a footnote

that is going to come up in the charge. We have the merging of 13 and 14 that we are running offline. The last one is if somebody has a term that can still go in there, we absolutely welcome it, and over the next couple days, we will send it out, make sure there is nothing else left, and then it will be on its way to the HITAC. Shelly, if you can wrap it up further, that will be great.

Task Force Work Planning (01:29:32)

Shelly Spiro
We will have a task force meeting on November 1st. Hopefully, we can just wrap everything up and get a thumbs up from everyone, and we can work with the ONC team to see what it would mean if we had to go to a shorter meeting.

Hans Buitendijk
All right, I appreciate it. We got just about to the finish, and we will get that done in time to have a complete document and set of recommendations for HITAC. Thank you for all the input and discussion, and we are going to run through the chat to see if there is anything else we need to include to fine-tune it. Let us know if anything else comes up.

Shelly Spiro
Thank you, everyone.

Hans Buitendijk
Thank you.

Adjourn (01:30:19)