The Office of the National Coordinator for Health Information Technology

Meeting Notes

INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA TASK FORCE (ICAD TF)

March 24, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

EXECUTIVE SUMMARY

Co-chair **Alix Goss** welcomed members to the third meeting of the Intersection of Clinical and Administrative Data Task Force (ICAD TF). Then, she summarized the goals for the meeting which were to come up with a structure for the next virtual meeting and to organize a path of workstreams to be developed by the end of the month.

Jim Jirjis and his team walked through the work that was done offline since the last ICAD TF meeting. They created a high-level prior authorization (PA) workflow model as a base to organize and drive the ICAD TF's work forward. This prototype for a PA workflow model focused on a use case for obtaining a wheelchair as durable medical equipment (DME).

The presentation was followed by a robust discussion of the workflow prototype's structure, opportunities presented within it, and what to prioritize from the process moving forward. Some key goals shared by ICAD TF members were to use a Venn diagram or other process mapping or an extensive list of information to discuss how to create a high-level framework to streamline, accelerate, and reimagine the process. They noted that there might be many different types of data that may not be standardized already, so they agreed to start with patient-specific data, like diagnosis data and USCDI data. They agreed that this framework could be used to determine what is missing from the process, and they also agreed not to place as much importance on the numbering of the steps.

Sheryl Turney thanked members for their participation and feedback, and she noted that the discussion about how to organize the next mid-level meeting would continue offline, with a recap to be provided at the next ICAD TF meeting. She invited anyone who would like to share input on the wheelchair example to get in touch, so they could be included in the offline meeting.

There were no public comments, but there were several comments written in the public meeting chat via Adobe Connect.

AGENDA

03:00 p.m.	Call to Order/Roll Call and Welcome
03:05 p.m.	Summary and Action Plan
03:10 p.m.	Wheelchair DME Order Use Case Walk-through and Discussion
04:05 p.m.	Recap and Next Steps
04:20 p.m.	Public Comment
04:30 p.m.	Adjourn

CALL TO ORDER

Lauren Richie, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the March 24, 2020, meeting of the ICAD to order at 3:05 p.m.

ROLL CALL

Alix Goss, Imprado/NCVHS, Co-Chair
Sheryl Turney, Anthem, Inc., Co-Chair
Steven Brown, United States Department of Veterans Affairs
Gaspere C. Geraci, Individual
Anil K. Jain, IBM Watson Health
Jim Jirjis, Clinical Services Group of Hospital Corporation of America (HCA)
Jocelyn Keegan, Point-of-Care Partners
Leslie Lenert, Medical University of South Carolina
Arien Malec, Change Healthcare
Thomas Mason, Office of the National Coordinator

James Pantelas, Individual
Abby Sears, OCHIN
Alexis Snyder, Individual
Ram Sriram, National Institute of Standards and Technology
Sasha TerMaat, Epic
Denise Webb, Individual

MEMBERS NOT IN ATTENDANCE

Mary Greene, Centers for Medicare & Medicaid Services
Rich Landen, Individual
Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin
Jacki Monson, Sutter Health/NCVHS
Debra Strickland, Conduent/NCVHS
Andrew Truscott, Accenture

WELCOME

Co-chair **Alix Goss** welcomed members to the third meeting of the Intersection of Clinical and Administrative Data Task Force (ICAD TF). She noted that several of her colleagues at NCVHS would not be present, because they were attending a NCVHS full committee meeting that was scheduled for the same time as the ICAD TF meeting.

To set the context for the meeting, she noted that **Jim Jirjis** and his team would walk through some of the work that was done offline since the last ICAD TF meeting. Then, she summarized the goals for the meeting which were to come up with a structure for the next virtual meeting and to organize a path of workstreams to be developed by the end of the month.

Co-chair **Sheryl Turney** thanked everyone for the work they did at the last meeting, which she was not able to attend. She was pleased with the initial workload they put together for the devices and is looking forward to the subsequent discussion.

Alix Goss thanked **Sheryl Turney** for reading through the transcript and for volunteering to work with the workflow team.

SUMMARY AND ACTION PLAN

Alix Goss gave a recap of the last meeting. She thanked **Lauren Richie**, **Rebecca Hines**, and **Tom Mason** for clarifying the authorities of the Health Information Technology Advisory Committee (HITAC) and the National Committee on Vital and Health Statistics (NCVHS), which have distinct subject areas in their respective authorities, but the 21st Century Cures Act encourages collaboration between them where appropriate.

She noted that they all want to see the burdens and challenges caused by the separation of clinical and administrative data sets and systems resolved, so they can better underscore interoperability and efficiency in the system.

They have been focusing on a high-level prior authorization (PA) workflow model as a base to organize and drive the ICAD TF's work forward She emphasized the need to focus on the "happy path" for the workflows and noted that they are being built out, based on the constructive feedback received over the past week. This will allow the ICAD TF to come up with a framework for a common understanding of PA, and, then, to look at the various other kinds of PA situations and best determine how to reduce burden and promote efficiency.

She summarized the themes of trust and transparency from the last meeting, which were picked up by the workflows group, led by **Jim Jirjis** with several volunteers, including **Jim Pantelas**, **Alexis Snyder**, and **Carolyn Petersen**. They met and focused on a detailed, high-level workflow for a wheelchair durable medical equipment (DME) order. **Jim Jirjis** and his team, with **Sheryl Turney's** support, were tasked with facilitating the discussion. Commentary and input from this meeting will be used to refine the DME model and, then, to help develop model workflows for other kinds of PA specialty areas in the future.

WHEELCHAIR (DME) ORDER: USE CASE WALK-THROUGH AND WORKFLOW DISCUSSION

Jim Jirjis gave an overview of the key goals designated in previous meetings. They were:

- Define the workflows in question in sufficient detail to be useful, but eliminate unnecessary steps
- Identify a practical ideal state for each, and make sure not to hardwire a bad process
- Identify opportunities to develop an approach to:
  - Standards
  - Data models
  - Workflow integrations
  - Transport methods
- Articulate organized recommendations for the HITAC

He stated that the ultimate goal areas of the HITAC and the 21st Century Cures Act are interoperability, increasing patient engagement and access, and reducing provider burden, and these workflow goals should complement all three areas. The workflows will be helpful only if they have the right level of detail. Then, the ICAD TF can successfully articulate an organized set of recommendations for the HITAC around the standard state of integrations and transport methods.

In the next cycle of prototype work, based on TF member feedback, they agreed to:

- Take a deeper dive on the next level of detail for a particular use case
- Involve the patient or delegate in the process
- Develop this use case prototype as a guide to then tackle the other use cases

He noted that the ultimate goal is to define the workflows with enough granularity to serve as a springboard for standards, data models, workflow integrations and transport methods.

Alix Goss thanked the group that built the workflow for their efforts to express the specific situation from both the patient perspective and the real-life evolution of what someone would experience. She liked the way it was represented, including the need for swim lanes of actors, and she hopes that they can build on the workflow.

Jim Jirjis presented the sample prototype for the general prior authorization (PA) process for a wheelchair (use case for durable medical equipment - DME). He noted that the group that developed the prototype was interested in using the most complex case possible, but then they settled on the example of PA for a wheelchair because it was more straightforward but still involved several entities. The actors and elements included the patient, the provider, the therapist group that does an assessment, the DME company that would be fulfilling the request, and then the patient and the delegate's activity in the process.

He walked the ICAD TF through the ten steps in the process, the three possible end results (more information is needed, PA approved, or PA denied), and any further actions or modifications that might occur after that point. The goal was not to hardwire an ineffective process but to examine it and submit comments on potential opportunities along the way.

Then, he spoke to a slide showing opportunities at many of the steps in the process. He stated that, in the current process, the patient is often left in the dark as to the actions that are happening, so the overarching opportunity communicated on the slide was to copy the patient on all communication and/or create electronic status tracking. He noted that an overarching assumption for each of these steps is that there should be transparency in the process.

The opportunities on the front end were centered around getting the benefits right upfront and collecting more information from the patient. He noted that, throughout the sample prototype, there are a lot of opportunities to define data sets and to make sure that they are either available earlier in the process or communicated as an automatic byproduct. The key factor they tried to achieve was to be sure that the patient was involved in the process as much as possible. Also, they focused on automation and making sure the necessary information and benefits are provided earlier in the process.

He noted that, in the end, if something is denied and more information is needed, they looked for opportunities to ensure that the patient does not have to start the whole process over; instead, they can simply provide missing information along the way.

Discussion:

Jim Pantelas noted that it is significant that the letter of medical necessity does not get finalized until after the DME supplier, the patient, and the therapist meet. Supposedly, this process occurs in this order because they have to justify every feature, and it is the justification of the features that is built into the notification that goes on to the payer. He stated that at this point, the process gets tied-up, and he gave some real-life examples. He noted that the letter of medical necessity that is outlined in step #3 does not get completed until about step #6 or later, in actuality.

Sheryl Turney asked members to look at many of the blocks and say they could be moved to different points in the process, and she encouraged the others to look beyond the order of events and to focus on the data that is needed for each decision. She wanted the task force to focus on ways to get the data communicated between all parties involved sooner.

She explained an example from her own life, in which her daughter was not given the correct size wheelchair following major surgery because the medical team did not let the family know in advance that she would need one. Because the patient and her family did not have the opportunity to give any input earlier in the process, the wrong kind of DME was authorized. Also, she discussed further complications in the process concerning the communication of whether the DME item was rented or owned.

Steve Brown thanked Jim and his team for putting the prototype together as a point of discussion and noted that having a standard notation for process modeling that is explicit, reproducible, and supports the information flows is important. He emphasized that they should consider not only data standards, but also process modeling standards, and he suggested that they reference BPM+, whose website is bpm-plus.org. They are working to do health care modeling with the American College of Emergency Physicians. Other members agreed with the need for a more professional process model.

Arien Malec inquired about the letter of necessity and where it belongs in the process. He recognized that the consensus at the time of the meeting is that it was more important to capture all of the steps and information and not to focus on putting them in a specific order.

Sheryl Turney noted that they will work on the ordering of steps when they transfer everything to the process model. It is more important to capture all steps and opportunities in the process and even work to reimagine some recommendations for moving forward.

Arien Malec stated that there is often an implied knowledge that something, like a letter of medical necessity, is needed for each step in the process, and they should work to identify the inputs, as well as requirements and how to communicate those requirements to all actors in the process.

Sheryl Turney noted her agreement and asked task force members to identify those situations when certain groups of data will be available and other times when there might be opportunities to solve additional problems that come up throughout the process. She discussed the example of those patients who have chronic conditions that lead to the need for a wheelchair or other DME and whether other clinical standards might be applied in these situations.

Gus Geraci thanked the team for the model and agreed with the comments that had already been made. Because this model will be a prototype going forward, he suggested a wording change; he asked that "Payer recommends alternative" under "PA denied" be changed to "Payer offers alternatives -- covered alternatives for consideration." He noted that most insurers do not recommend anything because they are not authorized to provide treatment. Rather, they are merely authorized to provide payment. Members discussed this wording change and noted that "identifying alternatives that are available" is another way to reword that step.

Anil Jain mentioned that other groups have looked at creating a template of PA within the context of using existing HIT standards or emerging ones. He noted that DaVinci has created templates around preauthorization, starting from the work done in the industry; he wondered whether they could take something that has been done already and use it as a starting point. He noted that there are many permutations of each PA situation, and he did not think they should spend all of their time developing the perfect prototype.

Alexis Snyder noted that a big piece of the problem is that different providers and different DMEs are working in different ways and in different orders. Therefore, one prototype is not going to be a fit for everybody. She still supported identifying the pieces and opportunities to make it flow better and to reduce the number of steps to get to the point of approval, but she thought it would be interesting to be able to note the variations that happen in different health systems or with different DMEs.

Jocelyn Keegan agreed with others who wanted to use the knowledge gained and models built by other professionals in the space of PA. She noted that this prototype is a great example that shows how much variation there is when you move between categories of PA, including DME, infusions and on-site defense, med surgeons, and physical therapy.

She noted the importance of normalizing the steps, regardless of their order, and gave an overview of related work being done at DaVinci to be able to understand how the process works.
She emphasized the patient's place as being in the center of the process and recognized the patient data required in the PA enrollment step. The goal is to keep the patient involved in the whole process through clear communication and making sure the patient is aware of the process as it is appearing.
She also noted the power of work happening in the market around smart applications and third-party integration, and she suggested integrating these into the workflows to create a more seamless process.

She noted that the ability to remove variability will allow them to figure out where they can take current work happening in the market and propose the best practices and identify where they can come up with new solutions.

Steve Brown suggested using proper standards and tooling in Red Hat, instead of PowerPoint, to do the modeling of all the common components and data elements between the many versions.

Jim Jirjis suggested starting with what information is needed (from the patient, from a therapist, from a DME company) to process the PA, instead of focusing as much on the steps. Then, they can define standards around the list of items needed to understand how that information can move and be defined. He asked if that would simplify the process and divorce them from the nuances holding them back.

Sheryl Turney agreed with Jim and noted that they initially needed the workflow to get common footing. She noted that the list of types of DME and the events that drive them is long, but they can use some samples from each of them to determine and start to standardize or normalize that data. She asked if there is a better way to gather the data and when the soonest it is available in the process. If data can be made available and shared earlier, then they can act on it more expediently.

Alexis Snyder noted her agreement with Sheryl and mentioned taking away the numbered steps. She suggested breaking it up into blocks or groups and listing under each group what needs to be collected, what happens at each point, or what needs to occur at the end. She reiterated the smaller workgroup's desire to choose a more complicated sample workflow to examine so any others they would work on in the future would seem easier.

RECAP AND NEXT STEPS

- **Alix Goss** gave an overview of the key themes, including the categories of PA mentioned by Jocelyn, the classes of data and examples for the major buckets mentioned by Sheryl, and that ICAD TF members supported the work done to prototype the workflow but are ready to jump to the next level of detail. Then, she gave them some key points to discuss to move the meeting forward.
- **Sheryl Turney** gave a summary of items on the list for the next steps. They included:
  - DME use case:
    - Develop a practical ideal state workflow for this use case
    - Develop high-level opportunity matrix for standards, data models, integrations and transport methods to support this practical ideal state
  - Other use cases – Medical Services, Hospital Services, Pharmacy, Specialty Services
    - Map out the other four use cases to this level of detail
  - Focus on refining the current workflows, or positing an 'ideal' one?
  - Also, she suggested focusing on developing a list of information needs for making a PA decision happen upfront instead of waiting to find out the decision at the end of a workflow. They could start by categorizing or developing those classes of information needed.

Discussion:

- **Arien Malec** stated that the first thing they need to know is whether PA, medical necessity, or some kind of preclearance activity is required for a particular procedure or equipment code. He noted that they need to determine if the payer requires a certain kind of code or preclearance for the procedure or product category UPC. He reiterated the previously discussed top of looking at the patient-specific, eligibility-specific requirements.

- He discussed the topic of cost information and noted that if there are major cost-sharing provisions, any cost-sharing that triggers Medicare-specific rules is relevant to patient payment. He noted that payment options that are required for DME are a factor, as well as greater or lower levels of complexity around specific information required by the payer or by one of the intermediaries. He elaborated on the example of ordering special medications.
- He summarized his examples by stating that first, they should address access to information about whether preclearance activities, prior authorization, medical necessity, or other requirements are required, and information about what is required, whether that information is patient- or planned-product-specific.
- Then, they need to consider information relative to the source; so, this includes what the payer requires, what the DME equipment or specialty firm requires, and other information. Then, they get to how to automate the workflows. He stated that those data requirements are going to be somewhat different on a case-by-case basis, but, at the very least, they need to get access to those up-front pieces of information.

- **Jocelyn Keegan** agreed with **Arien Malec's** points and suggested that the complexity of the type of PA based on the topic or the challenge the patient and doctor are facing. She suggested cutting through the complexity by having the caregiver bill as a simple item that can then be decided based on ICD-10 codes entered based on a specific diagnosis. Once the PA is approved, it is based on the patient's plan information, and she suggested that items could be automatically approved right away and then used later by the patient.
- **Alix Goss** asked **Arien Malec** to share his thought process as a discrete bolded list (included as an email after the meeting, see points below). **Sheryl Turney** noted that it could help people to visualize the situation to spur discussion during the next meeting.
- **Arien Malec** noted that he has a Venn diagram or a list of descending prerequisites in mind. Following the meeting, he shared this set of points to better illustrate his comments on Framework for ePA data and information flows:
  - Outer ring (required for anything else)
    - Eligibility/benefits coverage information (e.g., data returned from a 270/271)
    - Service terminology
      - Medications: RxNorm or NDC
      - DME: HCPCS, UPC, etc.
      - Procedure: ICD10 or SCT
      - Associated diagnosis/indication: SCT or CPT

He noted that this is DaVinci CRD/DTR but perhaps with the addition of coverage response or other information that is member/plan-product specific, and there is a fair amount of value to exposing coverage rules.

  - Second ring:
    - Status/state information on PA submission
    - There's an intermediate ground between fully electronic PA and paper-based PA, in which there is a standard way to open an ePA case and query for status, even when some or all of the data collection is electronic forms based.
  - Third ring:
    - Attachment and or query-based use cases to auto-populate ePA information and/or generate an order electronically (some of the wheelchair DME use case involved an electronic order between the provider/patient and DME organization, rather than ePA proper).
- **Sheryl Turney** discussed the next steps, including the possibility of taking the DME workflow that the workgroup developed and trying to bring it into a bulleted list. Then, they could identify what information is needed at the various steps and try to apply this to Arien's model.

- **Jocelyn Keegan** stated that she would like to build on Arien's idea that the data, itself, matures through a process. She reminded them of the brainstorming they did in a working session last year on price-cost transparency and compared the evolution of this process to that one. She described a patient's PA journey and how pain points could be triggered at different places in the data flow. She noted that they should understand that the patient is not static in the process and is, in actuality, moving through a care system to get this service or this surgery or this DME item in their possession.
- **Alix Goss** summarized recent points made. They included having buckets of high-level flavors of PA, a link to USCDI, Arien's bolded list, the layers of the PA onion, and the principles, goals, and assumptions that they need to start to capture along the way.
  - **Jocelyn Keegan** agreed with Alix's summary and elaborated on the example of the exhaustive exercise of moving enrollment out of the NCPDP standard. She emphasized the need to figure out the framework so niche areas can take form. She noted that the industry can identify the outlier contents of the USCDI.
- **Steve Brown** suggested amending the next steps slide so that a bullet develops a high-level opportunity matrix for standards, including a transport method to support a practical ideal state. He would like to add process models.
- **Sheryl Turney** noted other members' input **and** summarized the recent themes and goals of the meeting, and the need to come to a consensus on the next steps.
  - She has convened the smaller workgroup that created the DME process models, so they need to either take that work and go to the next step.
  - Or, they could define the type of data needed within that process to then try to apply it to the Venn diagram from Arien. Then, they could see how the two would match up and compare those for their next meeting.
  - Another option for a next step would take the picture of the model with all the opportunities listed and would evaluate which requirements are needed for each of the steps, keeping in mind that the steps may not happen in the order listed.
  - They could make a compilation of the types of data that might be needed and then determine at what point would that data be present in the process. Then, they could determine if those data requirements are supported by USCDI.
  - Sheryl asked if the members agreed with these ideas for the next steps. **Jocelyn Keegan** stated that being able to map out the process across all the different types of areas would be helpful and would let them all know what was left on the table.

Alix Goss asked members to pause their conversations to open the lines for the public comment period.

PUBLIC COMMENT

There were no public comments.

Questions and Comments Received via Adobe Connect

Alexis Snyder: maybe if we raise hands we can have some order to comments and evberyone will have a chance

Carolyn Petersen: In lobby, awaiting an operator

Steven Brown: for those interested bpm-plus.org

Jim Jirjis: steve do oyu have expertise using that

Steven Brown: I have immediate access to real experts

Steven Brown: at no added cost

Alexis Snyder: agree to kanguage with payer offers instead

jim pantelas: To Alexis's point: might it make sense to track the documents or work product produced at each step?

Carolyn Petersen: I think so

Alexis Snyder: perhaps instead of numbering steps, blocks of what happens at each point snd include lists

Jocelyn Keegan: yes agree on numbering

Steven Brown: red hat is open source unix that has a workflow engine

Steven Brown: ibm subsidiary

Jocelyn Keegan: there's an enrollment project between NCPDP and HL7 that's done a ton of this leg work

Anil Jain: Happy to connect folks to Red Hat (now part of IBM) if needed :-)

Jocelyn Keegan: DME, Infusion/Onsite, Buy/Build/$Medication, Med Surg, PT/Referral are big categories I think.

Jocelyn Keegan: Steps in not a linear order are: Benefit ID, Order/Prescribe, Enrollment, Patient Sourced Data/Letter of Necissity overlaid/sidecar with chattiness though communication between players to monitor state/progress/delays

Denise Webb: If we focus on the data needed, we can then also determine if the elements are already addressed in the USCDI and thus should be available in certified health IT

Jocelyn Keegan: USCDI is a start agreed.

Jim Jirjis: I agree. Would add hospital services (inpatient/outpatient)

Jocelyn Keegan: Yes Jim, good delineation

Jim Jirjis: I mean inpatienr versus observation approval by insurance company

Jocelyn Keegan: I'm more than happy to bring update on coverage requrements discovery, doctument templates/rules and prior auth support the 3 Da Vinci use cases in this area.

Alexis Snyder: Josh and Jim produced a narrative which would wok for what you are saying

Jocelyn Keegan: Maybe a table. ..i don't think we want to get into data specifics

Jocelyn Keegan: agreed

Denise Webb: And is the data recorded in a structured electronic format

Jocelyn Keegan: Sheryl's point is important here as narrow networks drive coverage decision for DME, pharmacies, services and out of pocket costs

Jocelyn Keegan: add a row for available or emerging standards. ..

Jocelyn Keegan: i think venn picture is important to understand overlap of same data for diff areas, arien.

Alexis Snyder: so maybe in addition to table but not on its own

Jocelyn Keegan: right

jim pantelas: It's a lot of diferent types of data, it's a lot of underlying condition issues. A wheelchair isn't a wheelchair - it's why does an insurer need to pay for the wheelchair, and why is this need diferent from all the other wheelchair requests.

Alexis Snyder: agree with Jim

Jocelyn Keegan: Please let me know how i can help.

Following the pause for public comment, the discussion continued.

Discussion:

- **Alexis Snyder** suggested breaking the information into blocks instead of steps and list what is needed under each one. Also, they could consider using a table format. She thought that a Venn diagram would be too confusing, and they would not be able to identify what is needed and who is responsible for it.
  - **Sheryl Turney** suggested starting with a table and outlining the process including opportunities, in order to structure the process.
  - **Alix Goss** noted that, because some members thought that a Venn diagram would be too confusing, she agreed with the idea to use a table.
  - **Sheryl Turney** stated that they would discuss the matter of how to structure the process offline and suggested contrasting the newly mapped information against the requirements of data that are currently in the USCDI. Also, mapping out what has been developed would allow them to see if there are steps they have not captured and if there are data that are not represented there.

  - **Jim Jirjis** volunteered to help with this next step of the process.
- **Sheryl Turney** stated that they can bring forward what has currently been approved as USCDI version 1, which is what is in the current interoperability rule. It is already well documented. She raised the question of what else is needed that is not on this list and suggested they then talk about how to bring that forward or accelerate those data elements to get them on the list. This would be done holistically because they are not going to be able to map every single piece of DME. She said they are trying to bring it up to a data class level or a category level.
- **Jim Jirjis** noted that mapping all of the different types of DME is daunting, due to the breadth of types of information and data needed to be collected from various stakeholders. He raised the question of what information is needed to justify a payment and what would technically "fulfill" an information request.
- **Sheryl Turney** discussed how to create a high-level framework to streamline, accelerate, and reimagine the process. They noted that there might be lots of different types of data that may not be standardized already, so they agreed to start with patient-specific data, like diagnosis data and USCDI data. They agreed that this framework could be used to see what is missing.
- **Jim Jirjis** summarized the discussion of creating a "higher-level" framework. He noted that they could start with patient-specific data, data about diagnosis, data in the USCDI, and then see what is missing. Then, they would create a high-level framework and not necessarily try to solve it with terminologies that do not exist.
- **Jocelyn Keegan** agreed with the idea to capture category information as described by Jim. She has seen progress in being able to automate quickly with discrete data points that are already digitized. She emphasized understanding what type of data is required and then understanding the players in the situation, whether it is an easy, multiparty, iterative type of PA, or the users are in a patient-centric journey.
- **Denise Webb** noted that it would still be helpful to work through the process around DME and wheelchairs and assume that a PA is required, even if each payer has different roles. Then, they can go backward and capture data elements, and they make determinations like whether the element can be captured sooner and who has the data element. After they have the data, they can start overlaying the roles, steps, and the order of the steps. Several members agreed that this process would be a good way to proceed.

CLOSING REMARKS AND ADJOURN

Sheryl Turney thanked members for their participation and feedback, and she noted that the discussion about how to organize the next mid-level meeting would continue offline, with a recap to be provided at the next ICAD TF meeting. She invited anyone who would like to share input on the wheelchair example to get in touch, so they could be included in the offline meeting.

The meeting was adjourned at 4:30 p.m. ET.