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

August 11, 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. Thanks again for joining our ICAD task force meeting, especially for those who have taken a break from our ONC tech forum to be with us. I'll do a quick roll call, and then we'll get started on the phone. We have Sheryl Turney, Alix Goss, Alexis Snyder, Andy Truscott, Anil Jain, Deb Strickland, Denise Webb, Gus Geraci, Jim Jirjis, Ram Sriram, Rich Landen, and Sasha TerMaat. Are there any others who have joined that I haven't announced? Hearing none, I'm going to turn it over to Alix to get us started.

Summary and Action Plan (00:00:43)

Alix Goss
Thank you very much, Lauren. Could we go to the next slide? So, today, we're going to do a little bit of recap now that we've completed roll call. We're glad all of you could join us today. We're going to focus most of our time today on a socialization and some general discussion around the recommendations-synthesizing work that Arien Malec and Rich Landen have been going through over the last couple of weeks. Rich is going to walk us through a document, and we'll take some Q&A, and that will be a nice setup before Sheryl and Michael Wittie from ONC start to share the draft working document for the report compilation, and we will have public comment before wrapping up with next steps. Next slide, please. One more.

To help us kickstart ourselves, we left off the last meeting with a really fruitful discussion around synthesizing the guiding principles and ideal state. I'll shout out to Anil and Alexis for their synthesizing team lead efforts to bring forward their work in describing the guiding principles and ideal state based upon our prior small-group and full-task-force discussions. They added to that some visioning statements, and also some segues into the Recommendations area through their presentation, and we had robust discussion that enabled us to address a few questions that they had, and they've been able to advance that work since our call last week, so we'll likely see a bit of that in the draft report Sheryl and Michael are going to start to socialize with us today.

That is a critical launch-off point in that at the last meeting, we also talked a little bit more about our report drafting approach and our timelines, and so, we have been continuing to adjust our timelines, as the synthesizing effort has been quite a lift in that the body of work that we had undertaken from March through July was really very substantive in addressing the prior authorization efforts, and in addition to all the synthesizing teams, we've also been compiling an overview of each one of the presentations that we've received over the last couple of months. If there are no questions – I'm going to pause and see if there are any questions – I think we can go ahead and go to the next agenda item, which is really for us to talk about the recommendations, so I'm going to invite Rich Landen to jump in here, and I'm going to support Rich in walking through the document. I'm going to capture notes for him, and also help with – if you raise your hands to make comments or ask questions, I'm going to help Rich with managing that queue while he facilitates the discussion around the recommendations. So, without further ado, Rich, over to you.

Presentation of Recommendations (00:04:02)

Rich Landen
Thanks, Alix. The exercise today is going to be similar to what we went through last week, and I hope we get the level of engagement, discussion, pointers, lessons learned, hints, and all that that we got last week. So, as background, the starting point for Arien and me drafting – actually, it's more Arien than me – drafting the recommendation started from the list of straw recommendations that had been captured on an ongoing basis on the prior task force discussions. And then, Arien took those straw recommendations, grouped them, organized them, massaged them, lined them up with the principles, and then started to put pen to paper, and have worked down the list of straw recommendations so that today, I think we've got 13 recommendations.

It's a work in progress. We've still got maybe 10% more of the straw recommendations that we have not yet incorporated, but Arien and I feel we're far enough along that you can get a good sense of what the recommendations will look and feel like and what the major content is going to be so that we can get the reaction from the full task force membership. My role after Arien took the first stab was just to take a second look back at the principles and make sure things lined up correctly. I went through the language to help improve the flow, the clarity, and the citations, and as we go through the document today, you'll see that there are still a couple of drafting notes in the margins that I left in because this is a work in progress, and there are things that Arien and I still need to look at; there are some things that we're recommending down the road that the editor take a look at as far as standardization and consistency throughout the document as to how we treat words like "task force" and "federal." Are they capitalized or lower-case? We should do it all the same way.

So, again, back to the task today, we're just going to walk down through this. We'll take it pretty much a paragraph at a time, and your reactions will be very valuable. Your questions, comments, and observations will help inform the next iteration of the draft. Let me pause there and see if there are any comments from our co-chairs or questions from the group.

Alix Goss
No hands are raised. I have no comments. Sheryl?

Sheryl Turney
I have not comments, thank you.

Rich Landen
Okay, let's get to it, then. On your screen is the introduction to their recommendation section, so please take time to read through the first paragraph, since I'm assuming that relatively few of the full task force have seen the document in this form.

Alix Goss
Because I'm showing the comment boxes, if folks would like me to make this larger, I can do so. Just let me know if it's a little hard to read or if you want me to turn off the comment boxes.

Rich Landen

So, in the first paragraph, we're setting the stage, the environment we talked about, the intersection and convergence of the administrative and clinical, and the point we're making is that for burden reduction, efficiency, and overall good sense, the standards processes in these recommendations should be natural byproducts of the workflow, and you'll see that in most of the document, we're talking about provider-side workflow because that's where the patient-clinician interaction is, but it applies equally to the health-plan-side workflow. Again, for ecosystem context, we're talking about a system that unifies both the clinical and administrative workflows. Any question about that first paragraph?

Alix Goss
No hands are raised.

Rich Landen
Okay. Next, we go into the historic – the separation between the clinical and administrative workflows, and because of things developing at different points in time, there is inflexibility relative to the administrative transactions. I think we're generically referring to those as HIPAA transactions, though that's been modified by subsequent legislation a couple times. And then, when we think of clinical workflows, we think of EHR and the work coming out of ONC. So, dealing with separate or parallel standards increases burden by making it more difficult for developers and informaticians to create integrated capabilities.

The different administrative and clinical standards use different content specifications, service models, and information models, so this began as a precursor to our link on the modeling work done by ICAD. In addition, we recognized that healthcare is moving toward an API world, and the administrative standards were typically designed for batch processing. Again, the core – the fundamentals – of the administrative standards – the X12 claims transaction, specifically – goes back to the late '80s and early '90s, so think mainframe, think at 12:01 a.m., you run the batch for the whole day. So, things designed in that environment do not necessarily play well in today's environment. Any questions on that paragraph?

Alix Goss
There was a chat box mention that there was a typo at the end of the first paragraph, so I fixed that. Anil now has his hand up.

Anil K. Jain
I think this is more of a broader point, and I struggled a little bit when we did the guiding principles and ideal state. How much of what you guys are writing here will be done even prior, in an introductory area, as to why we're tackling this subject versus having it be in the recommendations? I think this is all good material, it's just about the placement of it, which we can decide later on.

Rich Landen
Yeah. As I mentioned, we are aware that we will need to go back and revisit this after we see how the other sections come into existence and morph via the conversations with the task force, so that's a very good point.

Anil K. Jain
Okay, thanks.

Alix Goss
I think right now, Anil, you're really speaking to one of the main challenges we're all having. We haven't been able to get to the broader conversation of intersection, and so, we're trying to bundle up one part while we get ready to go to the next part, and I think Michael Wittie is going to have some interesting challenges ahead, and I'm glad he's listening to all of this discussion because it will help him in his editing exercise, and Sheryl, I notice your hand is up.

Sheryl Turney
Thank you, Alix. I just had a comment about the word "requires" in the first sentence of that paragraph. I think it is better said as "results in" versus "requires," and that's a factor of because it's a separation, that's what results, but I don't know if we would want to say it actually requires inflexible, redundant processes.

Rich Landen
I agree with that.

Alix Goss
Along those same lines of the sentence, I saw Alexis – I'm sorry, it's Denise Webb – thought maybe it should be "inflexible and redundant processes," so I incorporated that revision as well.

Rich Landen
Okay, good.

Alix Goss
No further hands are raised, right, Sheryl? I didn't know if you put your hand back up.

Sheryl Turney
You're correct. I'll move my hand down.

Alix Goss
No worries.

Rich Landen
The next paragraph talks about the different methods of adopting the standards. We don't go into detail here, but essentially, most of the administrative standards are promulgated by rulemaking through CMS and what is now the Office of Burden Reduction, whereas the clinical standards are promulgated through the Office of the National Coordinator. There are other programs within the federal government that can promulgate rules that adopt standards, and thereby create a little bit of a dicey dynamic when you look across the system. I'm thinking specifically of some of the prescribing and e-prescribing DME rules.

So, what we're proposing here after we give the background is a new process under the federal umbrella that brings all the different standards and promulgation rules and regulations together, and we talked about establishing a national floor, but rather than everyone – all the actors being restricted to the floor, there would be built-in flexibility for those who want to exceed that floor and do so without running afoul of regulations. So, we talk about the standards version advancement process, and then we compare and contrast the speed of development of the clinical regulations through ONC versus the speed of development

and promulgation on the – it used to be the Division of National Standards, now Office of Burden Reduction on the HIPAA side.

Alix Goss
Are there any questions for Rich on this paragraph? I see none.

Rich Landen
All right, next paragraph. We talk about how standards are tied to various federal and state programs, and we list a couple of examples of the value-based nature of these programs creating the business model for standards advancement, and again, back to meaningful use promoting interoperability, the certified health IT. So, that's the introductory overview. Are there concerns with any of the things we've said, or are there important aspects of an overview that we might have not incorporated that anyone thinks might be key?

Alix Goss
Alexis?

Alexis Snyder
There's really not a lot about patients here, and we have "patient at the center" as our top guiding principle, so it probably should be incorporated as it flows into the recommendations, I would think.

Rich Landen
Wow, I'm pleased. That's a good pick-up. So, if we can note that, we will work that in.

Alix Goss
Anil, and then Sheryl.

Anil K. Jain
Okay. How does what's being presented here relate back to the work that was previously done as a group?

Alix Goss
I know when Rich made opening remarks, he couched this as the body of work that we had already done in small working groups and task force discussions was all the launch-off points, and so, what you're being spared today is the very messy version of them going through all the purple text I had captured during prior discussions, either small-group or task-force, and they've been crossing them out, and I believe Rich noted that there was still about 10% of that work that needed to be synthesized to round out the recommendation section, so they've gone through that prior body of work. Rich, did I appropriately represent that?

Rich Landen
Yeah. The shorter answer is that the concepts here in the introduction were pulled from our discussions all along the series of meetings.

Anil K. Jain
Got it. So, if, when we read this later on, for example, we should recognize some of the key concepts like what Alexis brought up around being patient-centric and how those recommendations in that section are synthesized in this text?

Rich Landen
Yes. As we get into the specific recommendations, you'll see that at this point, I think there are two recommendations that specifically address the incorporation of the patient in the information flows.

Anil K. Jain
All right, cool. Thank you.

Alix Goss
Sheryl?

Sheryl Turney
Thank you, Alix. The one comment I wanted to make was if we wanted to make a statement relative to pilots because we have heard a lot about various pilots being worked on by different groups, but again, there's no standards mechanism to link those to, so I don't know if we want to make a statement about that similar to just identifying the inability to move a pilot forward to some sort of standards adoption.

Rich Landen
Okay, I'm thinking about that. In the recommendations themselves, we've got a couple of references to piloting, but it's not in the same sense as I hear you talking about now, so I guess my question is – I agree with you on what we've learned about pilots. Indeed, in a lot of the presentations the task force has received, we've been given information about various industry pilots, and I think my primary reaction is that we should make a note as a placeholder, but my question would really be is this where such a reference to pilots belongs – "this" being the overarching summary for the recommendations – or would that be more appropriate someplace else in the document? And, I don't know the answer to that. So, should we imply it and then look later? Do you have a feeling on that, Sheryl?

Sheryl Turney
I don't have a feeling on it yet because I think I need to see all the materials together to figure out where it would go, but I do think that – I hope we will have some recommendations relative to pilots and the enhanced ability to have some sort of adoption as a result of pilots more readily available to the industry as a whole.

Rich Landen
Okay, yes. We've got at least some of that built into the existing recommendations. I'm not sure all of it is. I thought you were going a little bit broader in talking about everything we've learned from why pilots that have been reported to us haven't gone on and actually evolved into effective industry usage. So, yeah, let's pay attention to that when we get down to the recommendations that talk about the pilots and see if there's substantially enough in there to meet your concern.

Sheryl Turney
All right, thank you.

Alix Goss
Alexis?

Alexis Snyder
I'm just a little bit confused about the flow and where this is going to work in the draft because I feel like when the draft went out a week or so ago and I started looking at it, all this introductory information, basically talking about the problem states and where the burdens are, et cetera, start off at the draft, and then, that section flows into guiding principle development, which flows into ideal state, and then I thought we were doing a lead-in paragraph for guiding principles. So, while all this is wonderful, it just seems like a lot leading up to an actual list of recommendations, and so, I feel like a lot of it is going to be redundant to how the draft starts off, and maybe then confusing for the reader. "Okay, you're telling me about the problems again." That's just something to think about – how it's going to flow. And then, I'll look forward to seeing the recommendations hopefully laid out in the same order as the guiding principles are so it flows.

Rich Landen
I think that's a great point. From where we are at a week or two ago when we started drafting that, I think we used the statement as kind of a standalone thing to provide some contextual relationships into which the recommendations would fit, but you've got a very valid point. If we've already stated these things elsewhere in the document, then at least some of this language would be redundant, so I'm happy to pass the buck on that back to the co-chairs, and specifically, our honorable editor – and, of course, the group as a whole – as we start taking a look at the components, not as standalone, but relative to the drafting that's been completed on each of the sections.

Alix Goss
I'm really excited to see all this come together because I've got very similar observations, Alexis.

Alexis Snyder
We think alike.

Alix Goss
All right. So, I thought Denise was going to make a comment. She's typing something up. Do we want to go ahead and dive into the actual recommendations, Rich? I'm not seeing any other hands raised.

Rich Landen
Okay. So, Recommendation No. 1: "Prioritize administrative efficiency in relevant federal programs. Task force recommends that ONC work with CMS and other federal agencies," and then there's a listing in parentheses of some of the agencies we know about, and let me mention that this is kind of a boilerplate phrase when we talk about working with ONC, CMS, and other federal agencies. You'll see these agencies repeated several times within these recommendations. So, we're talking here about programs, not the – other than ONC and CMS, the federal agencies are kind of in the rule as quasi-health plans or health plans more than as regulators. So, again, "…work with CMS, ONC, and other federal agencies to work administrative efficiency objectives into relevant federal payment programs: EDUS, MANAP star ratings, MSSP" – and, that's M-S-S-P, promoting operability – and, by the way, one of our notes to the editors is to spell out all those acronyms upon first use.

And also, then, beside the federal, "…private payers contracting through Tricare and FEHP, and that ONC and CMS jointly establish relevant certification criteria associated with the health information technology

used to further the administrative efficiency." So, this is getting back to who the health plan's sponsors are and building into at least the federal program requirements that the participating payers need to conform to these recommendations as part of their participation contract for those federal programs.

Alix Goss
I made one addition, Rich, that came across the chat box. I'm seeing no hands up, and I'm hopefully not going to make everybody dizzy because we had a little edit in the third paragraph above that I just wanted to capture before we missed it. Okay, there we go. Thank you.

Rich Landen
So, in Paragraph 1, the change was "including the federal agencies listed, but not limited to"?

Alix Goss
Yeah, so we don't limit ourselves.

Rich Landen
Reactions?

Gaspere C. Geraci
This is Gus. I am not a lawyer, but there's enough lawyer in me to say that we don't want to presume we've included all the pertinent agencies, so I like the phrase "including, but not limited to."

Rich Landen
Where would we be without the lawyers and those of us who play one on TV? Thank you.

Alix Goss
Just call me Crystal. All right, next recommendation? I see no further hands up.

Rich Landen
Okay. Recommendation 2: "Establish a government-wide common standards advancement process. The task force recommends that ONC, working in concert with CMS" – this is boilerplate again, "not limited to" – "establish a single consistent process for standards advancement for relevant standards for healthcare interoperability, including transactions, code sets, terminologies, and vocabularies, privacy and security use for conducting the business of healthcare irrespective of whether that business is clinical or administrative." So, it's one federal system for promulgating rules without the artificial separation of administrative rules versus clinical rules. And then, we give an opinion that the existing authority granted to the secretary under Section 1320 of the U.S. Code should be sufficient for the secretary. We're saying here we don't think legislative action would be required to allow the secretary to consolidate the rulemaking into a single process, rather than separating it across multiple divisions within HHS.

Alix Goss
Anil's hand has gone up.

Anil K. Jain

Yeah, just to make sure I'm not over-reading this a bit, where would you put clinical trials? Would you put them under the business of healthcare, and would that be included – for example, the FDA, NIH, CDC? Would you include all of them? I'm asking. I don't have an answer.

Rich Landen
I'm thinking not because again, we prefaced this by saying "promulgation of relevant standards for interoperability," and I'm thinking that the examples you named are outside of the standards for interoperability. And, you certainly don't have to agree with me.

Anil K. Jain
Okay. I have to think about that a bit. I'm not sure they would be outside interoperability, but we can –

Alix Goss
So, Rich, do you want me to make a note, or you going to noodle on it and let us know? This is not your last bite at the apple so far. You're going to have apples and cheddar cheese, apple pie, apple crumb – you have lots of bites of the apple to come over the next couple weeks. I see no further hands up. Shall we go to Recommendation 3?

Rich Landen
These are really the comments that we really well appreciate. We know we're fabulous, wonderful, very intelligent people, but we also recognize we don't know it all, so the way we word something – we're seeing it one way, but other people with different knowledge and viewpoints can see some of these domino effects, so please bring these issues up.

All right, Recommendation 3: "Converge healthcare standards. The taskforce recommends that ONC" – and, the boilerplate at this time, adding the National Library of Medicine, NLM – "and voluntary consensus standards organizations harmonize standards to create a consistent set of standards for code sets, content, and services that are evolved together to address multiple workflows, both clinical and administrative. The harmonized standards should use an underlying data model" – again, referencing back to the modeling work – "that is sufficiently comprehensive to serve both clinical and administrative needs.

"The task force recognizes that different standards development organizations may have particular expertise, and the task force recommends that ONC, working with those SDOs, establish domains and expertise around common standards. For example, if it is determined that an HL7 FHIR is a logical choice for initial underlying content model, ONC would logically work with ANSI X12 and the National Council for Prescription Drug Programs to establish authority for the FHIR domain for the relevant administrative standards, even though the underlying content model is defined by HL7, and not by X12 or NCPDP."

Alix Goss
Rich, I took the liberty of updating "ANSI" to be the accredited standards committee for X12, since it's ANSI-accredited, but it's… It's not "ANSI X12," it's "ASC X12."

Rich Landen
I've given that speech many times. How I missed it this time, I have to attribute to old age. Thank you.

Alix Goss
Your welcome. Andy Truscott has his hand up.

Andrew Truscott
It does happen from time to time. I just put it in the chat box. Wouldn't we want to work with HL7 themselves?

Alix Goss
Who's "we"? ONC, HITAC, ICAD?

Andrew Truscott
ONC. Would we not expect ONC to work with HL7, not just with X12 and NCPDP?

Rich Landen
Yeah, but the scenario – and, if the language is not clear –

Andrew Truscott
It's not.

Rich Landen
– we can work on this. The example says that ONC has decided to adopt HL7's work as the underlying model, so it's a given in that that ONC has worked directly with HL7, and so, where the example is then going is that after ONC has done this work with HL7 and adopted the HL7 model, it would then work with the other SDOs to ensure that they're on board with using the HL7 model. My screen just blacked out.

Andrew Truscott
So, I'm drawing a parallel with what we've done in USCDI. If we were to say – I don't like leaving things to chance and hope. If that's what we want to have happen, then we should say this is what should happen. Otherwise, it feels a bit wishy-washy. I'd love to see the transcription work that one out. "Oh, wishy-washy, I've got that." Do you see what I'm saying?

Rich Landen
I'm not quite sure.

Andrew Truscott
Okay, so, no. If we determine that HL7 FHIR is a logical choice for the underlying content model, okay. I think we would wish ONC to work with ASC X12, NCPDP, and HL7 to establish that the HL7 FHIR and how it is deployed is correct.

Rich Landen
Okay, yup. I think that's…

Andrew Truscott
Does that make sense?

Rich Landen

The language as Alix has transcribed it is clarifying.

Andrew Truscott
Alix is doing a much better job than the transcription service. I love the fact that "FHIR" is so much of what we say, and still, no one's updated the lexicon.

Alix Goss
Okay. I see Alexis's hand up.

Alexis Snyder
I think the way you just wrote it takes care of what I was going to say. I was just going to say let's stay away from wishing or "should," because that's more like the ideal state, and just say what the recommendation is. The specific language is better.

Alix Goss
Alexis, thank you for bringing that up because I've got some very specific coaching from ONC about how concrete and consistent we need to be in the framing of our questions, so I believe there was already an approach by Arien and Rich to that effect.

Alexis Snyder
Right.

Andrew Truscott
Okay. Just as a point of order, whenever we say "FHIR," we should say "HL7 FHIR." It's a minor thing.

Alix Goss
Thank you. Duly noted.

Andrew Truscott
Cool. I'll go back in my box. Thank you.

Alix Goss
Please, stay out. Are we good with Recommendation 3, Rich?

Rich Landen
No, we haven't gone through the last two paragraphs yet. So, "The intent is for a patient-centric model that would underlie both the clinical workflow and administrative processes. Wherever data are first originated in the interoperable system, they should flow to wherever they are needed without having to be manually recaptured or reentered. The harmonized clinical and administrative standard should take into account the data privacy and security policies of the system." In other words, the privacy and security have to be in there from the ground up. "It is important to clarify the task force recommendations for harmonized standards does not" – emphasis on "not" – "imply that the complete clinical or administrative record should be sent with all administrative transactions, or that legitimate users of the data should have unfettered access to the complete dataset; the principle of 'minimum necessary' must still apply."

Alix Goss
In the queue is Alexis.

Alexis Snyder
Hi. We had a bit of a discussion last week about the "collect once and reuse," and in the ideal state, we have a statement about an exception to that, and there should be certain red-flag areas, and we put in an example of height and weight, et cetera. So, somewhere in here, we probably need to incorporate that it shouldn't just be a manual recapture and reentry wherever possible so that it matches up because even from the very beginning, when we talked about guiding principles, ideal states, and recommendations, it's always been something we've talked about.

Rich Landen
Yeah, I think I recollect that conversation. We talked about data that is not static, and the example of weight is a good one. At what point in time was the weight measured, and how does one make sure one uses the most current or the weight that was current for the communication at hand?

Alexis Snyder
Yeah, it was less about most recent – I'm sure you used most recent – it was literally about making sure that, for safety reasons, certain pieces don't get reused, and actually get updated.

Rich Landen
Okay, I…

Alexis Snyder
If they didn't do a height and weight at your most recent visit – let's say you're talking about pediatrics and you're talking about prior authorization for a medication that's obviously going to have a dose that's specific to body mass.

Rich Landen
What I'm thinking is we should put a flag in here that refers us back later, and we can use the language that's developed in the other section rather than repeating it here.

Alexis Snyder
Right.

Rich Landen
Or, we can –

Alexis Snyder
I think it's going to be a lot of work to go back and forth and make sure that all of the recommendations that we all pull together as a group are not only reflected, but then, make sure that we have – we may not have even gotten into recommendations as a group that need to be added based on what we said about guiding principles and ideal states. We're saying, "Here's the principle, here's what it ideally should be, and we need to make sure we have a recommendation on how to get there that matches."

Alix Goss
I'm capturing that as a separate thought, Alexis, in addition to the other nuances, which I'm glad you talked about because I didn't go to the safety aspect, and I'm glad you came back and clarified, so I captured that, and I see no further comments or hands raised, Rich.

Rich Landen
I'm sorry, you said no further hands?

Alix Goss
Correct.

Rich Landen
I heard that there was one. Okay, Recommendation 4: "Provide a clear roadmap and timeline for harmonized standards. The task force recommends that ONC, working in concert with the aforementioned organizations, establish a clear roadmap and timeline for harmonized standards following the common standards advancement process, including adequate pilot and production usage, to raising the national floor."

Alix Goss
Anil's hand is raised.

Anil K. Jain
Yeah, this is more of a recommendation. I think Recommendation No. 3 is the main recommendation. It sounds like Recommendation No. 4 should be a bullet of it, right? If we're talking about Recommendation 3 asking for the convergence of these different standards and for them to be harmonized, wouldn't Recommendation 4 require Recommendation 3, or am I…?

Rich Landen
Not exactly. What Recommendation 4 addresses is what I, at least – and, I think I can say "we" – recognize is a defect in the current HIPAA rule promulgation process that we laid out in the introductory paragraph in that the rule promulgation as it currently exists is not timely, reliable, or predictable, so what we're stressing here in Recommendation 4 is that the rule promulgation process needs to be clear, predictable, and reliable, and ONC or the federal process needs to be accountable for getting the rules out the door in a timely manner. So, if that's not coming across clearly, maybe we need to look for some language there. Does that address your question?

Anil K. Jain
I'm not sure because in Recommendation No. 4, it refers to harmonized standards, and at least the way I read it, the harmonized standards were described in Recommendation No. 3. So, we don't need to figure it out right now, but I guess what I'm asking is whether this recommendation is truly a separate recommendation or it's trying to provide additional color around Recommendation No. 3. It may also have an additional component to it, but I would think that if we're referring to harmonized standards, it would be a sub-bullet, but again, it's my first time seeing it, so as Alix mentioned, there will be opportunities for further reflection and comment. It just seems a little bit odd to me, but if I'm the only one, then we should move on.

Rich Landen
Okay, we'll flag that. We may run up against the same issue in the next recommendation as well. Should it be standalone or a subset of No. 3?

Alix Goss
Rich, I can really feel that because of some of the work that the NCVHS members have been deeply involved in regarding creating predictability, we may have nuanced distinctions that others may not, and that's going to be really important for us to understand for our end state audience, so I think this review process is going to produce a number of these nuances, so I've earmarked it as such, and I propose that we move on to Recommendation 5 since there are no further hands raised.

Rich Landen
Okay. Yes, it's definitely an issue that is near and dear to those of us who have been participating in NCVHS. All right, Recommendation 5: "Harmonize code and value sets. The task force recommends that ONC work with CMS, National Library of Medicine, and relevant value set authorities to harmonize code and value sets to serve clinical and administrative needs. Where specialized code and value sets are needed, they must be mapped in with general underlying code and value sets." So, special sets can't be standalone; they have to be mapped to the larger sets. "As an example, in order to streamline prior auth workflows, the code and value sets used for code orderables, procedures, or referrals must be reusable across cleanly mappable **[inaudible] [00:48:30]** or crosswalked to the code and value sets used to determine administrative authorization for payment for the relevant orderable, procedure or referral."

The task force finds applicable to this harmonization the work of the NCVHS, specifically the February 13th letter that talks about the maintenance and custodianship of terminologies and vocabularies, and makes some recommendations about adoption processes or updates to those code, value, and terminology sets. And, the actual NCVHS letter, including its appendices, would be included here as a yet-to-be-numbered appendix in this final report.

Alix Goss
I'm not seeing any hands raised.

Rich Landen
Recommendation 6: "Make standards, including code sets, content, and services open to implement without licensing cost. End user licensing of adopted standards, code sets, and vocabularies is burdensome. In order to drive innovation and make standards-based capabilities available to the widest set of actors, the task force recommends that converged standards and the included components named in certification programs should be available to implementers without licensing costs for developers implementing the named standards. Ideally, such converged standards would be available via one of the business models that support full and open access to standards – for example, NLM national licensing of the code sets or standards, development business models such as those deployed for HL7 FHIR, or internet standards that support member prioritization for the advancement of standards – while making resulting standards and implementation guidance available through broad-usage licensing." That was a sentence.

"Alternatively, fair, reasonable, and nondiscriminatory licensing may be a requirement for production use or marketing claims performance." In other words, like we see for ICD and SNOMED, licensing individual

standards or implementation guides can be a real burden, and if there's a way to get those licenses such that individual implementers don't have to do the licensing, that's where we would like to go.

Andrew Truscott
That makes sense.

Alix Goss
There are no hands raised.

Rich Landen
Okay, Recommendation 7: "Develop patient-centered workflows and standards. The task force discussed the critical importance of patient access and involvement in key administrative workflows. Workflows define access to and reimbursement for care, and delays in these workflows are a key source of individual frustration with the healthcare system. Accordingly, 'patient at the center' must be a consistent design philosophy and built in from the ground up. The patient caregivers must be at the center of administrative workflows, and standards must be developed to involve the patient as a key actor.

"The task force believes that such 'administrative' information is part of the designation record set (as it is patient-specific information used for decision-making); if there is uncertainty on the inclusion of administrative workflows in the designated record set, the task force recommends ONC work with OCR to clarify the status of administrative workflows under the access provision of HIPAA." So, that was a long introduction sentence, but the recommendation is to make sure that there's no designated record set barriers to the patient information inclusion.

Alix Goss
If you're ready for questions – sorry.

Rich Landen
The second part: "The task force recommends that ONC work with other federal actors and SDOs to prioritize developing administrative standards designed for patient access and involvement. Even 'workhorse' administrative standards, like eligibility claims, EOB, and remittances, that are traditionally considered provider-to-payer – business-to-business – should allow access to the same API frameworks already supporting API access; converged clinical and administrative workflows, including prior auth, should be designed to support API access and patient engagement as a matter of course. As an example, benefits information provided to the provider via" – I think that's "eligibility transactions," the spelling on "eligibility" – "eligibility transactions should also be available to the patient via API; the content and status of claims/remittance should be available to the patient not only at the end of the process through the current EOB API, but throughout the process of claims and adjudication."

Alix Goss
You have two in the queue, starting with Alexis, followed by Anil.

Alexis Snyder
Hi, thanks. It's a lot for me to take in at once, so, later on with the draft, I'll probably have more to say about this paragraph when I can really think about each sentence. But, off the top of my head, the first and second

paragraph both should change the word "involvement" to "engagement." When we're talking about patient-centered, "involving" is not really patient-centered. "Engaging" is. Then, in the second paragraph, I think, it mentions benefits information toward the end – "As an example, benefits information provided to the provider should be available to patients." I'm not sure that it's benefits information we're talking about. Patients have all their benefits information from their health plan. It's…

Rich Landen
Sorry?

Alexis Snyder
Is there someone who can't hear? Can everybody else hear you?

Alix Goss
I can hear you, and there's somebody else who's come off mute talking in the background. Keep going, Alexis. I just wanted to make sure.

Alexis Snyder
Uh-oh. Whoever that is needs to mute. Anyway, I was saying that the benefit information is what we're trying to capture, and I think we also need to use the transparency language a little bit more, but like I was starting to say, benefit information is readily available from your health plan. It's more not being able to see – there's no transparency about what's happening to the process, and also, we've had a lot of discussion about how when we're talking about engaging the patient in the process, there's not really a way for the patient to actually be engaged in the process and provide information, and my quick example, again, as I just went through it this week – a provider tried to do something on their end, didn't get all the information in, and the NPs were doing it and did it incorrectly. I can't see it, the insurance company is rejecting it, I can't see why they're rejecting it, and I'm caught in between both of them, and I have no avenue to fix it.

Rich Landen
I'm struggling to follow because someone – I'm sorry, my screen is popping in and out, going black.

Alexis Snyder
I guess my overarching comment, too, would be that I'm just a little confused as we go through all the recommendations – again, we wrote all the recommendations as a group already, and things that were written in the workbook and the straw man recommendation sheets that went out – I'm not seeing a lot of…obviously, a lot of it, but I'm seeing a lot of pieces in it that aren't here, and so, I'm confused. So, all the pieces that I'm bringing up and that others have brought up are things that we've already discussed that were in the straw man recommendation, so I feel like we've started to rewrite what we already wrote, and left out pieces.

Alix Goss
We'll capture that, and I think that's the point of going through an exercise like this, and we know that they weren't done when they came today, so…okay. Anything else, Alexis?

Rich Landen

I'm still struggling to understand Alexis's point because on the one hand, I think she's arguing that we should take out benefit information available via API, and on the other hand, I think she's saying leave it in, so I'm really not…

Alexis Snyder
Well, I can try to re-explain it. I don't want to take up too much time, but first of all, I'm not arguing. I'm voicing an opinion. "Keep calm and collaborate." In any event, I'm saying that I'm not sure it's clear to use the word "benefit information" up front when we're talking about what should be readily available to patients because clear-cut benefit information – you have a copayment that's X, you have coinsurance that's 80/20, 70/30, whatever it be – all of that information is readily transparent to patient caregivers – to everybody – from their health plan. So, that's not the piece that we've discussed that isn't transparent. What isn't transparent and isn't available are twofold – what I was saying. First, the ability to see what's happening – the claim from the beginning through the entire process – and second, not having a way to be engaged in that, and in both paragraphs, you're talking about engaging the patient in the workflow, but here, I'm saying it's talking more about making sure the patient has their benefit information. We have that. I don't know if that makes it clearer. But again, I'm not saying anything new that wasn't already in the recommendations.

Rich Landen
Yeah, it makes it clearer. I think my sense of the wording in this example is not so much that the patient doesn't have access to the plan benefits, which, of course, they do, but it's an engaged patient monitoring via APIs the back and forth between providers or the status of a particular detail. So, what is the provider billing, what is the health plan saying is covered or not covered, just including that patient in the information flow? So, it's a level of detail that is transaction-specific, not something that I see as being available and applicable by the patient coming out of the benefit handbook.

Alexis Snyder
Well, I disagree. The benefit information is available – what's covered, what's not covered. Maybe we can put something that says it needs to be more transparent. It's there – maybe not every health plan makes it available in a way that's easy to find. I believe most do, though. It's more the other information. You can see a rejection when it's done, you can see an approval maybe 10 days later when it comes in snail mail, sometimes you can see a little bit more information about an EOB when something doesn't get covered or what your portion is that you have to pay that didn't get covered, but you can't see why the piece that should have been covered didn't get covered. It's those people.

Rich Landen
Okay, yup. I've got it now. So, we can go back and take a look at that again and see if we can make it a little bit more tightly focused on the transparency.

Alix Goss
I've made some of those comments, and while you were talking, Anil raised his hand.

Anil K. Jain
Just a really quick comment, and it may not warrant a lot of discussion, but I assume that, as Rich said, these recommendations have not yet been sequenced. Is that right?

Rich Landen
They have been roughly sequenced, but not installed. They've been grouped logically according to what we have, but not relative to a final product, and certainly not relative to the flow of the rest of the document outside of the recommendation section.

Anil K. Jain
Okay. In that case, I would recommend that we would move the recommendations around the patient and being patient-centric closer to the top just so we all remember why we're doing this, and then, the subsequent recommendations are how to support that.

Rich Landen
So noted, and not disagreed. Arien and I did play with some sequencing, and that was one of the things in an earlier sequence that we opted not to do based on our own assessment of prioritization, but I agree with you that "patient at the center" is such a cornerstone of this task force that we need to take a look at that again in one of the next iterations.

Anil K. Jain
Great, thanks.

Alix Goss
Okay, I'm making a note. Alexis?

Alexis Snyder
Yeah, real quickly, based on what Anil was saying and what I was hearing from Rich, I think in general, it needs to be sequenced with the way we already are sequencing, and if that gets changed, then recommendation sequencing should get changed to match the guiding principles, or it just doesn't flow as a document. When we say these are Guiding Principles 1 through 8, the recommendations should be laid out the same way. "This is Guiding Principle 1; here's the recommendation. This is Guiding Principle 2; here's the recommendation." So, it just doesn't make sense for a flow piece whether we're talking about "patient at the center" or any other principle, but "patient at the center" happens to be No. 1 in the way that the guiding principles have been sequenced.

Alix Goss
I think this is something we can definitely make a note of and talk to our editor about because I think you're right – we have to think about that end-state reader and that they're getting a whole story they can actually track with. I also think that we probably can't get too far down that pike until we actually have some of the broader conversation because I believe philosophically, we have had some discussions around not having separate portions talk about the intersection of clinical and administrative, then go to prior authorization or vice versa, but more as an hourglass, using the prior authorization as an exemplar, and so, we will certainly have an opportunity to weigh in on that as we move forward. We are in Recommendation 8. I would love to give Rich the chance to get through the last couple before we pivot. We do have to go to public comment at 4:20, but I would love to give Sheryl and Michael a chance to showcase some of the report's Google doc work that we've been doing. So, there are no further hands raised. Rich, if we could go to the recommendation, that would be great.

Rich Landen
Okay. The screen just bumped, Alix.

Alix Goss
I don't know what happened. Oh, it's back now.

Rich Landen
Okay, Recommendation 8 is simple. We're recommending the international standard, foreign ID card, or a virtual equivalent of what's called for in the standard. Questions or comments on that?

Alix Goss
I'm seeing no hands raised.

Rich Landen
Recommendation 9: We are calling for promulgation of an attachment standard, and we are specifically ANSI ASC X12, the 275 transaction Version 5010 standard because that is – and specifically, we're recommending that for the short term, not the long term, but that's the HIPAA standard that was designed to work with the prior auth and has not yet been promulgated by CMS.

Alix Goss
It's also the expectation that that's the transport method, not necessarily the payload aspect. There can be different aspects there. I suspect that we may have folks who want to weigh in on that recommendation, and before that train leaves the station, I'm going to suggest you move to Recommendation 10.

Rich Landen
Okay. "Encourage regular review of prior authorization rules." In short, we're again calling on the federal programs so that their contracted plan administrators or your payers update their rules regularly – at least once a year – and "The task force recommends ONC work with CMS to encourage transparency in the prior authorization process via published metrics on authorization and denial rates, rates of appeal, and metrics on appeal." So, annual updates – clear, simple, and if there's a requirement that the data shows it's never denied or seldom denied, then the bias would be to eliminate that requirement from prior auth.

Alix Goss
I'm seeing no hands raised.

Rich Landen
Okay, Recommendation 11.

Alix Goss
Wait, pause. I apologize. Just as I said that, Anil put his hand up.

Anil K. Jain
I'm sorry, it's a delayed reaction on my part. Why "encourage" and not "establish"?

Rich Landen

I'm sorry? I didn't hear that.

Anil K. Jain
Why does this say "encourage regular review" instead of saying "establish regular review"? Why can we only encourage and not require it in the recommendation as well as in the title?

Rich Landen
Yeah, good pickup.

Alix Goss
Thank you. Duly noted. No other hands are up.

Rich Landen
All right. Recommendation 11: "Establish standards for prior auth workflows. Work with federal actors and SDOs to develop API specifications to create an authorization, electronic prior auth, or related determination such as a certificate of medical necessity such that authorization-related documentation can be triggered in the workflow and the relevant workflow system, e.g. EHR, where the triggering event for the authorization is created." There's an example of when an authorization is required for payment for a procedure or referral for evaluation of treatment.

"The prior auth workflow should be enabled in the relevant ordering and referral clinical workflow. The task force recommends ONC work with CMS and other federal actors overseeing benefit plans to provide or incent – mechanism to provide or incent electronic prior authorizations. The task force recommends these standards include sufficient guidance on operating rules, including service-level objectives on latency and availability sufficient for prior auth to be incorporated in interactive workflows. The task force recommends that standards and patient guidance specify requirements on denials such that the denials are accompanied by clear, complete, and computable reason for denial such that actors can correct, if relevant, applicable causes for denial. Standards and implementation guidance should require any denial to address all deficiencies in the request, i.e. must evaluate the entire request and not simply issue a denial citing only the first in a potentially longer sequence of identifiable deficiencies."

Alix Goss
So, is this really one main recommendation with several sub-recommendations, or do you feel like these could stand on their own? Because one of the things we wanted to do is be highly discrete in our recommendations, or highly specific.

Rich Landen
These are all components of a prior auth workflow, so that's the unifying factor here. Good point. We may want to relook at this and maybe do an introductory sentence, and then have each of the recommendations as a bullet.

Alix Goss
Okay. I'm not seeing any other hands up.

Rich Landen

All right, 12 simply calls for –

Alix Goss
I apologize. Right as I said it, Alexis raised her hand.

Alexis Snyder
Right. I just had to have the time to get off the enlarged screen and raise the hand. I was just going to say maybe we should further add – we had the discussion before about – oh my gosh, I just lost my train of thought when I talked about un-enlarging the screen. I'll type it in the chat box. I have to think again.

Alix Goss
Okay, thank you. Your last two?

Rich Landen
Recommendation 12: "Create renewal mechanism for authorizations." It recommends ONC work with the usual cast of characters to "develop programmatic API specifications to renew an authorization where prior auth applies to services of long duration." So, it recommends that this be done so that authorizations can be renewed through these means without requiring a new authorization, and that such renewals of the existing authorization be enabled via standards-based APIs.

Alix Goss
Why don't you go read out No. 13 because we need to pivot in just a few moments to our public comment?

Rich Landen
Okay. "Include patient in prior auth." It recommends that ONC work with the usual cast of characters so that "prior auth systems are designed to interact with the patient or designees such that the patient receives notification and status, sees activities, and has the ability to view content associated with the prior auth (for informed decision-making and correction) and provide patient-generated information into the prior authorization process (for example, the ability to point out errors and to respond to such questions, if any, which only the patient himself/herself can answer)."

Alix Goss
Okay, I'm not seeing any hands raised. Alexis did type in her comment about discussing recommendations for a chance to address missing info and correct the PA before the denial that needs to be appealed, and I think that was back on No. 11, and I will just make a note.

Alexis Snyder
Yeah, it goes down towards the end, where it says to make sure you're being told what's missing and why it was denied, but we had a conversation about having a chance for the provider to fix what's missing before getting a denial.

Rich Landen
Good pickup, thank you.

Alix Goss

I have captured that, and I believe I'm going to stop sharing at this point so that we can go to public comment. Once we go into that, then we'll – I believe I'm turning it over to Sheryl and Michael after Lauren walks us through the public comment.

Sheryl Turney
Thank you.

Public Comment (01:14:51)

Lauren Richie
Thanks, Alix. Operator, can we open the line, please?

Operator
Sure. 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 question queue. You may press *2 if you would like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing *. Once again, that's *1 for a comment at this time. One moment while we poll for comments.

Sheryl Turney
Any comments?

Operator
No comments at this moment.

Sheryl Turney
Thank you. All right, well, we can leave this slide up. Alix, I think we can talk a little bit about the next steps for the recommendations, and then I'll pull up the draft paper because the next step for the recommendations is for the comments that were made today to be incorporated into the final draft, and then, those revised recommendations will be inserted into the draft paper, which we'll look at in the future. Hopefully, we'll start doing that as we move forward with our next meeting, and there is actually a lot of synthesizing of the material that's been taking place as a result of the small-group effort – all of the writers that have volunteered to put their time and efforts into all of this work – which we really appreciate. I'm just going to pause here to see if we have had anyone indicate that they'd like to make a comment from the public.

Operator
No public comment at this time.

Walk-Through of Draft Document (01:17:09)

Sheryl Turney
Okay, great. Michael, do you want to share the Google doc? Because I can't. I have to get on my personal computer to see it. So, just to restate for this team, there has been a lot of work going on in the background to pull this paper together, and also, we will be working on a presentation deck, which Alix has reviewed the idea of with this team already as well, but I just want to make sure you're aware that what happens

when we're synthesizing the information is that it might change slightly from how it was originally presented because as Alexis and others have commented, once you look at the flow of the information, you may have to edit it in order for the document, which has been written by many people now brought together, actually works together as a document. So, Michael, did you want to review the Google doc?

Michael Wittie
Sure. Can everybody see my screen?

Sheryl Turney
Yes, we can see it now.

Michael Wittie
Okay, great. In that way and to that effect, the editor, who is me right now, will shamelessly steal, adapt, and move content around as things develop, so you'll see a lot of stuff here, like in this first paragraph, that's very much background. It is going to appear elsewhere in other people's write-ups as well, and as more write-ups come in, we will hopefully pare that all down and put it all in a reasonable – we'll say it once and not repeat things we don't need to repeat. So, what I did was take a lot of the stuff that Sheryl produced and came up with a while ago **[inaudible] [01:19:11]** this is context. I'm not married to the order in here, obviously. And then, there's sort of a section to define things. A lot of this text is stuff I wrote that's going to be replaced by what we saw a minute ago from you all, which I think is much better, and you'll see my little notes in the document. I don't know if you want me to read this, or if you just want to see the structure.

Sheryl Turney
Let's just focus on the structure since we only have a few minutes, Michael.

Michael Wittie
Sure. So, I was sifting through a little bit of the background and then moving into what was really going to be describing our approach and the history of how we came to comprise this task force, and then introduced the concept of – so, the task force had this vision and this charge, and the first thing was "Okay, let's look at this exemplar that is prior authorization." It's sort of a poster child to demonstrate the necessity of alignment. And then, we'll move into an examination of prior auth, where we'll describe all that material, and again, a lot of it is copied and pasted from other places. It still needs to be edited because we haven't done that yet. And then, we'll move into describing how we came up with the data classes concept and the roles of stakeholders content, which folks wrote and is really great, and then, we'll analyze the standards and what's available, and then move in again – there's the adoption analysis that we saw that this data focus group did.

And then, we move into findings on standards – so, again, this is probably not the order we want things in right now, but there were recommendations based on the standards. And then, we move into the content from the guiding principles group, which really describes each of the guiding principles, and woven into the current structures from the guiding principles group as we start with the description of the guiding principle and then take – and then, this rubric repeats. In order to support this principle, the ideal state must include characteristics. It goes through each of those, so each of our guiding principles has that, and again, there are questions here from Anil and Alexis, who are the authors, that I've moved over into the Google doc framework.

We move through these, and then, I think, we'll put in recommendations to achieve the prior authorization ideal state, and then there will be some bridging material, and we'll move to discussing the broadening concepts that are not yet really fleshed out, whether that's expanded guiding principles, expanded ideal state, final recommendations, or inclusions, and then, we expect, of course, that all the other material that we have – the compendium, the summary of presentations, and then, maybe a crosswalk of the recommendations that we heard in the presentations – the ones we end up making – as appendices there.

Again, this is not in an ideal order yet. I think we're going to see all the pieces as they come together, and the plan will be to thread a story that goes from the statement of a problem, which is that there is this disconnect which causes burden, this task force came together to examine that, it picked a prime example, which is prior authorization, and considered the guiding principles, ideal state, and possible solution to improve that condition – the conditions of prior authorization – and that consideration led to a broadening of thinking of the greater integration of administrative and clinical data, and that broadening broadened the recommendations, and those are what will come in the end of this, and there will be a conclusion and a wrap-up.

Sheryl Turney
Thank you so much for that overview, Michael. I know we had to go through it fairly quickly, but we wanted to expose this overall group to it because after today's meeting, we are going to be including the recommendations into this final paper, and we are going to be releasing to you the Google doc so that you can all go in and review the materials at your leisure outside of this meeting, and then make any comments. What we're going to ask you, though, and we'll send this out with the instructions, is that you make your comments in the comment box, and then we will bring it back to this group, review all those comments, and then process the changes together as a group so that everybody is understanding of who made what change. Otherwise, it can get a little bit unwieldy.

So, some of the comments that have already come up today in terms of the way the recommendations were originally laid out, which were really grouped together with each of the ideal states and guiding principles – some of the recommendations may cross some of those, which may be one reason why they may not align as easily, but we can discuss all that relative to how it's organized once people are able to see the overall paper, and then we can certainly prioritize the recommendations and the placement of a copy based on what makes the most sense. The other thing we will be creating is a presentation deck from this document, and that's probably a couple weeks off, but certainly, by the beginning of September, we're going to be looking at that as well.

We do have another meeting next week, which is at the same time – 3:00 Eastern time – and we will be picking up from where we left off right now, talking about the broader intersection, and also continuing to have the report writers and the commenters offline, so I really want to thank everyone for all of their hard work in between these meetings. It's really been a Herculean effort, and especially some of the Excella and ONC staff, who have been participating in putting the compendium together. They've done summaries of all of the presenters who came to our group. We've had individuals who have helped support defining gaps. The way we're going to use those gaps is to actually look at all the recommendations, all the ideal states, and all the guiding principles to make sure that, as Alexis pointed out, there's nothing missing.

So, you won't see a gap listed by itself in the document. We're actually going to sue that to make sure that everything we've identified in that gap document is included. Also, we've looked at all the recommendations that were made by the third party that came to us, and we'll be using that list of recommendations to ensure that our recommendation list either addresses those recommendations that third party has made or we deem that that recommendation wouldn't be something we would want to support, but we'll discuss that also as a group. Any questions on how we're going to go forward?

Michael Wittie
Sorry, this is Michael. I'll just jump in really quickly. Again, comments on the structure and placement within the document are also welcome. If anyone has comments, just send them to me.

Sheryl Turney
Absolutely, and it will get difficult if people start moving things around, so please just either put your comments in an email or add them to a comment box in the Google document itself so we can keep track of where everything's going so what we show you is going to be consistent and we can keep track of how those changes were made. Alix, did you want to add anything before we close for today? Can we put up those slides for next week?

Alix Goss
It all sounds good, Sheryl.

Next Steps (01:28:18)

Sheryl Turney
All right. So, just a reminder, on this slide, September 9th is when we're due to have our presentation to ONC, and at this point, we are expecting that this work group is probably going to continue at least through the HITAC meeting in October, and so, I just wanted to make sure everybody is planning appropriately. Any comments or questions before we close?

Alix Goss
Thank you for sticking around a few extra minutes, folks.

Sheryl Turney
Yes, I agree. Thank you so much. All right, I think we can go ahead and adjourn the meeting. Thanks, everybody. We'll see you next week – same time, same channel.

Rich Landen
Thanks, everyone.

Lauren Richie
All right, thanks. Bye-bye.

Alix Goss
Good job today, Rich.

Adjourn (01:29:12)