The Office of the National Coordinator for Health Information Technology

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA TASK FORCE MEETING

May 19, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Alix Goss	Imprado Consulting, a division of DynaVet Solutions	Co-Chair
Sheryl Turney	Anthem, Inc.	Co-Chair
Steven Brown	United States Department of Veterans Affairs	Member
Gaspere C. Geraci	Individual	Member
Mary Greene	Centers for Medicare & Medicaid Services	Member
Alex Mugge	Centers for Medicare & Medicaid Services	Member
Jim Jirjis	Clinical Services Group of Hospital Corporation of America	Member
Anil K. Jain	IBM Watson Health	Member
Jocelyn Keegan	Point-of-Care Partners	Member
Rich Landen	Individual/NCVHS	Member
Leslie Lenert	Medical University of South Carolina	Member
Arien Malec	Change Healthcare	Member
Thomas Mason	Office of the National Coordinator	Member
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Member
Jacki Monson	Sutter Health/NCVHS	Member
Abby Sears	OCHIN	Member
Alexis Snyder	Individual	Member
Ram Sriram	National Institute of Standards and Technology	Member
Debra Strickland	Conduent/NCVHS	Member
Sasha TerMaat	Epic	Member
Andrew Truscott	Accenture	Member
Denise Webb	Individual	Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Michael Wittie	Office of the National Coordinator	Staff Lead
Josh Harvey	Clinical Services Group of Hospital Corporation of America (HCA)	Presenter

Operator
All lines are now bridged.

Lauren Richie
Thank you, and good afternoon, everyone. Welcome to the ICAD task force meeting. Of the task force members that have signed in already, we have Sheryl Turney and Alix Goss, our co-chairs, Alexis Snyder, Andy Truscott, Anil Jain, Denise Webb, Ram Sriram, Rich Landen, Sasha TerMaat, and Tom Mason. Are there any others that have joined, either by phone or Adobe?

Gaspere Geraci
Gus Geraci.

Jocelyn Keegan
Jocelyn Keegan is here.

Lauren Richie
I've got Gus and Jocelyn. Anyone else?

Steven Brown
This is Steve Brown. Did you get me?

Lauren Richie
Yes, I've got you now. Anyone else? Okay. With that, I'll turn to our co-chairs to get us started.

Alix Goss
Good afternoon. This is Alix Goss. I believe we're going to have an action-packed day of discussion. We have updates from our data classes workgroup and the ideal state and guiding principles workgroup. We're going to be talking a lot around those opportunity areas today. We also want to make sure that we have a quick level-set from last week's meeting, provide an update from our HITAC presentation last week, and then wrap up with our usual next steps and public comment opportunities. With that said, if we could go to the next slide, that'd be great – and, one more.

I'm going to lead you off before handing it over to Sheryl to talk about the HITAC update to give you a little bit of context about what we covered at our last meeting. The American Medical Association presented a very robust presentation in a very condensed manner. We are very grateful for all of the insights that they offered to us from their prior authorization surveys, putting a human face on prior authorization, refreshing us on their consensus statement aspects, and really giving us a tremendous visual related to this idea of the layers of the cake and how we might think about our work moving forward as we extrapolate our discussions from the prior authorization exemplar to the larger conversation of the intersection of clinical and administrative data, and gave us some really good thoughts around that from the analogy of the model of the layers of a cake.

There was a lot of robust discussion among the membership, which brought us up to the public comment period and the ability to then wrap up the session by talking about the planned presentation to the full HITAC last Wednesday and some questions that we were thinking of delivering to the HITAC to prompt discussion

after our update of the task force's effort over the last couple of months. That input from the membership was tremendously helpful, and after the call on Tuesday, it enabled us to reflect on the input and revise the series of questions and how we presented them to HITAC. It was a really good session. But, without further ado, would you like to take us into that update, Sheryl?

Sheryl Turney

Yes, thank you, Alix. We did make a presentation to HITAC about our progress to date which seemed to go over very well. We got a lot of input in the HITAC, which we expected and were happy to hear about. There were some recurring themes. Ken mentioned a number of things about the inability of clinical systems to be able to integrate with the administrative data. Clem brought up some issues related to the lack of standards that exist in the administrative data, which I think I pointed out myself in this framework when we discussed it, where simple things, even like weights and measures, are not consistent from various sources. John Kansky brought up the consideration that we definitely need to include the role of HIEs in the work that we're doing, and then, Arien brought up the topic of the current state of portals that are not integrated, which I think is aligned with what Ken had brought up.

And then, Sasha made a note about the standard coding, indicating that having more – I don't think it's a lack of standards, but even within the standards, and the example that's been used multiple times is for pharmacy, where you have LOINC and SNOMED, you still have some labs reporting in one, some in the other, so some amount of data normalization has to occur before the receiving systems can actually utilize that data, and then, in many cases, have to translate it so that it's common and they can – not communicate with one another, but have that same view where you're not distorting the view of what was intended.

A number of other comments came up. Jonathan brought up the point about making sure that we get the data right, and he had some examples of some initiatives that are going on in other venues where they talk about normalization, et cetera, and so there was quite a bit of chat on that as well. It sort of resulted in a recommendation that I have now documented for this group that we potentially think about recommending a federal health data model that basically incorporates both clinical and administrative data within it, and is utilized to help inform priorities, standards, certifications, et cetera, and even some of the work done in the USCDI that encompasses both clinical and administrative data. Today – from a payer perspective, I can speak to this intimately – we share a lot of data with many provider systems that is not actionable in the receiving systems; in many cases, it's spun off to an analytics engine, and it's not available at the patient level.

So, if we're really looking for data to be interoperable, that data needs to be actionable, and having been a board member of Care Quality all of last year, one of the biggest challenges we were trying to resolve for was to make a response to an administrative query actionable and required instead of being optional. To this day, it's still not a requirement in that trusted exchange framework, so we need to solve some of those things if we're going to solve for the greater question of improving the prior auths with our ideal state, et cetera. So, we're going to talk about that a little bit more, but not right now. There's a lot of other work that we need to do today, but I just want you all to be aware of that because it's something that we need to consider and discuss as we go forward in the future. Okay, Alix, back to you.

Alix Goss

Thank you. I did think it was a great opportunity for us to check in with HITAC. We got some good feedback and some additional insights which we'll be weaving into our body of work over the summer. Today, as I noted, we will be taking a deeper dive – I shouldn't say "deeper dive" – we'll be returning to our deep-dive work on data classes and ideal state and guiding principles. We've had a handful of folks who've been doing some offline work in addition to the data classes and the ideal state/guiding principles workgroup. As I noted at the very end of our call last week – actually, we had run over, and I made a brief reference that we will be forming a privacy and security small group to help build out those two areas within the ideal state and guiding principles. So, Jacki Monson and I will be facilitating that group. We've set up three calls, done an outreach to ask a couple people if they would come play with us on those calls, and we're getting some traction, looking for a few others to accept those invitations, and that will occur between now and the early part of June.

Today's discussions are rather important in that they're going to help us as co-chairs figure out refined next steps in the sense that we have had some really fabulous demonstrations and discussions over the last couple of calls to really help elevate our thinking and the potential areas for where we take prior authorization, so we need to bundle up that prior authorization focus, we need to extrapolate it to thinking about the larger intersection conversation, and we need to start building on that recommendation – the first one in the hopper, so to speak – to really help us vet other input that we've received and craft a series of conversations around the recommendations for prior authorization and the intersection of clinical and administrative data as a whole.

So, I want to propose that we ask if there are any questions on all of the updates that we've just delivered in the last 10 minutes before we then turn it over to Sheryl and Josh to walk us through the work of the data classes group. Okay, I'm not seeing any hands pop up.

Sheryl Turney
I didn't either.

Alix Goss
Okay, so I propose that you take us away, Sheryl and Josh.

Sheryl Turney
Thank you. I am going to turn it over to Josh, actually. I think he's going to share the current visual. I don't have the information to share directly because I haven't been involved with working with the group, and I apologize for that, Alix. I've just been really triple-booked in my day job. But, I think the data class work definitely has matured as you guys have been working on the ideal state and the guiding principles, and so, I think this current diagram gives a much better view of what the data classes are that we're talking about, and I also think if we consider the idea of the data model behind it, we can then look at that and think about how it could help us even better inform our efforts here. So, Josh, why don't you go ahead and provide a brief update?

Josh Harvey
Sure. Thanks, Sheryl. So, to both Sheryl's and Alix's point, as a workgroup, we've been thinking through at what point we consider the work that we've been doing complete for purposes of driving recommendations to the ONC. I think between a combination of the meetings that we've had to discuss the topic as well as

the overall positive feedback we've received on these calls for the work that's been completed thus far, in the absence of any remaining questions or loose ends that seem to need to be tied up, I think we want to pivot today and talk about potential next steps for where we could go from here.

So, just as a recap for where we've been over the last few weeks, we've essentially created a heat map of sorts that helps to lay out the environment that we're working in, the different standards that are at play, and the different levels of adoption and maturity across all of them from the different independent sources we've been able to glean. So, we've gotten to a point where we feel like there is a foundational shared knowledge about the state of the union for these standards, their adoption, and their use in the real world. So, from here, I think we wanted to talk about a couple of options for how we could take this work to the next level, thinking about that ultimate goal of driving our recommendations in the group.

And so, there are two ideas that I'll throw out here for the group to discuss, and then, I would also lean to Jocelyn and Ram, who have been instrumental in this work, to help make sure they add any color commentary that is needed. So, the two paths that we see as potential opportunities from here would be 1). Essentially doing a secondary inventory of not just the standards and the data classes that we've discussed, but also 2). The different constituents throughout the process and their particular data needs at different points in a given lifecycle of a prior auth request, for instance.

So, the way that could work is we've sketched out a couple of columns, if you're looking at the table over to the right-hand side, trying to delineate between providers, payers, pharmacy benefit managers, EHRs, and other intermediaries that we could potentially label as having different data needs at different points in the workflow. I think we're a little bit divided on how value-added this might be at this juncture just because of the second option that I'll throw out, which might kill two birds with one stone, so I'll leave that there for a second and pick up with our second option of how to proceed forward.

So, the other idea – and, this has been mentioned a couple times on recent calls we've had as a group – we started out with this notion of mapping out the ideal workflow and using that as a guiding light to help us work toward the ideal state, and then we had this discussion about how much of this puts the cart before the horse and whether we should revert to inventorying the data needs we have in the first place. So, I think what that caused us to do is to start from two different ends of the spectrum, and ultimately, we're getting to a point where I think they're converging in the middle.

What I mean by that is now, I think we've established some foundational ideas about the ideal workflow. We've also established some rules of engagement for what data we think needs to be in scope for the prior auth process, and we may now be getting to a point where we can switch gears and move back to trying to draw pictures of the ideal state and tie that to what our data needs are, and we think this will help us both visualize the process better and account for nuances in the workflow as well as really start to sketch out who needs data at what point in time and what is the most efficient manner to get it to them because looking at standards from the angle of whether they covered the data is one angle; there's an entirely different question about whether they moved the data to the right person or entity at the right point in the process.

So, we think that might be a good way to slice and dice what other gaps we might have that could help drive recommendations at this juncture, and that might be an extension of the work of our workgroup, or it might be that the task force might want to spin up a new group and potentially pass the baton to others who

can help visualize, and I'm sure there are a lot of different ways to think about this. So, those are my high-level spiels about the two different paths we've discussed. First, before questions and comments, Jocelyn and Ram, is there anything you want to add?

Alix Goss
Yeah, I think Jocelyn has her hand up. Go ahead, Jocelyn.

Jocelyn Keegan
Josh, I think you did a great job of walking through our conversation and where we come from. There's one point that I would point out for this group. I think that the roles are important, but to Josh's point, we need to put them in motion. But, as we were discussing gaps and having some philosophical discussions about where to head from here, Ram made a couple comments that triggered some of those early discussions we were having about workflow that made me realize that – I just added some commentary in that merged cell on the left-hand side – I think it's really important as we go through this process that we acknowledge that multiple parties are doing the PA over and over again as the patient moves through a care journey, and that we can't stop just at the PA being approved because often, much of the dysfunction around the things that create waste around the PA happen when somebody's presenting for payment or payment decisions are being made.

So, we added this line item, but didn't add any categories to it because I think we need to walk through these different scenarios to be able to really understand this idea of the service or the effort being done to be able to make sure that we fully deal with the entire workflow, and we had really been keeping dispense or payment out of our earlier conversations. That's why I think shifting toward this UML or drawn-out picture view of the journey of the PA will be really important to be able to flesh out other things like that. Until you put it in motion, it really doesn't call itself out. Great job, Josh.

Sheryl Turney
Thank you for that, Jocelyn. Can I ask one question, Josh? Under the data class "patient-generated," is that the patient-generated input?

Josh Harvey
That's a good question. So, we have left this category for patient-generated data in the table since one of our earliest conversations with the broader task force about the different data needs. So, this was brought up – I don't remember specifically who brought it up. I think it may have been mentioned by a couple of different people. But, I think we haven't had a real focused notion of what exactly that data might be, whether or not it would be truly a need for the process, or potentially an area where there might be some opportunity for innovation and improvement, but we did not find anything meaningful in any of the standards that we looked at that would help provide an opportunity for patients to share data throughout the process.

Ram Sriram
This is Ram here, if I can jump in. There are opportunities that we are looking at into the future because what's happening right now in terms of the – there's a patient-centric view where sometimes, the patient may need to get the PA directly when you are talking about the patient being the center of the universe here. It's just a thought. So, that's why we left it there for the future. And, you can see, especially with the telemedicine and those kinds of things, that the patient is going to play a big role in all of these things.

Jocelyn Keegan
I think this is a really important point from the conversation we had. Josh, I don't have the document open on my screen right now. Did we have our brain dump around the different types? Because what type of procedure you're trying to get a PA on will drive how much the patient-specific data is driving it, but Ram brought up this really powerful point around how today, the PA is essentially a provider/payer-driven activity, but in the future, getting the patient involved in the process could be really powerful and really change how it works overall.

Sheryl Turney
Right, and this is important because I was going to say originally, the reason we added that one was because they were talking about the wheelchairs, and in some cases, justifying the wheelchair to have to perform certain activities has resulted from the work that the person does, so I just want to make sure that we're saying here that it's still a requirement, but right now, we've noticed that there are no standards that support it. So, one of the things is we need to have definitions for all of the data classes to help us – we're going to need that in the paper anyway, and is that something that the team can help to expand on in the next week or so? Because I do think that's going to be helpful for the understanding of everybody who is not dealing with this on a daily basis.

Jocelyn Keegan
I think that's a really good point. Josh, I feel like we could take a stab at that. Ram, I don't know what you guys think would be good.

Ram Sriram
Yeah, we could do that.

Steven Brown
I'd like to jump in for a second. Where are the patients? I think we're admixing a bunch of stuff, and the reason it feels sloppy is because we're admixing a bunch of stuff. So, is there a standard for patient-generated data? Patient-generated data typically may be signs, symptoms, observations – the sort of things for which there are standards – and the issue is that the provenance of the data is what they're really trying to separate out in the entire class. You might want signs, symptoms, and observations from the provider, and the reason you're not finding is because it's not really its own class. It's a bit of metadata about the origin of that data.

We're also seeing a bunch of admixed stuff here, like we're talking about information models – sort of, but no one's really saying it. We're talking about data models, data types, and process. These are different things, so to get anywhere, you need to tease them apart and apply the right kind of modeling to it, and then you can make progress by separating the layers of the types of modeling deliberately, like deliberate separation of layers, and then you can get somewhere doing this. Otherwise, you're going to go around and around, saying, "Why are there no standards for patient-generated data?" and all that stuff. So, usually, when we do this, there are process models, information models, and data models. There has been a ton of work in information models. You guys must be familiar with the FHIM, the Federal Health Information Model.

Ram Sriram

You make some good points. In fact, those are some of the things we are discussing in terms of the data model, the process model, and the workflow model – however you want to look at it. So, these are the things that one needs to – we have to build a scenario in there to build those models, but we have not delved into that. One other thing which Jocelyn and I are talking about is how ONC might do that because that involves some work.

Sheryl Turney
Okay, great. We just wanted to confirm for everyone that we're going to capture that, Steven, and take a look at that federal health data model that you talked about, but we're going to raise our hands. I'll help direct the conversation based on the order in which people have raised their hands. So, thank you for those comments, and Jim, you're next.

Jim Jirjis
Thank you. I have two quick comments. One is the discussion around the patient-generated data had to do with our early workflows where it was around durable medical equipment where the patient ends up getting a wheelchair, but needs the pillow or some other refinement – not only to justify the prior auth, but to refine what was delivered. And, there were a lot of examples from people in that mini workgroup from their own personal lives where there was a need. The second thing is we talked about how this is iterative, and how there are multiple cycles for the very same issue because it's denied, and then they have to do it again.

Even as a hospital group, or even in a clinic, I'm wondering if there is enough in our data classes that addresses not just the benefits coverage, but what the rules actually are for any particular item that would need approval. So, sometimes people are in the dark; they know what data elements they have to deliver, but then they just get a rejection back. And so, on the front end, I think a lot of our discussions were where it is in our data classes here that the rules might be exposed so the people understand in a machine-understandable way what they need and why, and secondly, that when there's a PA response that is a denial or request for more info, there's a lack of granularity of data as to exactly why it was not given approval. I don't know if that's in the PA justification, that if we go deeper, those two pieces will come out, or if it's something we need to deliberate at the class level. We're in the dark – go ahead, I'm sorry.

Sheryl Turney
I agree with you, Jim. We did say that we needed to incorporate the PA rules, if you will, regarding when PA is required and what the rules are for submitting data regarding the PA. So, if we don't have them there, I know that's something that we did say we were going to include, so that's one that we probably will need to include. And then, we also said there might be PA data requirements, and one of the questions we asked was if it's possible that all payers require the same data, so at least for the providers, it's consistent even if their decisions regarding PAs might be different. So, we broke it down to what are the PA requirements, what are the PA rules, and then, what are the PA data requirements? Those three things would probably need to be added.

Jim Jirjis
I think that's the front end. The other thing that I know we experience is when the denial occurs, there's a generic reason, and there's an inability to learn – there's not enough granularity as to what was missing with the rule. The front end has exposed the rules and why you need what; the back end is asking for the reason for denial so we can improve our documentation or not submit that anymore. I don't know if that's –

I think there's a distinction there because that's how you reduce the rework. That's how you reduce having two, three, or four cycles before you pull the slot machine arm enough times before you finally win the approval. This may reduce that.

Sheryl Turney
Okay. And then, PA feedback – because the other thing we talked about is the gold-carding. If it's not going to be based on history with a provider, then if you have a provider that approves everything 99% of the time, then it might be trust but verify instead of prior auth in advance. That would need to be part of the feedback loop too so that you understand where you stand regarding your PA decisions.

Jim Jirjis
I would vote that these things should be a class so that it's not buried under… I would just submit for consideration that we're overt about it being a row or two in here.

Sheryl Turney
All right. Any other questions or comments?

Alix Goss
Sheryl, this is Alix. I had my hand raised.

Sheryl Turney
Go ahead.

Alix Goss
Yes?

Sheryl Turney
I'm sorry, we're not hearing you, Alix.

Alix Goss
Can you hear me now?

Sheryl Turney
Yeah, now we can hear you. You muted yourself out or something.

Alix Goss
The granularity of **[audio cuts out] [00:32:28]**.

Sheryl Turney
Unfortunately, Alix, most of what you're saying is not coming in. I don't know if it's…

Alix Goss
I can call back.

Lauren Richie

I think she said she may try to dial back in.

Sheryl Turney
Okay. Well, in the meantime, Steve, you have a question. Let's move to you right now.

Steven Brown
Sure. What if I were to offer a time-limited engagement of some experts who can do process modeling and somebody offers an SME to take on one process – a small one – where we could actually deliver an exemplar process model so you guys can see what it looks like and what capabilities and opportunities it would present?

Ram Sriram
Ram here. Personally, I think it's a great idea. What do you think, Jocelyn and Josh?

Jocelyn Keegan
I just stopped myself from typing "Pick me" into the little messaging box. That'd be great. Steven, I would say maybe just loop that person into our conversations because we've got a pretty good rapport going with the three of us, and I think we could bang out – I would actually propose we do one from the pharmacy side and we do one from the medical side to hammer out what the model actually needs to cover.

Steven Brown
I can't give unlimited resources. I have a couple of real experts – I sent you the list of EPM Plus. If I were to say I can give you 20 hours of somebody that knows how to do this modeling work and time-box it…

Jim Jirjis
Hey, it's Jim here. A simple medicine one might be inpatient obs versus inpatient status because there's not a lot of complexity in terms of workflow, just for consideration. If we did the med approval and the inpatient medical services for obs and inpatient, that might be simple.

Sheryl Turney
Yeah. What do other folks think? Those sound good. The one we have is the wheelchair example, and this would then get us into the medical and the pharmacy. So, we'd do a med and we'd do an inpatient.

Gaspere C. Geraci
This is Gus Geraci. I'll jump in on the inpatient versus obs. That's not so easy, but very popular. There's lots of controversy around that, so it would be a good one to tackle.

Jocelyn Keegan
I totally agree.

Steven Brown
What I'll offer you, I think, is that the first pill is free, and I'm not going to promise anything that will be final, different, beautiful, difficult, and solves the world, but what I will say is it will give some example of it so you guys can see a workable approach to squaring this stuff away, and then from there, we could decide whether you like this and want to do more of them, but it might be a way to get something tangible rather

than abstract. We can actually look at the model and see how the model steps through things and how it links to data flows and various types of decision-making and all that where you can then know – it ties everything together in a much more usable way. I'm not going to say we're going to do all the work because it's a huge number of workflows and all that, but if someone wants to volunteer to be the subject matter expert, I'll get someone who can drive the models to us.

Jim Jirjis
Around the medical, just to offer up – unless others do – we've done a bunch of work on that already, and also with Da Vinci a little bit, so I'm happy to help service this need from the medical hospital side if needed.

Gaspere C. Geraci
This is Gus Geraci. I can be an expert on the insurer side.

Sheryl Turney
Is that Jim that's talking?

Jim Jirjis
Yeah, Jim Jirjis.

Sheryl Turney
Could you guys say who you are when you jump in? Not everyone knows who speaking.

Jim Jirjis
Yeah, sorry. That was me talking about the inpatient obs/meds. I'm happy to help because we've done a lot of work on that. For the purposes of demonstrating what you're talking about, we're happy to help.

Alix Goss
Sheryl, this is Alix. I just wanted to let you know that I'm back on the call.

Sheryl Turney
Thank you. There are a couple of things. Alex Snyder has something to offer up. I want her to be able to speak, and then I wanted to just do a recap for Alix Goss. So, Alex Snyder, please go ahead.

Alexis Snyder
First of all, my name is Alexis. I just wanted to make that clear. I'm not even sure where I want to jump in at this point. I had so many comments along the way, but people just kept jumping in and speaking through the entire meeting. So, at this point, I was going to offer up – and, Alix, if you could jump in with what we've been working on in the smaller group for guiding principles and ideal states. Like we had done early on with the model in the DME and the wheelchair, we were talking about what it looks like and what is the ideal path on the patient's side – the patient-centered piece of what the ideal path looks like to get from the beginning to the end without getting that denial and lessening the burden for all involved.

So, I think that I would offer up from our group – and, Alix, again, if you want to chime in – that we've been discussing this in our offline meetings week after week, and where that piece plays in, and which models we want to use. In our meeting yesterday, we talked about having already visited that wheelchair piece, but

we made more notes in our tabs about that, discussing a model around pharmacy as well as medical. And so, that was my comment.

Now, my earlier comment – a couple people chimed in on what I was already going to say. The "patient-generated" tab originally came from one of the first task force meetings, when folks on the patient and caregiver side that are not part of the meeting today had brought up where there is a place for patient-generated justification and attachments, not just getting a justification letter from a primary or specialist for need, but where the patient can speak for themselves and really say, "Hey, this is what I need, and this is why," because it's not always so clear. So, I just wanted to clarify that piece as well.

Sheryl Turney
Thank you, Alexis. Go ahead, Alix.

Alix Goss
Thank you, Sheryl. Alexis, since I missed a bit of the back-and-forth, it's a little hard for me to chime in, but I can contribute that while I was hearing Josh, Jocelyn, and Ram give an update on their options and considerations, I felt like, "Wow, it's going to be interesting when we get to our guiding principles and ideal state discussion because there are a lot of similar threads in the conversation between the two groups." So, what I've been hearing is that there's this real – between yesterday's small group discussion and what I'm picking up here today, we do need to evolve the flavors of the use cases to beyond the initial thought around the DME/wheelchair, and to Jocelyn's earlier point, if we get a visual model, it may help us identify the other flavors of considerations that we may be missing in the body of work. And so, I think there's some value there in taking the next step, but I don't want to be too short-sighted in my comments considering that Sheryl wants to also give a little bit of recap so that I'm back on everybody's page in what I missed with my technical issues.

Sheryl Turney
No worries. I think it's a natural transition now to go to the ideal state and provide that update. Just so everyone on this team knows, we started those small groups so we could move things further more quickly, and also, it's only been through the small group efforts that we've gotten people to work at generating input to the workbook. So, if anybody wants to participate in that, all you need to do is let Alix or me know, and we will make sure that you are included. But, just to sum up where we are right now with the one update we've gotten so far, it does look like we need to add definitions to the data classes, and that we have some additional requirements that need to be included in some data class that has to do with PA requirement rules, data requirements for decision-making, and a feedback loop. So, we do need to include something like that. Gus offered up that he would potentially be able to make available about 20 hours of a process modeler's time if we can identify a SME, and the suggestion was to create an inpatient prior auth as well as a medication approval, which are two that we currently have documented.

Steven Brown
That was me.

Sheryl Turney
For those people that are on the team, just as a reference, the patient-generated was basically identified back in the wheelchair example, and we do have a process model for that that is available as part of our

artifacts that are out on the ICAD website under the ONC listing for our meeting, and in that, we did define that there are a number of reasons – Alexis Snyder was kind enough to recap those – that came out in this original meeting to define that patient-generated information is very important, but I do think it's important to note that today, there's no standard being developed anywhere that captures that information, so that's something that we might want to think about in our recommendations when we go forward. All right, I think that's the recap, and I'm going to turn it over to you, Alix.

Steven Brown
It was Steve Brown that volunteered 20 hours of someone to help with process modeling.

Sheryl Turney
I'm sorry. Thank you for that correction, Steve.

Alix Goss
Awesome. So, boy, there's a lot going on today. It sounds like we've got some great work to take the next step for the small workgroup team on the data classes. Thank you to Steve Brown for getting some support and resources for that. It looks like you're also looking for some guidance on who's going to connect you with the next layer, so hopefully, we can make sure to follow up on that chat box request.

Hopefully with the assistance of Alexis, Anil, Arien, and Tom Mason, I'm going to give you an update now on the guiding principles and future state work that we've been doing. For those of you who have been out on the workbook, you may notice that the "guiding principles" tab was renamed "work zone," and a new "guiding principles and ideal states" tab was created. What happened was yesterday, we tag-teamed in cleaning up the work and producing the Word document that we sent out to you, along with today's materials so that you would have something separate that you could look at and that I'll display in a moment.

One of the things that I wanted to use to backdrop what we're about to show is that the small working group has been meeting weekly for about 90 minutes in addition to our regular task force meetings. They have done a great job in synthesizing feedback that was offered in the "other considerations" and "recommendations" tab, which was work that Sheryl did to take third-party input to the full HITAC, consolidate that information from the last six months, and put that into a couple of tabs for us to look at.

Further, we had already done some work within this task force early on in our meetings to capture some guiding principles and ideal states, and we have looked at a number of artifacts from our compendium, such as the AMA consensus statement and the WEDI whitepaper. We've also added in a few other things – I'm sorry, I should add one more in there which is really critical, which is the ONC burden report. We've also factored into the considerations the principles for upgrading the HIPAA transaction standard. Those of you who've hung around me a lot know that I like to quote 162.940 on a regular basis because it is the 10 principles against which we need to measure any future modifications or adoptions of standards under the HIPAA realm.

So, the work I'm trying to sum up for you is that we have iterated to the point where we're able to produce the summary document for some discussions today, and I'm going to go ahead and share what's coming through as the Word document. I can no longer see the panels, I can no longer see raised hands, so hopefully, you're all seeing the guiding principles, so I need someone to tell me that first.

Sheryl Turney
Yes, we are, Alix.

Alix Goss
Thank you. I also want to clarify that Sheryl will be monitoring the hand-raise feature to help with taking questions, but before I'm going to take questions, I would like the opportunity to summarize this high-level category that we've put together and offer it up to the small workgroup members to provide some initial commentary, and then we can start to walk through the document in the time we have available, which is about 20-30 minutes or so. Maybe less.

With that setup, there are 60-something rows of considerations in the workbook which we have distilled down to this five-page working document that reflect principles and future state aspects related to the following categories: Patient at the center, measurable and significant improvement, continuous improvement, real-time data capture and workflow automation, transparency, security and privacy protecting, design for the future while solving needs today, aligned national standards, and the other bucket of uncategorized, but still want to capture.

We have a variety of points that are made for each one of these items. Most of them have at least one, if not multiple, and these reflect the combination of the ideal state and guiding principles. I'm thinking that as we get through these – somewhat today, but more especially through your offline ability to comment on this and send us your input – we would have the opportunity to improve this body of work, and then synthesize it into a clear vision. Once we have a clear vision of what this means along with the data classes and modeling work that we've just discussed, we can then start to figure out where we're at today, know where we want to go next week, and what are the steps from here to next week that we need to take to help the industry as a whole move forward, and those could become part of our recommendations path.

I think there will be an additional body of work that we will need to go through, which is to consider how these categories or summary statements apply not just to prior authorization, but how they meet our larger intersection need. With that, I would like to see if there are any comments before I start going through the document from the rest of the small group.

Sheryl Turney
No one has raised their hand at this time.

Alix Goss
Arien, do you want to offer any input on the framing of these categories, since you did the yeoman's list on that?

Arien Malec
No. It was more of just a first-pass bucketing of the copious, detailed commentary that we did, and it's really about how we elevate all of the commentary to summary items, and treating this as draft, we'd really appreciate feedback on whether we've got the right buckets, whether there's additional accommodation that we can do, and maybe the last comment is in the taxonomy world, there are lumpers and splitters, and I tend to be a lumper, and other people tend to be splitters, so maybe you get in there and believe that there

are two categories where I've made one, and some other people may be more aggressive lumpers and may believe there is one category rather than two. But, at the end of the day, we want to create something that's easy for the two federal advisory committees that we mutually represent to consume and comprehend with a couple of layers down that people can descend to to get all the detail and nuance that we've provided behind this documentation.

Alix Goss
Thank you, that's helpful. Any other comments from the small workgroup?

Sheryl Turney
Alix, we do have a question now. Is that okay?

Alix Goss
Absolutely.

Sheryl Turney
Denise Webb?

Denise Webb
Hi, thanks. Maybe you're going to cover this, but on the second and third bullet in the summary, both talking about improvement, is there a particular reason that those are separate rather than just being measurable, significant, and continuous improvement? That's one question.

Arien Malec
This is Arien. So, think about the third category. Maybe a better term for the third category is what used to be called the "learning health" system. But, the point here is – the second one is we want to make a meaningful and significant swing at the ePA problem, and the third bullet is that – and, sort of related, also, to the design for the future we'll start getting into today – is that we want to make sure that the data and information we're flowing off of ePA drives continuous improvement. So, as an example, there's a lot of discussion about when we consider ePA requirements to be topped out in the sense of meaningful use or promoting interoperability requirements where there's been enough work driving the activity upstream that you no longer need the gating check downstream.

Denise Webb
That makes sense. The only other comment I had is – maybe this is common for other people, but on the security and privacy, "privacy-protecting" just sounds awkward to me rather than "protecting privacy." That's just a suggestion.

Arien Malec
As I said, it might be better to go provide additional – this was literally a reconciliation that we did last night and this morning, so please treat this as a first pass at this, and something that really would warrant lots of good offline activity to do editing.

Alix Goss

And, to build on that comment, Denise, I'm really grateful that you're willing to join the small working group for privacy and security because we can tweak that title as a starting point.

Denise Webb
That sounds good, thanks.

Alix Goss
I commiserate with the… I got what it meant, but I wasn't sure it was resonating as well as I want, and it's great as a first draft. Any other comments or raised hands, Sheryl?

Sheryl Turney
Not at this time, Alix.

Alix Goss
Okay. So, Anil, Alexis, or Tom, is there anything else before I start walking through? I'm going to walk through each one of these very quickly, but before I do that, is there any additional commentary?

Anil K. Jain
This is Anil. I'll just say that I think it's – Arien, thank you so much for summarizing all this, and Alix, thank you for presenting this. It's really hard to summarize all the conversations we've been having into these high-level points, and I agree with Arien that when the broader group gives feedback, it's in the context of the details behind it that I think we are most interested in, so this is a nice, high-level, organized summary, but it still needs a little bit of work, as we will find out.

Alix Goss
Okay. I'm going to go ahead and jump in. So, having the patient at the center is about reducing the burden on the patient being the go-between or the driver. It ties into some of the cost transparency to the extent possible. With clinician/patient shared decision-making of treatment options, self-pay restrictions are accounted for, and we recognize that that particular aspect may get expanded upon by the privacy and security group. Jacki Monson and I talked about self-pay and the rules related to that as something we wanted to consider within that group, so that may get morphed on its own, but we're still looking for feedback if you have some.

And, the final consideration for the patient at the center related to the tools that exist for all those patients – and, we want to make sure that we're overcoming the digital divide, access, and socioeconomic and literacy barriers that we know to exist today that add to the complication of prior authorization. I'm going to continue to walk through these in a conversation style, so Sheryl and others, you just need to stop me as we're going because we're at 4:00, and I know that we're supposed to wrap up here in the next five or 10 minutes.

Sheryl Turney
You're good to go. No hands are raised.

Alix Goss

From a measurable and significant improvement perspective, it is important to us that actually, this time is different. We've been talking about prior authorization, and I know I've got a thorn in my side about how many times we need to talk about attachments in prior authorizations until we finally get something to happen in the landscape that makes a difference in the daily world. And so, we want what we do in this task force to have a measurable impact.

Prior authorization process reform and improvements will be driven by patient safety, evidence-based medicine, and reduced burden. It would be nice if 95% of the prior authorizations had a clear and unambiguous approval, getting back to that earlier conversation about the code values that get returned, and we think that we probably need to revisit the metrics when we get to the point of having some recommendations so that we have something much more concrete in this section, and that those metrics could be patient/payer/provider-related metrics. They might even need to be vendor metrics. I'm not sure. It's something we need to think about as we move forward.

As we discussed earlier, there's this continuous learning process bucket about having the ongoing learning system. As we look to the horizon, how do we make sure that we're continually improving the process that we would have significantly improved by the work of this task force and the resulting recommendations being implemented?

From a real-time data capture and workflow automation perspective, this is a pretty robust one, so it's not going to be quite as easy to summarize as the other ones, but when we look at the aspect of what happens, where it happens, and by whom it happens in the actual care delivery process, there are a lot of aspects that we need to address. The first one is that we want to routinely collect all or nearly all the data needed during the ordering steps. Can we get to an 80/20 rule approach that's supported by clinical decision aspects to help us with managing the prior authorization? That may take consideration of avoiding the redundant or separate systems that are involved in trying to perform a prior authorization.

And, regardless of the venue of care, the prior authorization process should be mechanically similar for both the clinician and the patient regardless of the plan, since patients move across the healthcare ecosystem and providers should not be burdened with disparate workflows depending on their venue. A doctor may work as a solo practitioner one day, at an urgent care the next day, and working rounds at a hospital the next week.

We want to support automation of the ordering and prior authorization processes for medical services and equipment through the adoption of standardized templates, data elements, and real-time-based electronic transactions among all the players. Any workflow utilized to support the prior authorization should auto-generate editable content to document in the process note or visit note the medical necessity so that clinicians don't have to redocument what they just did to justify the prior authorization request.

All insurance coverage will be identified and related support provided for coordination of benefits. For example, verification of insurance coverage eligibility, also known as the 270/271, is completed and supports ongoing coordination of benefit activities. Information required for recommendations and decision-making should be provided one time by the source whenever possible, so when we think about a patient and a provider working together to figure out what's next, they need to have all that information up front as quickly as possible from the payer source.

Our work should focus on automating prior authorizations through health IT and focus on what information can be exchanged to make any coverage decision better, faster, and more transparent. This avoids the thornier issues of dynamic decisions of what is covered and why and why not. This is about keeping ourselves at the right level in our point of view and commentary as the task force to actually make the changes that we think we can make.

Ultimately, we're really trying to collect once and reuse, as referenced in our charge, and this will also aid public health and research efforts. We want to increase end-to-end automation for processing prior auth, data requests, and response using recognized standards, and I wondered earlier if it's also not just standards and code set values for responding. I think that was brought up earlier, and we need to talk about it. I'm going to color-code that so I know to come back to it.

No. 10: Protect continuity of care for patients who are on an ongoing active treatment or stable treatment regimen when there are changes in coverage, health insurance, providers, or prior auth requirements. Workflow practices include triggers for expiring prior authorizations to prompt renewal activities, if applicable. Greater use of clinical decision support tools, accountable care models, and consensus-based guidelines to reduce the volume of prior authorization requests while increasing the value of responses and shared treatment decision-making.

Provider and payer systems can supply procedural pharmacy- or device-specific requirements and information needs to complete prior authorization processing so the integration of the clinical EHR and administrative PMS workflows will occur. Fourteen items in the category of real-time data capture and workflow automation – comments, thoughts? Sheryl?

Sheryl Turney
No one has their hand raised right now. Oh, we have one. Jocelyn?

Jocelyn Keegan
I'd love to understand Point 8 a little bit better about reusing data that's collected once. Do you mean inside of the PA process itself? Because I do think the statement around reusing the existing clinical data by a payer that could be used to deny a claim could raise agita and blood pressure for folks out in the industry.

Arien Malec
This is Arien. I think this came from some talk that we had potentially related to some COVID-19-related items, but out of that came the notion that these administrator processes can also be used, again, in the point of process improvement, research relative to ePA, and research relative to workflow and burden that is a valuable data asset. The metadata flowing off these processes are valuable data assets.

Jocelyn Keegan
I totally agree. I think it's a really important point. I just think that maybe the language might need to be spelled out a little bit further because it's often a barrier we run into when we're trying to implement.

Alix Goss

So, we are currently talking about prior authorization, but I do think it has the broader implications that we want to think about how we capture it once and reuse it, which has some really strong workflow implications. Jocelyn, do you want to talk a little bit about what kind of – do you think we shouldn't be carrying this through beyond prior auth?

Jocelyn Keegan
We actually had pretty extensive conversation on the Da Vinci side. We created a clinical advisory council this past fall around where that foundational guiding principles document really came from, and we had a very robust discussion – it was actually really positive – around the ability to reuse, and all of that agreement should be up at the contract level, and not at the data-permissioning level. I would classify it potentially as a rigor issue. I think when you talk to people who are hands-on informaticists inside provider organizations and payer organizations, they understand that collecting once and reusing is a really good thing to do, but I think getting people to the party becomes a big, divisive issue.

Anil K. Jain
This is Anil. Can I just add something? I think when we were discussing this, the context of this was around the presentation on the electronic report form, and that we wouldn't want to recreate any standards for getting additional data within the workflow, that we should reuse any existing standards for collecting additional data PA so that we would leverage existing standards. I don't recall any conversation within the small workgroup about reusing data because I think it's a very thorny issue, and could change the way that clinicians enter information if they believed it would be used for other purposes. So, I want to make sure that at least the conversations I recall were around the technology that was presented during the COVID-19 conversations from the CDC around the electronic report form and how it would be injected into the EHR. I was thinking – and, I think we were discussing – how that could be reused in the context of PA so that we didn't have yet another mechanism for data collection above and beyond the EHR.

Alix Goss
We did, in fact. You're spot on. We did talk about it specifically when were going through the "other considerations and recommendations" content. There was a very heavy COVID-19 aspect to that, but the concept of "collect once and reuse" was actually discussed before that, and was in the workbook, and so, I think it took on a little bit of its own life. I think there are downstream – from a USCDI perspective, data provenance is intended to be a feature that we can rely upon to appropriately enable sharing with public health and research as it ties to – I believe – consent management as a policy framework. But, I think we need to have some discussion about this because I think we've got two separate thoughts going on right now, so I'm interested in the feedback of how people are seeing it.

Anil K. Jain
Yeah. Just to put a cap on this – this is Anil again – I just think that in the context of public health and research, PA may be misplaced here, and we can take it offline into our small workgroup or hear from others because it's a broader issue. All the data that's collected in the routine clinical care should perhaps be used and reused for public health and/or research, but the PA itself is what I'm getting hung up on. Again, it should be a broader conversation.

Sheryl Turney
Thanks, Anil. Rich also has his hand raised. Go ahead, Rich.

Rich Landen
Could you scroll back up to – I'm not sure which number it is, but it had 95% approval.

Alix Goss
Is that the one you were referring to, Rich?

Rich Landen
I think so, yeah. My concern is why are we only talking about approval? I'm struggling a little bit with this because there are two legitimate answers. One is approve, and the other is deny, so –

Arien Malec
Yeah, this is a thing – we had good discussion yesterday, and I think we all agreed that what we want is rapid determination of the result, not rapid approval, but not a "pend," not a "check back later" – a clarity of response.

Rich Landen
Right. I'm comfortable with that, or if you're trying to say how far we succeeded in moving the needle. That would be helpful as well. We're talking about a steady state. You have to count negatives as long as it's a definitive answer because over time, the payer is going to take those who get routinely approved over and over again off the list. Thanks.

Alix Goss
A couple words came to mind, so I captured that. We'll factor that in. Yes?

Alexis Snyder
Alix, it's Alexis. I was just going to say that I think when we talked about this area, we talked about clear and unambiguous denials, which is something that Jim had mentioned earlier on the call today, that needing the information as to why something is denied to be able to either get a second chance to add information or appeal appropriately.

Jim Jirjis
It's Jim Jirjis. There is a reason for denial, but it's very generic, so there needs to be enough granularity to learn from it or to know what was missing or not met.

Alix Goss
Right. I guess I just – when I started to have my phone troubles, I wanted to ask you a question, Jim, about that, in that it's the standard code values – and, I'm just trying to – if they were remark codes… I can't remember exactly what they're using for responding to a 278 ask if it's the standardized remark codes – maybe Strickland or someone else on the call can remind me what we use for that because depending on which code set value we're using, we might need to think about how we pursue that because it might need to be held within the standards body or a corresponding organization, or it might need some more work on our part, and I just don't remember who owns that code set that we use to provide our response on approvals, pends, or denials.

Jim Jirjis
Yeah, I'd love to see the detail too. My guess is there's a lower tier of detail. I don't know how hard it will be, but it's important because it may reduce all the cycling.

Alix Goss
There's a longstanding history with how specific our responses should be, like on an explanation of benefits, and the industry will talk about – some people are lumpers and others aren't, like Arien said earlier. That is a world unto itself about remark codes, cart codes, and how we handle all of those, so we can take a look into that offline.

Jim Jirjis
One of the other lenses through which we should look at this is the notion that – the way it currently often works is if there's an inpatient denied, there may be a level of detail where the payer and the provider can agree that if certain things aren't met, then it becomes an obs. It could be a rule set; it could be driven on the right level of granular data. Otherwise, what happens is it gets thrown into this very manual appeal process, and so, one of the notions is that there could be if/then statements generated that both sides could agree on that might actually substitute the inpatient for the obs if there's enough granularity that we can agree or define it, for example, and that would decrease the burden on both provider and payer for that appeal process.

Sheryl Turney
Which is extraordinarily costly for everybody.

Jim Jirjis
Oh, my God. Just imagine if we could get granular enough that the provider and payer understood in these situations with this data if it's not met, blah blah blah, and with this subset, we would just automatically convert it. That could save an enormous amount of trouble while still having the peer review process for everything else.

Alix Goss
I made some additional notes. Are we good, Sheryl? Any other hands raised?

Sheryl Turney
I just wanted to make a note that it's 1:17. We have public comment at 1:20, and you still have more to go. Why don't you do until the next steps – or, no?

Alix Goss
Sure, let me do transparency, and then we'll put up the public comment slide and go from there. So, the next category of transparency is about Providers and patients have the information about what events require prior authorizations up front and readily available. There will be transparency as to when a prior auth-related policy was last reviewed, and the effective dates, so that provides the insight from the provider side of when the payers are maintenancing, so to speak, their prior auth policies. Third, it's to improve the channels of communication between the health insurance providers, healthcare professionals, and patients to minimize care delays and ensure clarity on prior authorization requirements, rationale, and changes. This is juicy. This will include intra- and interorganizational communication to ensure the data generated by all

the transactions are made available to actors to support continuous process improvements. And, the final item is a full audit trail should be available to both the patients and the clinician so there is a common source of truth about the status of any prior auth. Any questions on those?

Sheryl Turney
No one's raising their hand so far, so why don't we go to putting up the public comment slide, Lauren? And, we can go to public comment, and when we come back, we can put a hold on this and then pick this up in our next meeting because I don't think we're going to have time to finish the entire paper.

Alix Goss
We are not.

Sheryl Turney
Yeah, we want to go over next steps also.

Alix Goss
Yeah, and I'm hoping that folks have gotten through fairly far so people can review this, add their – you all have the Word document in your inbox. You can feel free to mark it up and send it back to me.

Sheryl Turney
That would be a great homework assignment.

Lauren Richie
While we're getting the phone number up to make public comment, I also put that in the chat box. So, at this point, we'll ask the operator to open the public line.

Operator
Thank you. If you would like to make a public comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 if you would like to remove your comment from the queue, and for participants using speaker equipment, it may be necessary to pick up your handset before pressing *. We will pause for a brief moment to poll for comments. There are no comments at this time.

Sheryl Turney
Lauren, I thought there was someone who had joined in the beginning that might have a comment. Maybe I saw it wrong.

Operator
Okay. Once again, if you would like to make a comment, please press *1 on your telephone keypad. I don't have anybody queuing up for a comment.

Sheryl Turney
All right. Okay, Alix, do you want to talk about next steps for the material that you guys presented, and then we can go from there?

Alix Goss
Sure thing. So, I just have to make myself a note as to how far we went. So, what's going to happen next is that I hope all of you will continue to take a look at the last page and a half of the four items and give us any feedback. The small working group will take the feedback from today and additional feedback and incorporate it. We'll go on a wee hiatus while Jacki Monson and I wrangle privacy and security with a handful of you folks, and then come back with hopefully – what I envision is to synthesize all of this information into a succinct vision for what's next, and we can start to consider how we're going to move forward. What I think will be important is also for this group to await direction from the full task force as we pivot from the prior authorization exemplar to the broader conversation.

Sheryl Turney
Thank you, Alix. Is there someone on the task force that would like to volunteer to be the SME that could work with the individual that Steve Brown had offered to ascertain to develop that inpatient as well as the med workflow?

Jim Jirjis
Jim Jirjis here. Josh and I can.

Sheryl Turney
Okay. Thank you, Jim and Josh.

Gaspere C. Geraci
This is Gus Geraci. I volunteered earlier, but I'll add my name again.

Sheryl Turney
Who is that again?

Gaspere C. Geraci
Gus Geraci.

Jocelyn Keegan
Sheryl, as available, I'm more than happy to participate as well. We've done this over on NCPDP for it a couple times, so I love the idea of moving it into a newer modeling format.

Steven Brown
While you do it, could one of you guys just send an introductory email so I get everybody's contacts and stuff? We'll get something going. I'm going to resource box it, but I think you're going to like what you see.

Jocelyn Keegan
I agree. I'm actually in the process of sending Steve a message right now, guys, so I'll just add Gus, Jim, and Josh to it.

Sheryl Turney
Wonderful. And, I'd love to participate in that meeting, if you don't mind, when you're establishing it. Thank you. This is Sheryl Turney.

Jocelyn Keegan
That's okay. I'm just going to volunteer Josh to wrangle us again.

Sheryl Turney
Okay, perfect. And then, in the prior discussion, we also did talk about the making of a couple of adjustments to the data classes work and definitions, and I'll work with Josh and Jim offline to see if we can get that information updated. Are there any other suggestions or comments from the participants before we recheck to see if there's any public comment?

Operator
I have no comments.

Sheryl Turney
Okay, no public comment. All right. So, again, we really do appreciate everybody's participation. I think this was a great meeting today. I think we made a lot of progress. Please do think about the suggestion I made about the data model, and we can add that as a topic to talk about next time when we're talking a little bit more and reviewing our progress on the three workgroups that we're going to have now – actually, four, because we're adding the new data model – or, process model – so that will be another update that we'll have. And, if we have no other final questions or comments, I just want to thank everybody for today, and I hope you have a wonderful week and a great holiday weekend.

Alix Goss
Well said. It's hard to believe it's Memorial Day already.

Josh Harvey
Thanks, everyone.

Sheryl Turney
Thank you.

Alix Goss
Take care, everybody.

Gaspere C. Geraci
Thanks, guys.

Jocelyn Keegan
Great job. Thanks, guys.

Lauren Richie
Bye-bye.