Meeting Notes

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

September 8, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

EXECUTIVE SUMMARY

Sheryl Turney and **Alix Goss,** co-chairs, welcomed members to the Intersection of Clinical and Administrative Data Task Force (ICAD TF) meeting. **Alix** reviewed the agenda for the current meeting and provided an overview of the activities of the previous meeting. Then, the co-chairs and **Michael Wittie** walked through a draft of the paper for presentation to the HITAC, and TF members resolved existing comments and held a robust discussion. **Sheryl** facilitated the ICAD TF's discussion of the broader intersection of clinical and administrative data. Finally, the co-chairs briefly reviewed the TF's plans for moving forward and the next steps. There were no public comments submitted by phone. There were several comments submitted via chat in Adobe Connect.

AGENDA

03:00 p.m.	Call to Order/Roll Call and Welcome
03:05 p.m.	Summary and Action Plan
03:10 p.m.	Review Draft Paper and Comments
03:40 p.m.	Broader Intersection of Clinical and Administrative Data
04:20 p.m.	Public Comment
04:25 p.m.	Next Steps
04:30 p.m.	Adjourn

CALL TO ORDER/ ROLL CALL AND WELCOME

Lauren Richie, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the September 8, 2020, meeting of the ICAD to order at 3:02 p.m. ET.

ROLL CALL

Alix Goss, Imprado/NCVHS, Co-Chair
Sheryl Turney, Anthem, Inc., Co-Chair
Gus Geraci, Individual
Mary Greene, Centers for Medicare & Medicaid Services
Anil K. Jain, IBM Watson Health
Jim Jirjis, Clinical Services Group of Hospital Corporation of America (HCA)
Jocelyn Keegan, Point-of-Care Partners
Rich Landen, Individual/NCVHS
Thomas Mason, Office of the National Coordinator
Ram Sriram, National Institute of Standards and Technology
Andrew Truscott, Accenture
Denise Webb, Individual

MEMBERS NOT IN ATTENDANCE

Steven Brown, U.S. Department of Veterans Affairs
Arien Malec, Change Healthcare
Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin
Jacki Monson, Sutter Health/NCVHS
Alex Mugge, Centers for Medicare & Medicaid Services
Alexis Snyder, Individual/Patient Rep
Debra Strickland, Conduent/NCVHS
Sasha TerMaat, Epic

SUMMARY AND ACTION PLAN

Sheryl Turney and **Alix Goss,** co-chairs, welcomed members to the Intersection of Clinical and Administrative Data Task Force (ICAD TF) meeting. Then, **Alix** reviewed the agenda for the current meeting and provided an overview of the activities of the previous meeting, during which the co-chairs led a deep discussion of the Recommendations section, including several edits and assignments to TF members to write revisions. TF members discussed options and approaches moving forward, and all were asked to review the Google document or a PDF of the draft and enter their comments offline.

REVIEW DRAFT PAPER AND COMMENTS

Alix Goss opened the presentation of the ICAD TF's draft recommendations document by explaining that Michael Wittie would share the most current version via the Adobe Connect meeting software. TF members will discuss the remaining comments on the draft report during the meeting.

Then, **Alix** noted that ONC secured a writer to assist the TF with the report and explained how current and future work on the report would lead to the development of a formal report. The writer will work on ensuring that one voice is used throughout the report.

Discussion:

- **Alix Goss** highlighted a comment on Recommendation #11: Standards for the Prior Authorization (PA) Workflow and discussed the thought process behind the recommendation. She asked if the comment had been resolved within the text and noted that the following text was added to the document:
  - The Task Force recommends that the chosen standard or standards be sufficient to:
    - Determine which orderables, procedures, referral or other activities are subject to prior authorization, medical necessity or other similar pre-approval checks
    - Determine the requirements and rules for approval of an orderable, procedure, referral, etc., sufficient to collect the required documentation or justification
    - Automate the pre-approval workflow using the provider's chosen technology platform without relying on portals or payer-specific workflows,
    - Determine the definitive status of a pre-approval request programmatically in the provider's chosen workflow
  - **Michael Wittie** explained that the text was updated by **Arien Malec** with suggestions from the comment, which was then marked as closed.

- **Michael Wittie** discussed the following comment on Recommendation #11, which was submitted at the August 18 ICAD TF meeting:
  - Should there be a recommendation that all implement RTBT, including eligibility and copay checks? Need to make sure that recommendations include drive for automation in workflow and eligibility checking.
    - Real-time is a goal as well but should not miss targeting other predecessor steps that reveal the requirements, etc. early in the workflow, including the possibility of avoiding PA in the first place, and that data submitted for PA are complete the first time as much as possible.
    - Focus on "right time" not necessarily "real-time" to ensure that relevant data is actually available.
    - Remember: not just automating an existing PA but having data in place in workflow to avoid need for a PA– with info on a specific patient's benefits, can order in compliance with that visibly when possible. (i.e.: right data at right place and time to act on it)

- NCPDP processes largely have this on the prescription side, but the 'other' side of care isn't there, need to catch up.
- Key point: Don't want to disrupt provider-patient relationships – providers may have additional information that may not be in the payor's purview and don't want to inadvertently create confusion by joining the clinical and admin data sets.

o **Sheryl Turney** noted that, in a previous discussion, the TF decided not to make real-time into one of their goals. Rather, the goal is for the data to be available when a provider needs to decide a PA. Data needs to be accessible in a provider's system. She noted that doing a real-time benefit check in a pharmacy PA is easier than the PA process for other procedures.

o **Jocelyn Keegan** acknowledged that the pharmacy process is more mature in terms of being ready for real-time that some of the clinical workflows are for medical PA. However, she emphasized that the TF should not back away from the expectation that the data should be available in the exchange in (or near) real-time. She discussed potential roadblocks to real-time.

- **Rich Landen** noted his agreement with **Jocelyn** in the chat feature and stated that the TF should set the expectation at real-time unless it is not feasible for the patient's situation.
- **Alix Goss** explained that this comment was several weeks old and might have already been vetted by the TF.

o **Tom Mason** voiced his agreement with the points made by other TF members and suggested that, from a burden reduction perspective, the TF should add language that allows a clinician or a member of the care team to be a part of the workflow.

- **Alix** noted her agreement and asked **Michael** to add a note to the document to incorporate members of the care team in these workflows, as appropriate.
- **Michael** referenced a previous conversation held by the TF about reducing the need for PA when the right information exists with the electronic health record (EHR) and asked if TF members would like to incorporate that concept into this section.
- **Sheryl** responded that **Michael** made an important point and emphasized that the first goal (ahead of real-time) should be to waive the requirement for PA for certain situations and procedures, especially in value-based care programs. Not requiring a PA in these situations reduces burden. She emphasized the concept of having the right person at the right time and for the right reason, with the right data, for clinicians, which **Michael** called the "Five Rights" in a comment on the document.
  - He said that the "Five Rights" in this context come from the clinical decision support (CDS) literature, and are:
    - o the right information,
    - o to the right person,
    - o in the right intervention format,
    - o through the right channel,
    - o at the right time in workflow.

- **Alix** summarized the concepts discussed by the other TF members.

- o **Anil Jain** cautioned the TF against neglecting to set up physician support, alerts, and guideline mechanisms in the EHR; if these concepts are built-in, electronic PA will become the exception rather than the rule, and the burden will be reduced. He noted that the TF discussed this topic during past meetings and suggested that they examine previous related comments.
  - ▪ **Michael Wittie** noted that there is some related text in the Guiding Principle and explained that he drafted additional supporting text that has not yet been included in the TF's documentation.
  - ▪ **Alix Goss** suggested that **Arien Malec** and **Rich Landen** begin to incorporate any text that is a carry-over from previous documentation or that has been created but not included in the document. The TF should be clearer about defining the "Five Rights," which **Michael** will do offline using older documentation. Also, she explained that she edited the structure of the draft document and added a table of contents and noted that the paper will continue to change after the TF continues with the broader intersection conversation.

- **Alix Goss** summarized the recent comments from the chat feature in Adobe from **Jocelyn Keegan** and **Rich Landen.**
- **Jocelyn Keegan** discussed the importance of patient-specific information and validation in the process and noted that all of the "Five Rights" need to be at the patient level.
- **Alix Goss** highlighted a comment **Anil Jain** made on Recommendation 12: Create Extension and Renewal Mechanism for Authorizations, which was:
  - o "We may want to expand this to include extensions, as well. For example, physical therapy may be extended, and a prescription may be renewed. Thus, suggest rewording to "Create Extension and Renewal Mechanisms for Prior Authorizations.""
  - o **Alix** discussed ways in which this process is burdensome.
  - o **Anil** confirmed that the text had been updated to reflect his suggestion.
- **Alix Goss** summarized the comments made on Recommendation 13: Include the Patient in Prior Authorization and noted the first one, from **Anil Jain**, was:
  - o "I would suggest that we be much more direct that the PA process be patient-centered with engagement, transparency, and empowered, to contribute information, etc."
  - o **Anil** noted that his comment was addressed within the edited text.

Alix Goss noted that the TF had concluded the review of the Recommendations section. In conclusion, she referred TF members to the Recommendations Background notes section of the draft document and asked them to review this section to make sure that all of their feedback was incorporated in the Recommendations.

BROADER INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA

Sheryl Turney began the ICAD TF's discussion of the broader intersection of clinical and administrative data by displaying and describing a slide depicting the flow of clinical and administrative data in an ecosystem that included the stakeholders (payer, lab, providers, surgical centers, the patient, etc.), the various electronic medical records (EMR) systems, and the processes around identity and consent management, patient information, and ADT and Gaps in Care Insights. She explained the various connections across the ecosystem and discussed how the ICAD TF's recommendations have addressed many of the connections. **Sheryl** highlighted the flow of patient, admission, discharges and transfers information between all the stakeholders in the interoperability pool. She described a provision that says hospitals need to share their providers and explained that it causes gaps with payers and in care. She explained that she created the slide to begin a conversation about the greater intersection of clinical and

administrative data and how information is exchanged that have not been discussed by the TF. **Sheryl** discussed the payer perspective in terms of belonging to health information exchanges (HIEs) and explained some of the intricacies of the HIE system, which places a burden on the patient. She provided some background on her family's personal experiences and challenges using multiple EMRs.

Then, she asked ICAD TF members to discuss the broader intersection or to share any feedback.

Discussion:

- **Anil Jain** shared several comments, including:
  - One exercise could be to see how other groups, like the Da Vinci Project, have depicted the clinical and administrative data ecosystems to see if the ICAD TF can harmonize the depictions.
  - What gaps in care can be measured if patient information is already flowing bi-directionally?
  - Think about which processes, outcomes, and definitions need to be passed between the different ecosystem players.
  - One challenge is having different data models for different data collection systems but also different rules. Consider depicting the business rules moving through the ecosystem as well as patient information as a way to determine if there are gaps or not.
- **Sheryl Turney** agreed with **Anil's** points and asked **Jocelyn Keegan** or other TF members to comment on other groups' depictions of the ecosystem. Sheryl noted that much of the Da Vinci Project's work is focused on use cases.
- **Alix Goss** clarified that **Sheryl** was asking about existing models in the marketplace that depict the impact of clinical and administrative data and that if the TF can understand some of those models, it can then glean the problem areas in an effort to harmonize or overcome gaps.
- **Jocelyn Keegan** discussed how vendors, providers, and payers are working within the industry to meet challenges and noted that some of them are using application programming interfaces (APIs), while others are not. The Da Vinci Project's work has been around identifying the business challenges and developing implementation guides, which provide a framework for identifying rules and determining how to navigate them. **Sheryl** did a good job describing this in her summary. At the highest level, Fast Healthcare Interoperability Resources (FHIR) based solutions and APIs are being used. She discussed how the Da Vinci Project is working with the first versions of implementation guides to validate exemplars (out of 100s of different PA interactions in the community) and to answer the following questions:
  - Is a PA even needed in this situation? If so, which rules are needed, and how can they be navigated?
  - Using things as they are currently defined in FHIR, how can they be constrained?
  - Where in the workflow would they appear?
  - What data is available at that point in time to be exchanged between two partners? (This information will be used to automate the business challenge.)
  - If there needs to be an adjustment for the resources for creating profiles for specific business problems, how would this be done?
  - **Alix Goss** summarized the description by stating that Da Vinci is providing a way for the industry to solve issues through creating frameworks for models of data flows that can be automated by machine learning.
  - **Jocelyn** responded that **Alix** identified a powerful point. Developing templates for common interactions will allow care providers to have the highest capacity to care for patients. Also, she noted that the framework and templates for common interactions are the most important components because not everyone in the industry is using FHIR at this point.
  - **Alix** summarized the two policy-related themes:
    - Meet stakeholders across the industry where they are with a diverse set of complex technology investments.
    - Find ways, moving forward, where the core of the data and the alignment the TF has discussed enables the creation of frameworks that span administrative and clinical ecosystems that stakeholders can implement along the way.

- **Jocelyn** clarified that her perspective is that everyone is on the journey with stair steps of progress, and the policies should on-ramp those who are not on the stairs or are just getting started and reward those who are farther along, not constrain them.
- **Alix** responded that **Jocelyn** has captured points from the TF's small group discussions around recommendations that, though there are industry leaders, there is still a large amount of work to be done. The TF has to figure out on-ramps, bridges, and the right destination for all, despite their technology status, because not all stakeholders have the same access to capital.

- **Alix Goss** asked if the TF should consider downstream data uses that are not just clinical or administrative, and, if so, how to include population health like public health and vital statistic records. Where are the boundaries, and how does public health fit into a clinical or administrative bucket, moving forward?
  - o **Anil Jain** responded that these are good questions and highlighted that many stakeholders will have a more vested interest in public health needs in the future. The TF should use the opportunity as they go through the effort of harmonizing clinical research and research operations related to public health to create new efficiencies. The TF should consider the additional use cases that would be benefited by their work on aligning clinical and administrative data.
  - o **Alix** responded that reducing burden and increasing the flow of data for vital records were connected to research for evidence-based medicine.
- **Jocelyn Keegan** highlighted the needs for population-level data. The plans and provider systems that are more advanced and can support statistics at the system level. She noted that there is a separation in supporting public health versus population-level health information in Da Vinci's.
  - o **Alix Goss** responded that she did not mean to conflate public health and population-level health and thanked **Jocelyn** for clarifying the point. **Alix** noted that she meant data flow needs that burden providers.
  - o **Sheryl Turney** discussed disparities in reporting all-payer claims databases (APCD) data that are not captured in the same way and described how the Centers for Disease Control (CDC) asked multiple payers for data on COVID-19 and found that some payers provided the data with codes and others used diagnosis-related groups (DRGs). She noted that her concern is that APCD data will morph or have layers added to it as it goes farther from its source, and she emphasized the importance of consistency in terms of the capture and exchange of APCD data.
  - o **Alix** noted that **Sheryl's** comments about porting the provenance of data and related consent aspects were interesting.
  - o **Sheryl** described the conditions in the APCD world, including the prompt payment rule, and explained how this impacts the ability to make payments. She emphasized the need for the TF to focus on the current workflows instead of the ideal state. She supported connecting vital records but noted that the TF should be aware that there are limitations on this from some state rules and laws.
  - o **Alix** submitted several comments:
    - She responded that this is the secondary usage of vital statistics, and she was thinking about the concept that providers need to submit data to various public health registries (like birth, death, immunizations). That information flow out of EHRs could be a burden, so the TF should think about the information flow and services that enable this process as part of their data model to reduce the burden and benefit time limits.

- She discussed how the work on aggregating data sources for APCD data informs policymaking and emphasized that downstream data fidelity would be accomplished through the TF's robust data mapping recommendation.
- She noted that **Sheryl** elevated another aspect in the broader convergence conversation of clinical and administrative data: data gets used downstream for a wide variety of things. Does the TF need to focus on policymaking around the use of downstream data?
  - **Sheryl** described the APCD waste calculator, how it is used by states, and her experiences with it. She noted that education needs to occur.
- **Anil Jain** submitted several comments:
  - It is important to think about the use cases, and the ICAD TF should not minimize the challenge of having additional use cases.
  - The code sets, documentation, diagnoses, procedures, and how they are described all serve the TF well from a clinical and administrative point of view, except for the exceptions **Sheryl** discussed.
  - The TF should harmonize all of the various ways vital statistics are described and discussed the example of a death certificate as a less complicated example. Descriptions become much more complex when it comes to public health and clinical research. The TF should not try to minimize complexities in use cases but should try to create an environment for the use of correct, common code sets, and terminologies. This harmonization will help additional use cases.
  - **Alix Goss** voiced her agreement with his points and noted that, for example, death record generation happens outside the EHR. The TF should create boundaries around downstream data use while keeping out of the weeds of the complexities of use cases. She discussed the comment **Rich Landen** made in the chat feature in Adobe, which was:
    - "My feeling is that we do need to incorporate public health, research, vital records into the Converged Ecosystem. I don't know that we're at a point where we can propose solutions, but we do need to ensure that while working on clinical/admin data convergence we leave both the architecture and the expectation for further work on public health, research, vital records."
    - **Anil** noted his agreement with **Rich's** comment.
- **Sheryl Turney** asked if, because the TF discussed the theme of expanding the need for code sets, they should also take the following steps:
  - Identify a sample group of data from the administrative side to be examined from a United States Core Data for Interoperability (USCDI) perspective as a starting point.
  - Translate things like Admission, Discharge, Transfer (ADT), and gaps in care insights into business rules.
  - Recommend that certain code sets and standards be used for certain purposes to make research-based data more consistent and more easily attained.
    - **Sheryl** discussed the example of the CDC needing to normalize reported data before using it.
  - **Alix** responded that she is struggling with the question.

- o **Anil Jain** noted that he would leave researchers to determine how they want their own information represented. He discussed his experience with clinical research and noted that the TF should not add burden to the system. Rather, the TF should acknowledge that work that needs to be done and to create an environment by which that work can be done and then be brought back into an environment where clinical and administrative data can be harmonized. The TF should not ask doctors to start collecting the significant, more granular data needed for some public health projects or clinical research. The TF should encourage those in public health and clinical research to use a more refined, minimum data set.

- o **Alix** responded that the TF has language around the coding process and code sets in their existing recommendations and guiding principles. There should be policy that factors in the downstream environment, but there is plenty of ability to pull content for public health messaging from the EHR. The TF should encourage the automated flow of information and should focus on the level of the broader intersection. A different group of people could look at whatever mappings of the code sets have already been pursued.

- o **Anil** responded that **Alix's** comments made sense and described an example of a public health project studying asthma and the conditions of a patient's home, which might be haphazardly collected in the EHR, though they are important for public health. He noted that a situation could be created that there is a USCDI model that is created about a patient's home, and they should not give the impression that this kind of information will be collected on every patient. Data that is a byproduct of clinical care should be made available downstream, but if it is not a byproduct of clinical care, then they should go through a community-based process of understanding what it takes to collect that data.

- o **Alix** agreed with **Anil's** comments and noted that **Jocelyn Keegan** also voiced her agreement in the comments while sharing additional concepts in the chat.

- **Sheryl Turney** noted that, at the next meeting of the ICAD TF, there will be a discussion of the comments provided by the HITAC following the co-chairs' presentation. However, the TF should also continue to focus on the conversation around the broader intersection. She suggested some themes on which TF members had already discussed that they could use to focus their next conversation, including:

  - o Look at the data from an ecosystem perspective, rather than the use case level, and focus on code sets and harmonization to ensure that administrative data is captured.

  - o Ensure that stakeholders that are not in tightly coupled systems have the ability (through standards or a certification process) to share data on the patient at the member level within the EMR systems. Discuss how Da Vinci's work can help.

  - o Continue to think about the interplay of downstream data with public health and vital records.

Lauren Richie opened the meeting for public comment.

PUBLIC COMMENT

There were no public comments via the phone.

Questions and Comments Received via Adobe Connect

Andy Truscott: Just joined - sorry I was late.

Lauren Richie: Hello Andy

Andy Truscott: No hand raised - as I agree with it :)

Denise Webb: Hello, I am on now. Had a meeting run over. Sorry

Lauren Richie: Hello Denise

Jocelyn Keegan: Jocelyn Keegan here.

Jocelyn Keegan: Michael has lots of background

Rich Landen: Very hard to hear Michael

Rich Landen: I agree with Jocelyn: we should set the expectation at 'real time unless real time not feasible for this patient's situation.'

Jocelyn Keegan: proxy is important here. . .

Jocelyn Keegan: provider team, provider representative.

Jocelyn Keegan: Tom is right, we should assume and maintain reality that docs do very little of this work today.

Rich Landen: Sheryl's point is fundamental: if no PA necessary, that's the most efficient workflow.

Jocelyn Keegan: Add

Jocelyn Keegan: ADD patient specific to the right data, right time, and gets it more specific. . .

Rich Landen: For editing, Tom Mason's point should be carried throughout the document: when we say "provider" we include the whole team. Similarly, patient plus authorized rep. And last but not least, health plan can/should include designated business associates.

Jocelyn Keegan: Only point on 13 is in an ideal state patient should not need to be involved or aware of PA processes.

Rich Landen: My feeling is that we do need to incorporate public health, research, vital records into the Converged Ecosystem. I don't know that we're at a point where we can propose solutions, but we do need to ensure that while working on clinicnal/admin *[sic]* data convergence we leave both the arcchitecture *[sic]* and the expectation for further work on public health, research, vital records.

Jocelyn Keegan: But there is huge value in freeing pop level data out of the 50 differen *[sic]* PDF reports into actual data that can be digested between partners :)

Jocelyn Keegan: I agree with Rich, if not this report, putting a firm hand up to demand funding of public health data and make it portable, automated is critical from emergent (COVID, measles), routine (schools, vaccines, episodic (cancer, chronic illness).

Jocelyn Keegan: Agree complete with Anil about creating environment to start these projects. The communities need to drive, but we create min data set and acknowledge these need to come together.

Rich Landen: I agree with Anil. If we go toward specifying datasets, we'll wrap ourselves and many others around the proverbial axle Alix referenced earlier this call.

Jocelyn Keegan: There are many exisitng *[sic]* industry efforts in/out of HL7 FHIR Accelerators and multistaker *[sic]* holder SMEs in the weeds here.

Lauren Richie: To members of the public: To make a comment please call: 1-877-407-7192 (once connected, press "*1" to speak)

Jocelyn Keegan: I"m [sic] more than happy to brainstorm other stakeholders. I think we're missing Carequality, Commonwell, Gravity as critical areas of use cases. . .all other accerlators ot [sic] understand primary/secondary use of data to gain full benefit of freeing data. . .but this is opening a can of security, data permissions use that FAST is covering in general. . .

Gus Geraci, MD: Thanks, all!

Following the public comment period, the ICAD TF co-chairs continued to recap the major themes discussed, which included:

Discussion:

- **Alix Goss** thanked **Sheryl Turney** for her previous recap and asked if she had finished her list of themes.
  - o **Sheryl** highlighted the importance of **Anil Jain's** previous comment about taking inventory of ways in which others have depicted the intersection of clinical and administrative data as another theme for the next meeting. She suggested that perhaps Da Vinci's use cases, and other groups' work would be helpful and encouraged ICAD TF members or others to submit any relevant information to the TF co-chairs. Also, she discussed her experience with collecting information for a similar public health project to the example **Anil** discussed (of the interplay between environmental factors and asthma) and described the related challenges. Due to COVID-19 and potentially other public health risks, these types of projects will only increase in importance, and clinical and administrative data will be needed.
  - o **Alix** asked **Sheryl** to clarify her comments, and **Sheryl** responded that the TF should look at overall themes in the broader intersection and not specific use cases.

NEXT STEPS

Sheryl Turney provided an overview of the next steps and explained that, on behalf of the ICAD TF, she and **Alix Goss** will present the draft report and recommendations to the full HITAC at their September 9, 2020, meeting. The HITAC will only see recommendations in the PowerPoint; they will not see the full report document, so TF members were encouraged to review it and provide additional feedback. Then, at the ICAD TF meeting on September 15, the TF review the feedback from the HITAC presentation and discussion and will reconcile all final comments. The TF will continue to focus on the broader intersection conversation. Finally, the co-chairs will deliver the final recommendations and report to the HITAC on October 21, 2020.

ADJOURN

Sheryl Turney and **Alix Goss** thanked everyone for their participation and reminded them that the next meeting of the ICAD TF was scheduled for 3:00 p.m. ET on September 15, 2020.

The meeting was adjourned at 4:29 p.m. ET.