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

July 21, 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
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
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

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

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Welcome again to the ICAD task force. Of the members, we have Alix Goss, Alexis Snyder, Anil Jain, Denise Webb, Rich Landen, and Sasha TerMaat. I do know that a few individuals, Andy, Deb, Ram, said they may be a little late. And unfortunately, Sheryl is not with us, so I will turn it over to Alix to get us started. And I will just quickly ask, have I missed anyone in the roll call? Okay. All right, Alix, it is all yours.

Summary and Action Plan & Recommendations Discussion (00:00:43)

Alix Goss
Thank you so very much, Lauren. Could we go to – yep, awesome. So, our agenda lineup for today, now that we have completed roll call and welcome, is to do a brief recap from last week's meeting. We are going to move into the recommendations discussion. There was one area remaining for us to tackle, and we actually have an additional one related to a data model that we are going to discuss today, in addition to continuous improvement.

We are then going to present some of our thinking related to the report draft writing plans, and the convergence conversation, and how we will be framing up the intersection of clinical and administrative data portion of our task force work, now that we are bringing the prior authorization detailed discussions to a wrap. We will conclude with public comment and next steps. Thank you.

So, let's go ahead and recap our last meeting. I want to really do a big shout-out to Jim and Josh, who presented a data classes and standards document, really synthesizing the work of the data class and related standards discussions. They presented it in terms – a new table in terms of availability, adoption rates, and usefulness. This will be very helpful as we move forward into the report writing efforts. We also discussed some gaps in the standards, variation, and coverage of data classes and adoption, and some implications related to the task force recommendations.

Following that robust discussion and recap from Jim and Josh, we moved into recommendations brainstorming. We focused on designing for the future. There was a straw man from which we launched the discussion, thanks to the small working group, who put forth some very clear thoughts around: we need to craft recommendations to what we think is right, even if they are hard or will take on some challenging issues. I was personally very pleased to see the level of support from the full task force in regards to a number of the recommendations that we reviewed related to the standards floor, a unified process for standards advancement, and leveraging the interoperability standards advisory framework to support convergence, and the overall need to align national standards framework to support clinical and administrative needs. We found ourselves quickly sliding from the prior authorization focus to the larger intersection conversation, which is a natural pivot at this point in time.

We also then continued to have some discussion around real-world need for the separation between clinical and administrative data, and how that has been slightly artificial to date, and how we are going to reduce burden as we move forward. Any questions on that last meeting recap? All right, seeing no hands. If we will go to the next one.

What we are going to do now is we are going to pivot to a working document that we have had on Google Docs that has been the landing zone for the guiding principles, ideal state, and overall recommendations brainstorming. Hopefully, everyone is able to see my screen. I am displaying the document. And to help us

focus in, I have got the two key areas for today in orange. We are going to talk about continuous improvement. The small working group did meet after last week's task force meeting, so we have a few recommendations for your review and consideration as a launch-off point for that section.

Then, we want to talk about a data model. This is a topic that my co-chair Sheryl had introduced, this concept of aligning towards a Federal Health Architecture or some sort of a data model that would support us with bringing clinical and administrative data together. So, that will be the second area that I would like to spend time brainstorming today, before we pivot into report writing and convergence conversations.

So, without trying to make you all dizzy, I am going to scroll down to the continuous improvement section of the document. This is, as I noted, new content. It was produced last – I think it was, believe it or not, just Thursday, from the small working group. The concept of continuous improvement as a guiding principle was underscored by the ideal state framework of payers having an established process for regularly reviewing and communicating the services and medications that require prior auth, and eliminate requirements for therapies no longer warranting them. The payer reviewing communication processes will have established, predicable cadence, such as the CPT annual update process. So, that is the ideal state that we are working towards.

We came up with two high-level recommendations for your consideration and evolution today. First one is: A). Leverage HEDIS, and Star ratings, and other industry vehicles to expand yearly review to be industry-wide, and related sharing of policy born date. The expectation is that the last review date should not exceed a year review periodicity, which is the norm for plans that are accredited. So, this is really talking about how do we leverage plan ratings and quality ratings to really help us have some teeth related to ensuring that there is an industry norm for reviewing a prior authorization policy, and that we know when that policy was actually born, when it was created, and subsequently, that it's being reviewed on a regular basis.

To support our discussion, I think I will stop at this one to see if there are any questions on Recommendation A. Okay. Seeing no questions, I am going to go ahead and move on to Item B, which is a recommendation to establish through CMS and ONC authorities a deadline for industry to build in codification into health IT tools, such as order management tools, e-prescribing tools, electronic health records, practice management systems, and case management systems.

So, what we are trying to do here is to force the codification and the data capture tools that support clinical and administrative data purposes downstream. We noodled on whether or not to evolve the codification of data to enable automation, and how to capture the needs for codification, such as trust and friction considerations of requiring proof today.

These are the two straw man recommendations for continuous improvement for a learning health system. Have we gone far enough to really create our ideal state related to continuous improvement? Sasha?

Sasha TerMaat
What do we mean by "build in codification"?

Alix Goss
What do we mean by "build in codification"? I believe what we mean by that is – and I see Jocelyn's hand went up, so she may want to chime in here as well. Is that what you are answering, or asking a question, Jocelyn?

Jocelyn Keegan
No. It was my commentary, so I thought I would speak to it.

Alix Goss
Please.

Jocelyn Keegan
So, I think a concept here, Sasha, was one of the challenges we have had over on the prior auth side is, while we have gotten folks to take their existing question sets and put them into an electronic format, we have essentially digitized forms, we have not really fully taken advantage of the fielded data in the EHR as much as we can. So, the idea of it being codifiable just means that it is able, as individual data points, to be acted upon, as opposed to sort of a blob or a document type of transport, so we can make it more interactive.

Sasha TerMaat
I think my worry about the way the straw man is drafted here is that, to some extent, this is already an expectation of ONC certification program. For example, the certification program has long had the expectation that diagnoses would be coded against SNOMED, or that e-prescriptions are written in a structured format with RxNorm codes associated, or that lab results have a LOINC code.

And so, if we put B into our straw man, I do not know what we are describing there that is new and different in a way that could actually be enforced or acted upon as a recommendation by CMS or ONC. I think we would have to be more clear and likely more specific about what data and what code sets we were feeling were lacking in the current program for that to be a really effective recommendation.

Jocelyn Keegan
I think that is a really important point. And I think part of what we are seeing is, I think, the bar is already higher for the data that is at rest in the EHR, and the data that is based on the existing administrative transactions does not have that same level of expectation on it.

Sasha TerMaat
So, then maybe we need to adjust the systems listed in B to acknowledge that this is already an expectation of ONC certification for EHRs, but is more of a problem for other systems.

Jocelyn Keegan
I will leave it to the folks that understand the policy side better than I do about whether or not we would need to call that out.

Alix Goss
Okay. So, I am trying to edit on the fly here, folks, in response to this thoughtful discussion. So, establish through CMS and ONC authorities a deadline for industry to build in codification into health IT tools, beyond those which are currently governed by the Certified Health IT Product Program. Should call it program. Sasha, am I getting at it?

Sasha TerMaat
Yes, I think that is helpful. One other thing I think we have learned from ONC's certification program in the past is that it has a detrimental effect on usability if the requirement is written in an unintentionally over-prescriptive way. And what we really want is for the data to be accessible for interoperability purposes, not actually dictate how it is necessarily captured.

For example, smoking status was a source of much revision in past ONC certification policy, because some of the initial certification requirements required a very prescriptive capture, which was less detailed and perhaps less useful than different systems had evolved on their own. And of course, it was important to have ways to standardly express smoking status across systems, but it does not matter if a system supports a more granular capture, as long as they could map to that standard expectation when exchanging with another system.

And I think we would want that same principle here. Our intention is not to limit the way data might be captured in different systems, where different tools might be more applicable to one specialty or another. The goal would be to identify the sort of minimum necessary set to exchange for interoperability purposes that meet our needs for prior authorization and other flows, without interfering any more than is necessary

with the data capture. Does that make sense?

Alix Goss
So, it's a balancing act between the data capture dynamics and the systems capabilities? I am not sure I am hearing you right, Sasha. I am trying to make sure I have got my arms around what you are asking.

Sasha TerMaat
I think when we write policy goals, we want to articulate them as what is necessary for interoperability to meet our use case of streamlined prior authorization, for example. We want to avoid being overly prescriptive about what type of data would need to be captured or how it is captured, as long as the data is available for the interoperability purposes that we need.

Alix Goss
Sasha, I am not sure I am understanding what you are asking me to do, or are trying to get us to consider as a modification, or maybe as a whole new addition.

Sasha TerMaat
I think I would just change the phrasing where it says "build in codification." I do not know what that means, kind of to my earlier point. I think that is a very ambiguous phrase. I think what we want to say is, "to support interoperable exchange," not, "build in codification."

Alix Goss
Yeah, I am getting a ton of background noise. I am not sure if that is on my line, and apologize, or if anyone else is picking up on that. To ensure interoperability…

Sasha TerMaat
Or interoperable exchange.

Alix Goss
Because I think the whole point here is that we want to make sure that as much gets captured, and then translated from the way we speak to the codification that really underpins interoperable exchange. So, is –

Female Speaker
I think I see –

Sasha TerMaat
I think the fear of what we have learned from the past certification, though, is that if we write a policy that is overly prescriptive about how data is captured, it can have a really detrimental effect on usability and the possibility to be flexible with that across different specialties, or settings, or use cases.

So, I think the goal we should express here is that certain data is important to have in a standardized, codified, for example, format for interoperability for this use case, and if certain systems do not support that, that is a priority of ours; but I actually think it would be really detrimental to specify a policy about how data has to be captured.

Alix Goss
I do not think that was what we were trying to do. I think we were trying to say, once you get the data, you need to be able to make sure it can be codified so that it can actually be interoperable and shared. I think we all should be mindful that everybody does their job a little bit differently, but we can still get to the same outcomes. And it is how you have that ability to work with the tools on your desktop to enable those interoperable exchanges are going to be underpinned by codification of data.

So, as the modifications that I have made in Item B, does that address your – because what I hear is more of a concern about, do not tell me how I have to do my job and enter information from that patient-provider

interaction into some system, or if I've got some other ancillary system beyond order management, like case management, how that job is done; just make sure that the data that I have captured in that job is interoperable, and that ties to codification.

Sasha TerMaat
Yes, I think that makes sense. And I think what we have drafted, the revisions accomplish what I was trying to express.

Alix Goss
Got it, okay. So, thank you, Sasha, for confirming. We have addressed your two concerns. And I have just lost my connection. Yay. Okay, I guess I am coming back in now. All right. Hopefully, you guys can still see my systems, or Excel can tell me what I need to do – once Adobe relaunches for me, what I should do. And maybe in the interim, Steve Brown can chime in. Or have you lost me altogether?

Steven Brown
Can you hear me?

Alix Goss
Steve?

Steven Brown
Yeah, can you hear me?

Alix Goss
I can.

Steven Brown
Oh my God. So, I think, as someone that has spent an awful lot of time with these standards and meaningful use, I think you need to be very careful about overestimating the coverage of standards for real semantic interoperability. Just because a lab test has a LOINC name does not mean that there are sufficient standards for transmitting the data in a useful way. There are all kinds of lab fields that are not well-covered by standards, for example. So, I think it needs to be done very carefully.

The next thing that I would like to bring up is orders. Orders are a completely different animal, right? And just because you can name a lab test or name a medication, there are all kinds of other information that needs to be looked at with equal vigor. So, I think that these need to be done on a case – looked through given a data element, like a medication by data element, with a careful eye towards are the standards really adequate for what we are thinking we are going to do with the data? And I think we are going to find that there are significant gaps.

Alix Goss
So, what you are saying is that we think that we have really good code sets and ability to be specific in our information that we are exchanging, but you are really saying that the underpinning terminology, the vocabularies, or related standards will not meet our needs?

Steven Brown
I am saying that we may find gaps in absolutely necessary related standards. So, the way I try to explain it to my administrative superiors is that we have – well, it is like, we have the marquee item in the domain. Like, we have RxNorm, isn't that great? But look at all the other components of a medication order or a medication dispensation, right? We have LOINC for lab testing, that is great; but the results, they are wild, right? I mean, you can say, "Plus, plus, plus," or you can say "three plus" for white cells in the urine, and there are any number of examples like that. So –

Alix Goss

I think that you are getting a lot of support for those comments, based upon the chat box, but do you think that we need to have a straw man recommendation related to this?

Steven Brown
What I would suggest is that we try to figure out what – for a given use case, for a data domain, maybe the recommendation is we go for a particular type of data and recommend that additional analysis of gaps in standards necessarily for semantic interoperability be undertaken.

Alix Goss
I am going to hopefully scroll this up. Let me move this down. So, I think this is separate, as I look at the – as I think about your comment, it seems to me that we could benefit from advancing some work around terminologies and vocabularies. If we want to get to codification, this is – we are forever going to be in the situation I think that you described, which is, it is where it is today, but we can always make it better.

Steven Brown
Well, that is one way to put it, but I mean, I think you are in trouble if you start demanding codification to standards that are incomplete for the job. You would be better off if –

Alix Goss
I think you have sold us all on that point, so I am trying to translate that, Steve, to what does that mean from our recommendations perspective? And if you are not sure, that is fine. But I feel like it is highly actionable, and I have got queue of people raising their hands right behind you, because I think they may want to have some comments on this.

Steven Brown
I have stirred the pot; I will stop.

Alix Goss
Always get the pot stirring.

Steven Brown
I was having **[inaudible] [00:23:26]** though, so I had to say it.

Alix Goss
Okay. So, I see Rich, Jocelyn, and Anil all put their hands up, and I thought I saw Tom Mason's hand up a minute ago. So, I am looking for those who want to comment on the specific item from Steve before introducing an additional item. Rich?

Rich Landen
Yeah. I want to support both Steve's and Sasha's points in that our recommendations, I think, are in the right direction, but we have got to be at a point where we specify what codified data we want out of the system, and to Sasha's point, not specify how it gets in there. So, we need to be a little bit more specific than saying, this stuff needs to be interoperable, but we cannot get overly prescriptive about how industry creates the codified data or where they create it. That has got to be up to whoever the developer is.

And to Steve's point, yes, there are innumerable gaps in data and – or in standards, and I think that is really beyond our scope. So, I like the approach that we are taking, that we do not – we, as the ICAD, or eventually, HITAC, do not need to solve that, but we format our recommendation in such a way is that we actually task ONC to look into the feasibility of what codified data elements are there standards for, and ONC has got a long history of doing that exact thing, and then apply that specifically toward the prior auth, and then more generically toward the convergence of administrative and clinical data. So, we are actually recommending a glide path more than a solution. Thanks.

Alix Goss

Jocelyn?

Jocelyn Keegan
I actually just agree with everything Rich just said, and I think that just acknowledging that that work needs to be done so we do not sound Pollyanna-ish I think is incredibly important. But I think we are where we are, and so sort of avoiding our past mistakes, but identifying – and I think it is out of our scope – identifying that this work needs to be done and that people need to be identified to make this work happen for real.

But I think that, to me, there is a pause between saying everyone must do it the same way or have the same rules, versus this is the subset of data that is required around a particular disease state or regime, is where that expertise needs to be applied to make sure that the standards are fit for purpose for the work that we are doing. So, it is going to take investment from those, to me, areas to make sure that we can get to that desired end state.

I would not want us to think that we cannot start today, knowing that there is work to be done, versus it continuing to be a blocker on making any progress, because I think that has been one of the big challenges with the 278, is it is so broad and so flexible to meet everyone's needs that the rules to use it have never been efficient enough to get people to the consistency to actually make it work in an automated fashion.

Alix Goss
Yeah, that is actually a really good example in the prior authorization, Jocelyn, because we use – there is an internal code set to X12 for the generic messaging, and then it expands out, and it actually – in more robust capabilities for prior auth, you can use the LOINC codes. That could be how we could tie that in to kind of build on Rich's idea about applying the PHI to LOINC code values, and then the broader intersection glide path.

Jocelyn Keegan
And I think that Alix gives us a great place to point out where some of the existing business models around code sets are challenging.

Alix Goss
Oh, okay. So, let me translate that to, there can be cost implications and accessibility to code sets that are barriers.

Jocelyn Keegan
That sounds great.

Alix Goss
Okay. Consider pursue –

Jocelyn Keegan
And Alix, I apologize; I have to drop for a little bit. I'll be back.

Alix Goss
Okay. Okay, so pursue options for industry-wide access to code sets. I thought we sort of already had this before, I think potentially under real time and automation. Okay, so I am just going to make that a note. And, Anil, you have been very patient.

Anil Jain
No prob. So, agree with everything that has been said. And the way that I am thinking through this – you guys can sort of tell me if I got this wrong – I think we are all saying that we are going to push for existing code sets that we want to leverage and maybe expand them to those use cases, but we also want to identify those gaps that may exist, and then have ONC figure those gaps out, and then invest in them. But we also

want to recognize the semantic challenges that existing code sets may have in the use cases that we are describing. And as a clinician, I can tell you there are plenty of aspects of where sometimes picking up the phone and talking is probably the right answer, instead of having two technical systems interact. So, we do have to recognize that because there are semantic limitations, there could be unintended consequences of having this sort of automated technical exchange of information that makes a decision or adjudicates a decision about a specific patient.

So, going back to the 80/20 rule that we have been discussing as a group, we want to make sure that the vast majority of use cases are covered, but that the semantic limitations will probably require us to deviate from some sort of automation in that 20% of cases that we have been alluding to. So, what I am suggesting is acknowledging that there are semantic limitations, even if the code sets were perfect, and acknowledge that there could be unintended consequences if we are not investing and understanding the semantic limitations carefully enough, because it's just too easy in a busy practice to let things be automatic without picking up the phone or having human-to-human interaction that somehow, in some cases, may have prevented some issues in the past. So, I love the idea of pushing for codified standards, but that semantic aspect of it needs to be acknowledged in this group.

Alix Goss
I tried to capture a note there, Anil, about, "Be careful of semantic limitations and unintended consequences in busy practices." Not sure that is where you wanted me to capture that. Is –

Anil Jain
I was not looking at the screen, so let me see if I could quickly look at it. I think the most important thing is that semantic limitations can introduce unintended consequences as we move towards automation. We had in the past a poor man's way of preventing bad things from happening, although it wasn't perfect, which was two people would speak to each other.

Alix Goss
You are being asked to give an example, I believe, by Steve Brown.

Anil Jain
Sure, sure. So, let's take a complicated patient with rheumatoid arthritis who has tried a few different medications. All the sudden, I, as a clinician, is recommending that the patient be put on a – perhaps a more expensive, but a different type of medication. Oftentimes, you are asked by that – the patient has tried X, Y, and Z before, and sometimes, that could be codified. To Tasha's point earlier – or Sasha's point earlier, rather, that there could be – this patient was on this medication or that medication, but it could be that the clinician is making a decision based on drug classes. And in the past, you would pick up the phone and speak to somebody that you could explain why it is not a good idea for us to try A, B, and C, and move right to the choice, which may not happen if we rely solely on data which does not capture, because of all the reasons that we have already articulated, the full semantic understanding of a patient's condition.

And I just lost the connection. Am I still on?

Alix Goss
I hear you.

Anil Jain
Okay.

Alix Goss
For sure. Very clear.

Anil Jain
Yeah, I lost the meeting, the online Adobe meeting, but that is okay. But yeah, so –

Alix Goss
It will come back. If not, exit out, and it will come back right where you left off. I was surprised how easily it worked today.

Anil Jain
Yeah, not a problem. While I do that, I will just quickly say that specialists – I am a primary care doc when I do practice, but specialists probably have tons of examples where the data does not capture all the criteria that would be required to do auto-adjudication. And to the points made earlier, ICD-10 is not granular enough in some cases, or too granular in other cases, to be any good for this kind of purpose.

So, I think prior auth is a great example of where we run into a semantic challenge with code sets, because we are trying to get a system to make a decision about a real person who cannot be represented with just codes.

Alix Goss
I am hoping that example provides context for you, Steve. I noticed that you used an "X." It looks like you are disagreeing with the earlier comment, and I am not sure if that was intentional, or raising your hand maybe in –

Steven Brown
Well, that was old. But I guess what I would say is, I see two different things here. One is that ICD-10 is often not sufficiently granular, and it is a classification system, and we all know that, and that is a good discussion to have. So, then the other case is that the drug classes are inadequate, and that may be a standard problem. And I think there is a third instance where the case is simply too complicated to express using any sort of reasonably understandable information.

Anil Jain
Right, I agree with that.

Alix Goss
So, I think this is good commentary. Looks like Alexis is agreeing with it, with the similar example in her own world. And I think that as we move forward with crafting recommendations, we need to take this into account, either as its own kind of recommendation, or maybe it is just part of the commentary that we will add in when discussing a recommendation.

I am not seeing any further hands up, and so I would like to, in the remaining time that we have on the recommendations discussion, move down to the data models. So, one of the things that –

Anil Jain
I am sorry.

Alix Goss
Oh, Anil? Oh, yes. Please, go ahead.

Anil Jain
Yeah, I just want to make a quick comment. I think one of the challenges that – and again, I am a very part-time practitioner these days. But one of the things that we do not do a great job of, from an informatics point of view, is we do not capture in codified form the decision-making process. Yes, we have codes for diagnoses, and procedures, and medications, but we do not know how to codify the branching logic that a clinician and a patient working together may have used to make the decisions.

So, as much as we want to emphasize using codes, until we have a better way of codifying decision-making, we are always going to have that gap. And so, this way, policymakers, and patient advocacy groups, docs, and payers, and plans do not misunderstand that we are not going to have a perfect automated system

until we can codify the decision-making process, which does not exist in any meaningful form in healthcare. Even best practice alerts and decision support tools do not fully address it.

Alix Goss
Any comments or thoughts on Anil's input? Okay, seeing some chat box, but no one is raising their hand, so I am going to go ahead and move on to the data model discussion. The reason I want to move on to this is that – because we have been – Sheryl introduced an idea of this concept of needing a data model, and I think it is emerging from some of the data classes and categories discussion, and that there was some anticipated discussion around this week of what kind of data model, or is there a data model.

And as we have been looking into this in Sheryl's absence, it seems to some of us within the ONC sphere, in our research, that we may be bringing ourselves back to this concept of FHIR as potentially the data model we want to be exploring; that there is, in the Fast Healthcare Interoperability Resources, the standard – the internationally-based standard of Health Level 7 has the capacity to handle administrative data, as well as clinical data. And that I think it is clearly understood that the financial management aspects inside the HL7 standard may not be fully baked into the FHIR standard, but that there is a strong linkage, when you look at EHR records, the convergence of data kind of objectives, that USCDI and the use of the US Core version of FHIR could be a logical place for us to work at bringing a data model together for clinical and administrative data.

As such, I am throwing this out there as, should this data model idea be a category? Potentially, it's part of the real time and automation item, but we have not discussed this aspect of how do we get clinical and admin data models to come together, and what is a logical approach to that? Would folks propose that we look to FHIR to be the grounding model for data?

Steven Brown
This is Steve. I have a couple of comments. I think that the data model is absolutely essential for exchanging data in a consistent and interpretable way. There is always an intersection – there is tension between the intersection of a terminology model and an information model; nevertheless, it is essential, and there should be some recommendations or some eye towards recognizing that the two go together and neither can stand alone. One of the problems with FHIR as a data model is it is often not very strongly tied to the terminology model, and it is –

Alix Goss
I am sorry; it is not very strong to what? You broke up there, Steve.

Steven Brown
To the terminology model, right? So, you need an information model –

Alix Goss
Terminology, okay.

Steven Brown
– a terminology model that is bound to it as sort of your entry price for – just the entry price of semantic interoperability. The folks who are experts in this area – and maybe we would want to get one of them to educate us a little bit. FHIR is, I think, oversold in terms of their out-of-the-box ability to do that. And it is also, by domain, not necessarily internally consistent. And you can also –

Alix Goss
When you say "domain," do you mean domains within healthcare, or do you mean domains as in multiple lines of business, not necessarily just within healthcare?

Steven Brown
I mean, across FHIR resources, it is not always consistent.

Alix Goss
Okay.

Steven Brown
Right? So, if you have an observation, and you have a thing, and you want to say that it is not true, or you want to express laterality or something like that, it is not always done in the same way. So, there are absolute weaknesses. It is very popular, and it is still rising on the hype curve, but I think there are significant challenges that would need to be understood before simply endorsing that.

Another thing to consider is a statement model. A statement model is a type of small information model that is used to make statements about the occurrence of an event about a patient. So, right now, HL7 has examples of those as well, and they are not inconsistent at all with FHIR. So, I would not immediately throw out, for instance, the FHIM, which is a very large, wide-scoped information model, and say that FHIR is going to solve all of what the FHIM could do, because it will not.

Alix Goss
Did you say "SIM" or "RIM"? Because you are on a cell phone, and I am losing a little bit of the quality there in understanding if you said the Reference Information Model of HL7, or something else.

Steven Brown
No, I will put it in the chat box. The FHIM, the Federal Health Information Model.

Alix Goss
Okay, yes, because the Federal Health Information Model, which – so let's talk about that a little bit. Do you want to maybe give us a little bit of what is the Federal Health Information Model for folks?

Steven Brown
Well, I mean, I am not going to give a – I only know people that worked on it. So, what the Federal Health Information Model is, it is a UML information model that describes and interrelates all kinds of different important nouns and verbs in relationships in healthcare. So, let's see. I mean, there is a ton of modeling work that has been done, and you can go **[inaudible] [00:44:23]**.

Alix Goss
But I think that you are touching upon some of the research that some of us did in the last week to try to – because we thought Sheryl might be back today, and she had some ideas around this, and that we are not really seeing a robust Federal Health Information – or Federal Health Architecture team in place anymore. So, there had been historical information. So, I think what we probably need to do is think about this conversation from a higher-level sort of recommendation perspective, which is, we need someone to go figure this data model out, and maybe we do not want to make it at the FHIR level.

Steven Brown
Right, but you should not just do it because FHIR is cool; you should do it knowing the limitations.

Alix Goss
We should do what is right.

Steven Brown
Oh my God.

Report Draft Writing Plans (00:45:24)

Alix Goss
Okay. So, I am going to think that we need to involve a recommendation at a higher level of thinking for

data-model-aiding-convergence aspect. And I am going to put a placeholder on this, and we can come back to it. What I would like to do is go ahead and pivot – I am not seeing any hands up, and I apologize if I have missed somebody raising their hand; does not appear that anybody has.

So, what I would like to do is I would like to pivot on our agenda, so I am going to stop sharing. I think there are magic hands at play to help us pivot to the next section, which is to talk about the report draft writing plans. And so, I think Michael Wittie and I are going to tag team, likely with some support of Lauren as well. I think what we want to do is start to introduce to you our thinking of the report writing effort, sort of the timelines, and what that means to us as we move forward with our meeting schedule and offline work that we have been advancing. And so, I believe at this point we are going to start to see Michael Wittie's desktop and – or his slide from him, and hopefully, he is going to be able to make that a little bigger.

Michael Wittie
Can you see it at all?

Alix Goss
I can see it. It is beautiful.

Michael Wittie
So, that is the first one.

Alix Goss
Okay, so –

Lauren Richie
I am sorry.

Alix Goss
Go ahead.

Lauren Richie
I was just going to ask if he could zoom in a little bit, that is all.

Alix Goss
Oh, okay. So, what we want to do is start on the first…is this the first slide?

Michael Wittie
Yes.

Alix Goss
Okay. I am going to have to make my screen large so that I can see this. Let me do it this way, because it is pretty tiny. Okay, there we go. I just moved it to my other monitor. Apologize for the delay.

Michael Wittie
I have got it maximized, so this is all I can see. So, yell at me if somebody is typing a comment.

Alix Goss
All right, I can do that, because I can now see comments because of the way I pivoted my screen. What I would like to do is get rid of that Microsoft search command option, if we could do that somehow.

So, we have put together, to present to you today, an outline of the next – is it two months? Possibly three months of our work. Today, we want to present to you what we think is the calendar forecast so that we can get your feedback.

We would like, on Thursday, to kick off a report synthesizing group. And what I mean by a synthesizing group is that there are folks who have been involved in small working teams, and we have been bringing that work back for discussions and iterations with the full task force. We have engaged in outreach, and have folks who are willing to help us with synthesizing the work that we have done so far into content that could go into a master report. We are envisioning that the efforts of synthesizing will enable us to be ready for the anticipated arrival of an editor that can help us with one-voicing and smoothing out the final report draft that we are going to produce to present to HITAC in early September.

The editor, you will notice as we get further into this outline, is not expected until the middle of August. As such, we have got a plan to do parallel work of synthesizing efforts to date, while we, as a full task force, pivot to the broader intersection discussion.

In working with Sheryl and with Lauren, it is clear that the HITAC federal advisory committee has sort of three lenses that they leverage or use as a result of their 21st Century Cures genesis, and they are tied to interoperability, privacy and security, and patient access. These are three high-level buckets – categories, if you will – of thinking that we would like to use in helping us pivot from the prior-authorization-focused discussion to stepping back and saying, what haven't we talked about that we need to, so that this report really puts a line in the sand and can help us have a pivot in the industry.

It is also envisioned that we may be able to use those three categories of interoperability, privacy and security, and patient access as a higher-level framing in our report. So, as such, we propose that for three weeks, we – for the next three weeks of task force calls, that we hold three separate discussions focused around those three categories, and then wrap up our thoughts about those three categories and the broader intersection discussion on August 18th.

Meanwhile, the offline synthesizing teams would be summarizing the efforts to date, and we would start to get content ready to go into a template document. We believe we can create a Google document to help us with that initial compilation work, so that when the editor comes, they will have a launch-off point to create a clean document and one-voice our work, enabling us to pivot the full task force discussion on August 25th to the draft presentation that Sheryl and I should present to the full HITAC on September 9th. We will talk about that on August 25th, and then be working offline to complete the slides and a draft report.

On September 1st, we would like to talk about the draft report review. September 8th, we would like to share the final HITAC materials we intend to deliver on September 9th, when we want to present, during a HITAC meeting, the draft recommendations, and then ask for feedback from HITAC on the report, so that we could then, in September, later part of September, be working with this team as needed to update and revise that report as necessary, ultimately leading to a final deliverable to HITAC October 21st, and we would present and deliver that officially then.

That is a high-level plan, and I am going to stop there to see if there are any questions. I am not seeing any questions on that, nor chat boxes, so I hope my Adobe has not frozen.

Could we go to the next slide, Michael? Again, can we somehow get rid of that box? Do not know. Maybe if you go to slide mode as opposed to –

Michael Wittie
Maybe. Is that better?

Alix Goss
No. I do not know. "Microsoft search is disabled," is all I keep seeing, and maybe that is on my screen. It is on my screen, so I apologize. All right, that was a user error. Okay, it is a fun day in ICAD Land.

So, let's now talk a little bit about ICAD task force agendas. Okay. If we start to put the pieces of the puzzle together, using – I just lost Michael's screen. Michael, did you use –

Michael Wittie
Is it back?

Alix Goss
Did you –

Michael Wittie
No, is it back? Oh, I lost connection. Let me reshare that. Okay, can folks see it?

Alix Goss
It is coming back as you speak.

Michael Wittie
You can see it?

Alix Goss
There we go. I can, I can. We are good.

Michael Wittie
Yay.

Alix Goss
All right, so just flip back one slide for me. So, I walked through this first slide, and this is sort of the big picture. So, now if we go to the next slide, what does that big picture timeline really mean to getting the report content synthesized and crafted?

What that means is that, offline, we have got – you will see on this that we will have each of the meetings that we have – we know we have slated between now and the HITAC presentation September 9th, with interim rows reflecting the things that we want to tackle in the report, or the work that we have yet to do in the sense of the broader discussion conversation that we want to frame around interoperability, privacy/security, and patient access. And that there will be a cadence of doing some offline work, bringing it back to the task force, getting feedback, and then iterating it into the master document, ultimately getting back to a full task force review of content, leading us up to the point of being able to have a compiled report, hopefully the end of August, very beginning of September, that the task force members will be able to review front to back.

Michael or Lauren, do you have any other commentary to add to round out this discussion?

Michael Wittie
No, I think you covered it.

Alix Goss
Are there any questions? Rich Landen?

Rich Landen
Yeah, it is very ambitious, but good job. It seems to be what we need to get us to where we need to be by when we need to be there.

Just a quick comment. The August 25th meeting date, there is an NCVHS hearing that date, so that means that Alix, myself, and Deb Strickland will probably not be available to ICAD. I do not see the three of us as making or breaking the task force discussion, but I did want to call that out, just in case that was a concern to others.

Alix Goss
Yeah, and I do not believe that Jacki Monson will be at that hearing for us as an NCVHS member. Maybe she can be – as a participant in this group, she can maybe be here. But I agree with you. I had communicated to Lauren that we have a CAQH CORE hearing on prior authorization and connectivity rules on the 25th and 26th, so we would not be available that day. And so, we are envisioning Sheryl will be back and will facilitate that session. On a similar note, I will not be here next week, because I am actually going to try to take some time off. See if that happens.

I do think, to your point, Rich, that this is aggressive, a very assertive timeline, and that we are going – I am extraordinarily grateful and appreciative of those folks that have accepted my invitation to play, such as yourself, Rich, and Alexis, and Anil, and Jim, and Jocelyn, and Deb's already working on the gaps. I know I am leaving a few people out there. We are also doing some additional outreach to folks that can help us with providing some general guidance and kind of perspectives, because sometimes, a couple of us are too in the weeds, so we have enrolled a few folks to help us keep it at the right level.

There is more than enough room for everybody to play in this. So, if you would like to be a part of the crafting/synthesizing effort, please know that you are more than welcome to come to the party.

Okay, so I think that we have just wrapped up that discussion. If there are no other questions, what we will do is we can – we did not distribute this in advance because we thought you might have some comments on it. So, we can go ahead, and I think we should probably get that out to everybody so you can have it at your fingertips, or we will, if nothing else, include it as an attachment in our standard – the next deck that we send out, since this is really upgrading the next step slide. Pardon? **[Inaudible - crosstalk] [01:00:43]**

Michael Wittie
I have lost Adobe.

Alix Goss
Oh, good. Good, good, good.

Michael Wittie
But I will send that around.

Alix Goss
All right, yeah. We can talk about it in the debrief meeting later today, Michael. I think just putting it in the new deck will probably be easier for attendees as opposed to sending additional interim documents. I also think that when we have some folks get together on Thursday to talk about the actual synthesizing effort, and what those activities might look like, and the sprints we want to go through, we might have some honed thinking, so I would like to have a little bit of noodling time between now and the next meeting so we can iterate those accordingly.

So, one of the things that I was hoping to do today was to introduce this idea of the three areas. We realized after we designed the slides that I had to kind of talk about the convergence conversation in the overall timeline kind of walk-through; but for a number of you, you are on HITAC as full members, and you probably have seen this concept of the interoperability, patient access, and privacy and security framing. And so, I am really curious to hear from folks, as we want to pivot from having this prior authorization, very heads-down, focused discussion to the broader kind of intersection conversation.

There was some back-and-forth that we had internally about how best to frame that; how do we go from this heads-down discussion to the broader discussion? And so, we thought these three categories of privacy/security, interoperability, and patient access could be good ways to help us think about the broader conversation. Is this framing resonating for folks? I wanted to get some feedback on that to help us with

speccing out some subsequent agendas. Alexis?

Alexis Snyder
Yes. I mean, I think that we have talked – a lot of our planning and problem-solving has surrounded all three of these areas. We have talked a lot about interoperability. We have talked a lot about patient access. We have talked a lot about all three; privacy and security as well. And so, it makes sense to me that that might help with some of our framing, because I think folks will find that there will be a big overlap between what we have talked about and those principles. So, I think that that might be a great help.

Alix Goss
Well, and one of the things I was thinking about is that, in the report, do we take a simple approach of saying, here's what we did, and walk through the sequence; we talked about this, and we talked about this? And so, we get prior auth, and then we get to the broader intersection conversation. Should they be sequenced, or is it really that the framing is around these categories, these big pillars, and that we want to craft a story in our report that maybe uses the prior authorization as sort of the example that we are leveraging; but that ultimately, our guiding principles, our ideal state, and our corresponding recommendations really are about the broader conversation in the end, and so that maybe there is sort of this straightforward glide path of our report that is sort of beyond the normal, "this is what our charge was, this is who played, this was our process."

We are trying to get to this end state to reduce burden, improve the system. We needed a way to think about this convergence conversation, so we looked at prior authorization, kind of had some experiences, or we came up with determinations of what we needed to do to fix it as a result of all of our efforts. And that kind of then leads into maybe the end state "So what did you really learn, ICAD task force, and what do we need to do next" messaging to HITAC, so they can review those recommendations and decide how they choose to advance them to the national coordinator.

Alexis Snyder
It is definitely a piece of the larger puzzle when you speak about the broader guiding principles in those three pieces that come out of HITAC. So, certainly framing it as a parallel and the correlations that we found with prior authorization that fit into all three of those areas makes sense.

Alix Goss
Yeah, because one of the things I am struggling with is this idea that we need to have a prior auth section, and we need to have an intersection of clinical and administrative data. It is that we need to really have –

Alexis Snyder
But I think those also go hand in hand, right?

Alix Goss
Right, so why would we have different section on possibly ideal state, or guiding principles, or recommendations? It is really that I think what we have to do is figure out, what were we missing in our prior work because we might have been heads-down? And then –

Alexis Snyder
[Inaudible – crosstalk] [01:06:24]

Alix Goss
And so, if we –

Alexis Snyder
I was just going to say that I think all three of what you just said comes together. So, I think the background work was our work in ICAD of figuring out ideal state; guiding principles to lead to the recommendations. So, I think, at the end of the day, the recommendations include, right, in one area – not even breaking it

down into categories, but are including our recommendation is ideal state, and how to get there.

Alix Goss
Thank you.

Alexis Snyder
The guiding principles to get there.

Alix Goss
Thank you, Alexis. Denise, I see your hand up.

Denise Webb
Hold on, I have to un-mute myself. Okay, there I go.

Alix Goss
You are.

Denise Webb
So, when I think about this intersection of clinical and administrative data – and our discussion has been obviously quite heavy on prior authorization, which, to me, is really a very strong use case that has a need for that intersection of the clinical and administrative data. But as we are looking at it from three aspects that the HITAC is focused on from the 21st Century Cures Act around interoperability, privacy and security, and patient access, I think we do have to raise it up a level and discuss that in our report in terms of the future state – well, if you look at the present state of the patient, I have to go to my provider to get my clinical data, and then marry it up with what has happened on the payer side in terms of what has been paid and not paid, and wouldn't it be nice if we did not have to do that in the future; that there was an intersection of the data about me across the payer and the provider side?

And I do not know how we are going to get there, but that does play into interoperability, it plays into privacy and security, and choice by the patient on what they do want blended together and available to them. So, I think that is more umbrella than prior authorization, which is around a very specific need.

Alix Goss
Thank you. I feel like that is affirming that we are creating a lens to help us make that pivot in our discussion. And we have effectively got the next month to walk ourselves through the broader conversation at the higher level, using those three lenses. And then I think we have already got some background, the prior authorization work, that we can then, as we are synthesizing, think about how these all fit together, and then can pull into the report.

Are there other comments on this proposed approach? Okay, hearing and seeing none. I appreciate the feedback. This will help us with some prep work. We are scheduled for public comment at 4:20, but I think that we – I am not seeing any comments or hands raised at this point. So, Lauren, would it be acceptable for us to advance to public comment early?

Lauren Richie
Sure thing. And we will just ask the operator to open the line, please.

Public Comment (01:10:17)

Operator
If you would like to make a comment, please press star one on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press star two if you would like to remove your line from the queue. And for participants using speaker equipment, it may be necessary to pick up your handset before

pressing the star keys. We will pause for a moment to poll for comments. There are no comments at this time.

Next Steps (01:10:51)

Alix Goss
Okay. Well, we will leave the line up. So, I think that while we wait to see if any further comments come in, I am just going to – you can leave the slide there, but suggesting that next week, based upon our agenda, we will do the pivot to convergence of clinical administrative data deep dive. We will do some work to prepare for that and help with Sheryl's facilitation of that session next Tuesday. That will also be informed by some additional work that we will do this week with the synthesizing team, so thank you again to all those who had volunteered to help with that. August will be all about report writing and creating content for the broader intersection discussion, as we have just discussed several times, all leading us to our September 9th presentation of the draft report and recommendations.

With that said, Operator? Lauren?

Lauren Richie
I do not think so. I do not think there were any other comments.

Operator
There are no comments at this time.

Alix Goss
Okay. Well, I would like to get everybody back 15 minutes of their day. Any objections? I love being on mute. Okay. I am going to take silence as endorsement that you would all like to get back 15 minutes of your day. Thank you, Rich and Gus, for responding. And I hope everyone stays safe, stays healthy, and stays cool amidst these dog days of summer. Take care, everybody.

Lauren Richie
Take care. Bye-bye.

Male Speaker
Bye-bye.

Adjourn (01:12:42)