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

September 15, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

Speakers

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

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

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Welcome again to another edition of our ICAD Task Force meeting. A quick roll call, and then we will jump right into today's agenda. We're joined by our co-chairs Sheryl Turney and Alix Goss. We also have Aaron Miri, Anil Jain, Arien Malec, Denise Webb, Gus Geraci, Jim Jirjis, Rich Landen, and Steve Brown. I do know a couple of other members that will be joining us late, but are there any others on the phone that haven't been announced yet?

Sasha TerMaat
This is Sasha.

Lauren Richie
Hi, Sasha. Anyone else? Great. I will turn it over to our co-chairs to get us started for today.

Alix Goss
Sheryl, are you all set?

Summary and Action Plan (00:01:02)

Sheryl Turney
Yes, I am, thank you. Thank you, Lauren. Thank you, Alix. So, for you today, I'm going to do a little summary on what happened at the HITAC meeting, and then also, what we discussed in the last meeting, and then, Alix is going to lead the discussion that we're going to further on the broader intersection of clinical and administrative data that we began last week, then we have time for public comments, and then we're going to do next steps. So, we can go to the next slide.

So, as you may recall from last week, we began the discussion of the broader intersection of clinical and administrative data, we reviewed some final recommendations and comments that we had discussed from our overall paper, and then, we had a really great discussion that began the work into the broader intersection discussion, and we really focused on three or four themes, and those were patient at the center and what that really means if we look beyond prior authorization. Hold on a second. I have something in my eye.

And then, we looked at additional parameters that we might want to discuss around transparency and what that would require, and then, also, looking at making sure that our discussion and recommendations focus on where people are, and we know that across the continuum, there are many different healthcare partners that are in different places. They have different levels of sophistication when it comes to EMR systems, when it comes to their ability to utilize tools, and from a patient or caregiver's perspective, so we started discussing all of those things, and we'll really look forward to a more robust discussion on that today. Alix and I put some thoughts together offline. I'm bringing those back to you today to spur the discussion. We really do appreciate everybody's work as we try to start with that picture that we had last week, which was

really only meant to help us move in this new direction, so, thank you for that. Why don't we go to the next slide?

Discuss HITAC Meeting and Feedback (00:03:40)

So, the discussion in the HITAC meeting was quite energetic and very helpful. We started by providing recognition for all of the extensive work that this entire team has done and the support we've gotten from ONC and Excel. We went into some detail in the guiding principles and ideal state, which I covered, and then, Alix covered the recommendations and discussed each of those at length in the session with HITAC. We got a lot of questions, which was really good, and did get some recommendations.

So, in the feedback that we received in the session, we got a lot of questions relating to releasing the paper early and additional healthcare partners – who we've already heard from, mostly – who wanted to see the finished paper before it's actually published and get another opportunity to weigh in on it before it actually goes to ONC, and that's clearly not the protocol.

So, what we have discussed, and what we are doing and will continue to do, is present sections of the paper for us to comment on and review. Of course, we want to review and edit the entire paper with the task force as a group, and that is appropriate based on the public forum that we're in, but releasing the paper in a way that perhaps would not support the current protocol for federal work wouldn't serve any of us, so we have indicated to all of those that have comments to participate in our meetings on a weekly basis, comment in the public comment section, or submit written comments to us, and we are taking all of those into account. As you know, we've been cross-checking our guiding principles and ideal states, as well as recommendations, based on all of the healthcare partners that have come forward and either presented virtually to us, in writing, or via email, so we will continue to do that, as we have done in the past.

That seemed to be the theme of many of the public comments that came in during the HITAC meeting, but also, there was definitely a theme to focus more on the patient and the caregiver involvement, and to that end, because we were only presenting a summary of each of the recommendations, some of the detail behind it that was in the paper itself wasn't as obvious – it wasn't highlighted – so I do think we have much of that, but we did want to focus on that, and so, as you will see in the broader intersection discussion we have today, we want to re-review that topic to make sure that we are looking at patients at the center, and that is one of the themes that we need to make sure is there for our broader intersection conversations, and also, we will be re-reviewing the paper to ensure that that theme comes out throughout the paper.

The other topic that came up to some degree – I believe this one was raised by Cynthia Fisher – was the price transparency, and the notion that she was presenting was that a patient should be able to get their price estimates for an approved procedure, and it shouldn't be approved for a specific doctor or facility, but they should be able to then take that approval at various prices and measure it against the open market. Personally, I think that's a difficult concept to implement because in today's world, at least, we all have contracted providers, so the assumption is that contracted providers are going to be less expensive than non-contracted providers, and most of the tools that are provided to patients via their employer groups or their payers will allow them to choose a provider and should have estimates for them in terms of what the cost is.

But, the complaint, which is a fair one, is that not all of the costs are necessarily in that picture, and so, what might happen is you might go to a facility for a procedure – this actually happened to me recently because I had to have a mole removed, and I got a bill from the facility that said they weren't in network. Now, I'm being told that was a mistake and they actually are in network, but no one wants to go to a provider and then find out they get a facility bill that A). They didn't know about, B). It wasn't a contracted provider, so all of a sudden, they're responsible for $12,000.00 they didn't know about, or C). Maybe the anesthesiologist wasn't in-network. So, certainly, this is a concept that we need to take into consideration as we are discussing what the recommendations are. I don't know if this is a problem that we can solve with what we're putting forward, but it's certainly a concept we need to address. We've already discussed it as part of our group, and I do think it's something you're going to hear more about as we talk about the broader intersection, but I do want to make sure we give that ample time to have that discussion here.

I think the theme of some of the other comments that came from HITAC were certainly the convergence of standards, where there is some intersection between standards groups and that recommendation that indicates we should try to resolve where there are conflicts or harmonize where there are conflicts. I will say there is probably going to be some scrutiny from outside as a result of that recommendation, so there was a suggestion that if we provided more detail in those areas, it would be helpful to us and to ONC as they're considering the option.

And then, there were also some themes relative to pilots and the standards promotion model that would be utilized, similar to what we do with the current standards models and what is currently happening with USCDI – how we get the administrative data looked at as part of a USCDI future version. And then, There was another one that I highlighted, which was – oh, that's the patient engagement journey, and I actually put a picture together which we're probably not going to share today, but it was one that I didn't present to HITAC but thought about after the HITAC meeting where in today's world, even with the current interoperability focus, a patient would go into a third-party app and really still have some burden because in order to connect to all of the different healthcare partners that patient has, they need to provide some login information for each of those partners, and that in and of itself can be burdensome depending on the health condition of the patient and the number of healthcare providers that patient has.

And, oftentimes, if you can't remember the login for something with these systems – I've experienced this myself – they don't reset passwords immediately, so you have to wait and come back into it, and by the time you get the information, you go through the whole process of forgetting it again, especially if you're at the ages where you're writing things down, they're on little pieces of paper, and then you can't find the paper. You're not supposed to be writing it down in the first place, but everybody does.

You can see in a real-world example that I've put together on the page – and, I'll hopefully share it in a future week – that there's still some burden even for the patient to try to get all this data into one app and then have it available, and then, when it's in the app, how is it presented to them? Is it presented in a way that's going to make it easier for them to see what's going on, and how will they be able to assimilate that with each of the providers that they're visiting? So, there could still be some burden and complexity with having the data all in their phone or all in one app, and this is stuff we have yet to see. But anyway, I think that's enough of that piece of it. Any questions?

Alix Goss

Yeah, we have Arien's hand up.

Sheryl Turney
Go ahead, Arien.

Arien Malec
Thank you. So, I have a comment and a suggestion. I definitely noted the level of enthusiasm that many folks had about participating in the draft report and viewing it. I agree with everything that you said. I think there's a – I would suggest a positive frame on exactly the same comment. During the meeting itself, I think you heard me try to present some of that positive frame-out. There will be multiple opportunities for interested parties to be able to comment on the report through any of the mechanisms that are provided for public comment, and I think we should encourage participants to continue to do that and reassure them that all of the material in the report will be publicly available prior to approval of the report by the full HITAC. Nothing in that statement is contrary to the policy and procedure that we follow. It lets people know where they can comment.

I guess the comment to all of that is this is really emblematic of the importance that the U.S. healthcare system places on this topic. There's a lot of passion, there's a lot of interest folks have, and all the comments were very positive. I think it's reflective of how important this work that we're doing is, so, thank you.

Alix Goss
There are no further hands up, Sheryl, but if I may, I'm raising my hand.

Sheryl Turney
Yes, absolutely.

Alix Goss
I think Arien makes a really good point. We are a task force of HITAC. HITAC is the federal advisory committee, and there are some rules and protocols that we need to respect, as you've both discussed, and so, I'm appreciative for the opportunity for our messy work effort of the task force to be so transparent and available to anyone who chooses to come on the ride with us as we're working through a variety of conversations every week, and I know sometimes it may feel a little bit disjointed to folks, but some of the pain of going through comments and cross-checking things is the way we've been trying to be very transparent, not only with the members, but also with the public, so I'm appreciative of the federal advisory committee processes and the role that we play in supporting HITAC and their protocols, and so, I think that that's – I'm looking forward to us advancing our discussions, especially around the broader intersection conversation, and being able to get into – even just for ourselves, who are working in the weeds on this, to get our arms around the content and put together a cohesive draft report.

So, I think that will be coming rather rapidly. I also wanted to acknowledge ONC in that they have placed an editor under contract. Her name is Susan Kanaan, and she's done work in the NCVHS realm. I think most recently, I'm familiar with the crafting of the 13th report to Congress that she did with that team, so I'm looking forward to all of us getting actively engaged in the Google document and providing comments in the task force so that we can have something cohesive so that when we get the feedback and we ask for

the industry's broader review and comment on the processes that HITAC advances, they've got a complete picture to think about. Thank you, Sheryl.

Sheryl Turney
All right. That's was really my summary, unless there were more questions. As others stated, we were thanked. I think everyone thought we worked really hard and have done a great job overall, and they're looking forward to the final draft that we're hoping to submit by October 15th for the October meeting, so we've come a long way, but we still have a lot of work to do, and I appreciate you guys working with us for maybe another six weeks to get this finalized and resolved, and I will now turn it over to Alix.

Broader Intersection of Clinical and Administrative Data (00:18:44)

Alix Goss
Thanks. Yeah, it was really nice to hear words like "support enthusiastically" and "exemplary work," and hats off to everyone in the task force and to those who provided public comment as well as presentations. Sometimes, for myself, it's complex when you're in this iterative workspace to feel like you're making progress, so I think last week's presentation helped all of us see how it's coming together.

So, we're now pivoting to the broader intersection of clinical and administrative data, as Sheryl indicated in the summary recap last week. She gave us the picture to help us get our creative juices flowing, and hopefully, now, I'm seeing that my screen is being shared. Can everybody see it? Okay, thank you. So, through a collaborative effort after last week's robust discussion, we sat down and put together themes, so we want to walk through what we think we heard from you last week in the discussion that really is about how we are going to think more holistically about the ecosystem and that convergence aspect of the different frameworks we have for governing clinical and administrative data, and although we've tiptoed into this work a little bit through our prior authorization lens, we have the opportunity to step back and think more globally, so we really jumped into the deep end of the pool last week on that.

So, what I would propose today is an approach where I walk you through our synthesis of what we think we heard from you last week, a few notes that we captured along the way from HITAC to give us a start-off point to get our creative juices flowing this week, and through the process, which I believe Sheryl will be helping with along the way if we have questions, et cetera –

Sheryl Turney
Absolutely.

Alix Goss
Thank you. We'll give you a recap of the document which will enable me to stop periodically, have some discussion, get your input, I'll make Track Changes notes along the way, we'll confirm that we heard correctly last week, we'll bring up to speed those who couldn't have the pleasure of participating last week, and we'll give them the opportunity to weigh in. We'll then move into a couple new areas for us to start exploring, and hopefully, this will give us a nice approach this week and maybe another week or two to think more broadly through that convergence conversation. I'm not seeing any hands raised.

So, this is hot off the presses. I just finished editing it. It was set up two hours ago. Thank you to Michael and Sheryl for their input. In crafting this document, which – we really thought one of the overall principles

that we heard last week when we were talking about the broader intersection conversation was that portals don't have a place moving forward here when you think about the workflows of a given stakeholder, and in this case, we're not necessarily talking about a patient, although maybe we could get there eventually, but I think we're really talking about the payer-provider-stakeholder. Overall, there was a comment about how we really don't want portals. We don't necessarily think that's a part of the world moving forward. We want to meet people in their natural workflow. I don't know if there are any initial gut reactions to that. I don't see any hands raised, so I want to keep moving, but I'm going to give you an overview, and if something really gets in your craw, raise your hand, and we can stop and talk about it.

The next thing that really emerged was there was a converged ecosystem that needs to include additional actors from what we've been discussing. In this case, we talked about public health, title records, research, and policymaking-type actors, and that we needed to strive for an environment that's supportive of public health and vital records without creating burden or new provider data capture activities. So, we wanted to extend what we already have today as far as tools. I'm getting a bit of background, but hopefully no one else is.

Additionally, we thought about the use beyond clinical – this concept that's in our actual charter. It was around the capture/reuse kind of concept, and we talked about how labs, public health, registries, et cetera can add burden to providers, but the value is even more apparent in an emergency situation. Could folks please put themselves on mute if they're not talking? I would greatly appreciate it. **[Inaudible] [00:24:04]** health and registries can add burden to providers, but the value is even more apparent in an emergency situation. Think about the California, Washington, Oregon, and other western fires that are happening right now, as an example. But, the data has to be reconciled and integrated from different sources, and we may have disconnect with the coding that's happening.

And, research has a different flavor than those other actors of labs, public health registries, et cetera because they have different data and they use it differently, but also, vital records could be connected, and it seems very logical from what has been happening in a variety of places that they're already connected for EHRs and data submissions through health information exchanges into public health registries, but the problem with that is that we have identified that some states may have restrictions on bidirectional activities, which can kind of slow down the ecosystem.

Capturing and exchanging data across all these functions seamlessly will require consistency, and it has real potential to reduce burden – this Holy Grail of "record once and reuse" – which really led us into some United States Core Data for Interoperability discussion, which I'll get to in a little bit as a separate topic. There was this concept of a minimum dataset that allows a refined way of looking at an aligned clinical/administrative picture for these downstream stakeholders to see what they can do as a baseline that may need to be expanded later, so we're trying to figure out how to use what we have, align it with USCDI, which is very analogous to a number of the other prior authorization focuses that we've had, but we really need to take it to the next level and expand our thinking out.

And so, the first portion of our conversation was very much around these public health registries, and when I say "labs," I'm referring to lab registries, not the other dynamics we discussed with prior authorization labs, and it ended up expanding this conversation into the supporting care specialty and long-term care delivery

flows, and I'm going to talk about that next, but I'd like to pause and just sort of talk about this aspect of public health focus that we had last week and see if there are any comments, concerns, or additions.

Sheryl Turney
I don't see any hands raised, Alix, but I do know that there is some concern over data sharing. It actually came up in the FAST meeting on Monday by a number of different constituents when they were talking about sharing clinical data related to how payers in particular might use that data for secondary purposes or other purposes, and I've actually heard that directly. I think Steven Lane brought it up in the comments of two of the sessions I was in multiple times, and he's on HITAC, and he has brought it up in HITAC as well.

So, there was some concern about providing only the minimum necessary data for data exchange requests, and then, also using or repurposing that data for other purposes, so I do think it's something that, in terms of the broader intersection, we need to speak to in some framework because I do think in most instances, the interoperability rules currently – and any of those that I can imagine we could recommend – we wouldn't basically be saying that healthcare partners would ignore their business agreements – the BAAs that they already have in place, so if they are exchanging data for the purposes to support what we have here, we wouldn't be saying they would depart from that and then use the data for any other purpose, but I do think it's something that requires some notation, and I bring it up because also, when we're talking about public health reporting and lab reporting, there have been concerns as well that that data would be used for other purposes, and not just those that were submitted.

So, maybe we would need to have some context around the data-sharing for those purposes being limited unless there is authorization by the patient because I think that has been a subject that's come up in multiple venues I've been part of as well, and it's caused some people to be concerned about sharing the data in those types of forums, and that the data might be used for other types of research beyond what they anticipated. And, now that **[inaudible – crosstalk] [00:29:40]**

Alix Goss
So, you have – yes.

Sheryl Turney
So, there we go! I think Steven was first, but go ahead.

Alix Goss
I'm right there with you. Steven?

Steven Brown
Okeydokey. Can you hear me?

Alix Goss
We can.

Steven Brown

So, one of the things I want to point out is that there is probably a type of standardization that you guys may not have thought about as much. We've talked about terminology standardization and that sort of thing, which is all true and complicated, but we also need to put on our radar standardization of what an observation about a patient looks like. That's going to sound arcane –

Alix Goss
I'm sorry, you broke up a little bit to me. Can you just say that word again? An observation of how the patient looks?

Steven Brown
No, an observation about a patient. So, if you're going to assert that somebody has a problem at a particular point in time, or doesn't have a problem, or whatever, the way the terminology payload is delivered with appropriate context needs to be looked at and standardized because that's the only way you can interpret the information. So, there are things called statement models that are basically very small information models that standardized how you deliver payload about a patient regardless of what that payload is, and if you –

Alix Goss
I'm not sure how to capture what you're saying 1). Because I'm having a little bit of difficulty hearing you, but 2). Because I'm not sure if you're just – if you're introducing a concept where you're taking us to a place of – maybe we have a recommendation of something or an activity we need to undertake.

Steven Brown
Right. So, what I'm saying is we need to not only consider some of the organizational things like consent and some of the terminology-related or standards-related things that we've talked about today – using ICD or whatever – but there's an intermediate technical level called a statement model, and I think that needs to be reviewed with some opining done. Without paying attention to how you send the data over – like who the patient is, when the observation was, and if the observation was negated, uncertain, or whatever – that seamless reuse of the data is impossible.

Sheryl Turney
I'm understanding what he's saying there, Alix, and I think this came up in the discussion where some people have recommended just sending the full clinical record, and there is interpretation that needs to be had of that full clinical record, and also, in most cases, it's too much information, and then someone has to go fishing for it. So, at the end of the day, some information may only be applicable because of the state the person was in at that moment, and then never seen again, never modeled again, or something like that. Is that where you're going, Steven?

Steven Brown
Not exactly. Where I'm going is that to reuse data, which is what we're talking about – record once and reuse – you have to have standards for how you represent the data, like using SNOMED for problem lists or something like that, but you also need to have standards about observations **[inaudible] [00:33:48]**. If I were to say Steve Brown has pneumonia –

Alix Goss

I just lost three words.

Steven Brown
If were to want to say that Steve Brown has pneumonia on September 15th, it's important that you use pneumonia from SNOMED, but it's also important how you identify the patient, how you identify the time, and how you identify whether it was present or absent – things like that. So, if there are small information models, that's our metadata of an observation that are essential to at least address because if you send them differently every time, it's just as hard to interpret as if you don't use the same standard.

Alix Goss
Yeah. As somebody noted in the chat box, you keep going underwater a little bit with your audio, so I don't know if you're driving or not, but I think what you're trying to do is also talk about the actual status of the patient, which sounds very institutionally oriented or hospital-environment-based, but I'm struggling as I'm listening to you to understand what you're saying and how it tracks to provenance of the data and its permitted use aspect. Maybe that's where you were headed.

Steven Brown
It's all of that. So, provenance – is that any better?

Alix Goss
You've got really – we're good.

Steven Brown
Provenance would also be included in the metadata about an observation. Where'd it come from? Who made it? So, if you don't include that in a standard way and you send the blob of information to someone, they don't have any way to parse all that out. So, how do you reuse data at a receiving organization unless the metadata is standardized as well as the observation?

Alix Goss
Okay, that helps.

Steven Brown
So, how do you know, for example, that if you say someone has no known drug allergies, it's the same as having drug allergies that are negated?

Alix Goss
Okay. I'm trying to capture some notes here. I know we had a lot of hands that came up in the queue, so what I want to do is see if Arien, Anil, or Jocelyn, who put themselves in the queue, want to piggyback and discuss your point, and if they do, Sheryl, I think we should call on them. If not, I think we should then run the gamut. Jocelyn is saying, "Pick me!"

Anil Jain
This is Anil.

Alix Goss

Go ahead, Anil.

Anil Jain
So, just very quickly, it is about the comments that have been made. I think we have to separate out, for example, the secondary use of data that's provisioned by HIPAA after deidentification from alternate uses or additional uses that were not contemplated when the data were being collected – the whole repurposing – and I think those are two different concepts, and I want to make sure we don't mix the two up. They see the words "secondary purposes" up in the paragraph up there, and I think it's important that we not confuse the two issues.
The second comment would be about what Steve is saying around the metadata that helps us understand how information was collected. I think you can keep going through layer after layer because then, you can start getting really complicated. I think the first step would simply be to make sure that existing standards that exist – for example, LOINC codes when making observations – and all the details surrounding them would actually be completed, which seems to still be a challenge right now. I get Steve's point, but we're not even close to having to deal with that issue right now. We see a lot of secondary data – and, I'm using that word loosely – we see a lot of data in our business, and I have to tell you, even when standards are being used, the problem isn't just context, it's just that the standards are being used in a variety of ways. So, I just want to make sure – I'm not minimizing what Steve is saying, but we've got a long way to go before we can start to standardize the metadata. We still need to get some best practices and guardrails around the use of standards that exist already, if that makes sense.

Steven Brown
I think that's exactly right. Even if you do that really well, though, I'm telling you you're still going to fail.

Anil Jain
Possibly, but I think as the broader standards committees and communities start to grow with their ability to start standardizing what you're calling metadata – the perfect example would be if you've got two blood test results for the same test from two different machines, don't I need to know which machine it was if there are different normal ranges? So, you can keep going down this road where there's more and more detail added to the point where the payloads are very complicated, and you're basically reproducing the entire universe of information that was being generated. What I'm just saying is that we might need to do this in phases and let people catch up to what might need to be standardized. That metadata could kill any practical use of the secondary data or secondary use of the data if we're not careful.

Alix Goss
So, I saw that Jocelyn raised her hand, and I also wanted to chime in here, and Arien, you did not, so I'm going to jump to Jocelyn next –

Arien Malec
Sorry, I did raise my hand, and I've been waiting patiently.

Alix Goss
Do you want to comment on Steve Brown's suggestion? That's what I was trying to wrap up before…

Arien Malec

I will; I'll wait my turn.

Jocelyn Keegan
I'll be quick, Arien. So, from my perspective, when I listen to what I think are the very legitimate concerns that I hear Steve raising, I think that they're partially about getting us through the maturity of using these standards, but there are a couple things when we think about recommendations and where we weigh in that are going to be important.

I think the first is understanding what value sets we're using, defining those value sets in a meaningful way, and creating some minimum bar for compliance of people using the standards to be able to show that you're demonstrating it, but I also think that there's this bigger picture, and I have the privilege, good fortune, or bad luck – I'm not really sure which – to get to work across a number of different standards orgs, and each standard org treats getting to that semantic interoperability that I think Steven's digging at in very different ways, and I think there are best practices out there, and so, I find that we're often having conversations about the value of using FHIR – raw FHIR – at an API level, and then, the importance of the implementation guide on top of – you have eight implementation guides for a specific use, and I think how that data is being used fits for purpose for that use helps to tease out why it was gathered in the first place, and I see that now that we're a couple of years in with Da Vinci, there are – we're in the process of creating example sets, more and more examples of how somebody would – from one type of interaction to another type of interaction from a particular implementation guide, really building out what are almost libraries.

If you're going to do this for this specific diagnostic scenario, this is how you would use it even to a lower level of granularity, and that's growing. That's us figuring out as an industry how we would work together with these particular domains or standards to get to that best practice way to use it. It doesn't get all the way down, and I think that there is danger in us not moving forward. I think we have to start using it, so we have to use these tools with an eye toward growing and maturing, but also safety and caution around full automation when we know that the data inside of it might be imperfect. NCPDP doesn't use the implementation guide and example set. They use a different methodology around there being a base standard and transaction, and then an implementation guide that goes along with it, and as more and more people use the guide and questions come up, we keep augmenting that. We basically expand FAQs and get better and better definitions so that the guide that can tell you how to use it can evolve faster and ahead of the slower wheels of an actual standard maturing.

So, I think there are tools out there across all the different standard sets that get at the point I think that Steve is making; I just think that we need to be very clear that being able to exercise that granular type of feedback and guidance is incredibly important to make sure that whatever is rolled out is actually usable in the current world that we live in versus some perfect state that doesn't exist yet. I'm going to cede to Arien.

Alix Goss
Arien, the floor is yours.

Arien Malec
All right, thank you. Two things. First of all, on the original topic of privacy and data use minimization, the recommendations already make this note. I think it would probably be good to put it in the preamble as well,

but if we're worried that we've forgotten the note about minimum necessary and data use minimization, that that is appropriately captured. We should look at and make sure that it is. No. 2 –

Alix Goss
Before you get off to the races, I can't type that fast. Privacy and security by design – I'm talented, but not that talented – by design is a part of our PA principles and recommendations. And so, one of the things I think you're saying is it's so important, let's call this out in the report – call out in preamble and stage-setting in the report.

Arien Malec
Yeah, that's right. I think sometimes, people will not read the recommendation. They'll only read the executive summary, and it's important for things that are as foundational as privacy and security to repeat it in the executive summary so that people who are scanning it go, "Oh, okay, we're not sending the data off to the world," and they'll interpret that anyway, but at least we're reiterating it appropriately.

Alix Goss
Got it, thank you.

Arien Malec
The second piece, just related to the tangent that we were just on, is that the concept of information models is one that we've been at and thinking about for a long time. There's work, for example, that CIMI has done – work that's been done as part of FHIR to create higher-level information models. I generally agree with the concept that information models are a good thing, and also that if we wait until the perfect information models are developed before we get to standardizing ePA, we won't get there, that there's a lot of value in getting ePA information flowing, even if it's not backed by an ontology and an information model that specifies the precise meaning of a clinical encounter, and one of the values of doing that is that we can always improve and iterate it over time in response to the needs on the ground, and also, assuming that we use the right standard, take advantage of additional standardization that is being done, as I said, orthogonally to this concept of ePA.

So, my recommendation with respect to this topic would be that we reiterate that information models are a good thing, that the approach that we've taken to unify standards allows ePA to take advantage of information models, and also that the approach that we've taken with respect to incremental and iterative improvement allows us to not make the perfect the enemy of the good and allows us to make progress toward more robust, ontologically rigid, and specified clinical interoperability.

Alix Goss
Thank you. I'm –

Steven Brown
I think that's entirely reasonable, and we shouldn't just be setting goals for tomorrow, and so, I would agree with what's been said. I've included in the chat some information – if anyone wants to look – about the CIMI work in HL7 with something called analysis normal form that might be informal.

Alix Goss

I guess I'm also looking to take your general reaction and translate that into a – so, you're asking for a guiding principle. Are you asking for an ideal state commitment? Are you proposing a specific recommendation? Because as we're going, we're going to do this body of work very differently than we did our prior authorization deep dives. This is about stepping back and saying we've done a great amount of work with guiding principles, ideal states, and recommendations, so what haven't we talked about? Where do we need to go next?

So, with wanting to craft a report and to work with an editor and get that crafted and get your review feedback – and, that is a collective "your" for the task force – and have it delivered a week in advance, ideally – if we can make it happen, that would be perfect – a week before the October 21st event – we haven't figured out all of our milestones, but we have had our kickoff with the editor, and we do have a timeline. We'll try to figure out our milestone timelines next week. Sheryl, I feel that we need to start asking folks to be very specific, and once they introduce an idea, we would hear "I'd like to see a guiding principle, ideal state, or recommendation," and I think that will help us start to round out our approach. So, Steve, since I didn't make that request to anybody up front, is there any –

Steven Brown
What I'd say is if you're trying to hit the target of record once and reuse, then terminology standards are a necessary evil, and I'm arguing that small information models are also a necessary evil that can be implemented gradually. I keep calling them evil, which is probably not the right thing for a report, but an ongoing capability enhancement in the areas of both terminology standards and information modeling standards to include statement models is going to be necessary for the long haul if you really want to record once and reuse.

Alix Goss
And, that may go back to some of our – so, if I could translate what you're saying, you're saying that our recommendations need to fully address that, and I think that we have some of those things already addressed within our recommendations. I'm actually not hearing you ask for something new, other than that the people that would do the work to do the data mappings and the modeling to maybe span the two ecosystems need to include that.

Steven Brown
It's additional analysis work, not just at the level of terminology mapping, but at the level of small information model development and adoption. So, you can throw it all in the same standard stuff. It's just a slightly different view of the standards that are necessary. That doesn't negate anything that's been said. It's an addition for ongoing work.

Alix Goss
Okay. So, we need to think about the specific ask, or if it's something in an awareness that somebody who does the detailed dive – because we're trying to address what needs to happen and recommend where to go. We're not saying how things are happening, so somebody who picks up some of our recommendations is going to have to take – if HITAC agrees and elects to advance to these to the Office of the National Coordinator, then we're going to – there would likely be work that would happen on the other side, and that's part of that deep dive on that side.

Steven Brown
Absolutely. We're not here to make SNOMED better either or whatever, but we are suggesting that various standards be enhanced, and this is a different type of standard that needs to be on the radar of whoever inherits this mess.

Alix Goss
Got it. I think that helps me understand where you're coming from on that, so, thank you. I think I've captured it, and I also see that Anil's hand is up.

Anil Jain
Yeah, and again, not to negate anything that's been said – I think Steve is right on, but let me give you a slightly different perspective. One of the things that we often see in clinical practice – and, I'm fortunate enough to still practice very part-time – is that we might inadvertently add some burden to the clinical setting if we have to start collecting information in a way that the information models can represent. So, one way we could balance this out because I'd like the maturity process – I think the information models are critical over time to really make the best use of the data for secondary purposes, but perhaps what we ought to do as a recommendation is to say that it ought to be done in stages of priority, and one area we can use as an example would be in infectious disease or emerging pathogens, and simply say that the information models that should be done to align clinical and administrative data for secondary use would be in areas that are a high priority to our society right now.

As opposed to adding burden in all facets of what a primary care doc or a specialist might do with their patients, we should focus on a very narrow sliver so that we can really make a difference in an area where having a better understanding of the data might be more critical, as opposed to having a very general sense of the use of information models. I'm just worried that we're going to add burden to the system that's already overburdened.

Steven Brown
I would never intend that there be any added burden whatsoever, and if any user interface is designed to make people adapt to a different information model than what they've already done rather than just standardizing it, then they've failed miserably. Providers should never see this.

Anil Jain
Yeah, I think you're right, but unfortunately, what we often see is that the burden of standardization on the back end often will impact the front end. Just to give you an example we can all relate to, think of going from ICD-9 to ICD-10. Find one doc that's doesn't think it's a little bit harder with ICD-10 just to figure out exactly what you want to say about a patient. It's better for downstream data, it's better for public health, and it's better for billing, but for the clinicians, it's a little bit harder, and all I'm suggesting is that as long as we recognize that, our recommendation should be that we move toward this direction and give tangible areas where we can introduce the community to build these information models in an area that's going to be important to all of us.

Alix Goss
Thank you. I see no further hands up. I think we had a robust discussion there. I started to capture a bit of a recommendation, and in consideration of our time here today, I want to start to move on to the next area

that we discussed last week, the supporting of care specialties and long-term care delivery data flows. It's along the same lines as a bit of what was discussed, but this is around transitions of care still in the clinical setting, and it's more about exploring how to create a system where data available to providers can be made available to others in the care continuum, and although we have an issue related to tools sometimes where not everybody has the same tools, I'm going to defer that topic for a moment so that we can focus on the information being available to the relevant actor and their workflow downstream so that they can again use it in their various workflow environments and help them with addressing the gaps in care because sometimes, we don't always understand what's needed downstream.

So, one part is to make sure everything gets there, and I want to talk about that part here before we get to not everyone having the same onramps or tools. Any concerns with this recap of a theme that we really have a continuum of data flow consideration that we need to address? And, there are some interesting dynamics when you deal with specialty care or long-term care environments and the porting of the data. Anil, I see your hand up.

Anil Jain
Yeah. I think this is something that we live every single day as clinicians or anyone who gets quality reporting where they get told what the care gaps are and our definition of the care gap versus the plan's definition of a care gap. I'm sure Sheryl would agree with this – every single ACO, every single value-based care contract will have a different set of metrics. Some are gaps in care that we would agree with; some are simply different metrics. And so, I think we have to consider – I think I made a comment a few meetings ago that if there was a way we could somehow share the rules that folks are using to identify these metrics because what might be considered a care gap from the health plan's point of view, who may be measuring these and the patient could be quite confused when I share one set of recommendations and the plan might share another, because all of a sudden, they're both sharing data – we need to understand the different roles that people have within the ecosystem. What is the role of the physician and the clinician, and what is the role of the plan?

The last thing we want to do is have a patient be told that they have a care gap that the clinicians don't agree with, or at least have the opportunity to discuss with their patients, and I think that to have that somehow be brought into the discussion around the intersection of clinical and administrative, we have to recognize the fact that there's not always going to be agreement when you start to match this data on what is a true care gap and what is a quality metric that somehow needs to be satisfied, and how we recommend that come together may simply be that we start to share the rules that are being used to measure, and that harmonization could start pretty quickly. I don't know if that makes sense, but the last thing we want to do is add more confusion for the patient.

Alix Goss
As I'm listening to you, I'm trying to parse out what it is that we can do here. So, it seems to me that there's sort of a general principle about supporting it, but there's this challenge of…

Anil Jain
Well, I think there are two things. The first thing is the recognition that simply by sharing data back and forth between the ecosystem partners, we're not somehow going to have a magical way of identifying care gaps. That's just not going to happen. There are so many different rules that people use. That's the first thing. It

makes it a little easier, but it doesn't remove some of the challenges. The second thing is that we have to keep the patient in the center. What's in the patient's best interest, and how do we take this intersection and give the patient a harmonized understanding of what's happening with their health and healthcare? I do not think that is for us to decide as a committee. I think we need to make sure that various groups understand that they're going to have a new toolset, which is the combined data. How do we now create a harmonized view for the patient so that they're at the center?

Alix Goss
Okay, so you're trying to take this back to existing guiding principles. I agree with you that the patient is at the center and that's part of the by-design foundation, along with privacy and security, that we're trying to build all this stuff on. So, if there's a –

Anil Jain
Well, maybe others who are more artful with the language can figure this out better, but what I'm trying to say here is that we can't lose sight of the fact that all of a sudden, because we got more data and data from two different places, folks can start running metrics on that data without having some unintended consequences where the patient may now be confused. How we say that and how we align that and harmonize it is what I thought this group was going to try to put some guardrails around.

Sheryl Turney
Right. This is Sheryl, and I would like to just – I understand where you're going with this, Anil, and I do think that there is the recommendation that you had, which is to focus on the rules for the care gaps versus sharing the gaps themselves, and by communicating the rules for the care gap, we would potentially be more helpful to the clinicians. I'm trying to measure this against a few examples. Someone has come out of the hospital, and they haven't had a follow-up appointment in 30 days with their clinician. To us, that would be a care gap that we would send to our PCP and say, "They should come in and see you because they've been out of the hospital for 30 days and don't have any follow-up care" or "We received a prescription, so we're sharing this information back to you because you can then reconcile with a prescription that you ordered for this patient."

Anil Jain
Sheryl, I think –

Sheryl Turney
Suffice it to say that care gaps come from multiple places. Some are related to **[inaudible] [01:01:54]** needed, some are related to quality, which you mentioned already, and some are kind of legislative. I know in some HIEs that are state-mandated, some of the quality measures are provided to us, not things that anyone is choosing to follow, so there are all those things. So, reconciling how we handle all of that, you're saying that just because we have the information available doesn't mean it's going to be easier for the patient. It could actually make more burden.

Anil Jain
Well, the patient may not have more burden, they may just me more confused. I'll give you a perfect example. It happens today already, but it happens in a more limited way because the clinical data – one side may not have it fully, but let's take something like colon cancer screening. If I had a patient who had

chronic conditions which meant that a colonoscopy by a gastroenterologist might be risky, the last thing I would want to do is send that person for a colonoscopy, but it's quite possible that the person might end up getting a note from their plan saying, "Hey, you need to go get a colonoscopy." I think there are ways we can get around this, but my only point is that all of a sudden, there's going to be more data out there and more opportunity to be misaligned with the way the health plan might see the care of a patient or a member and the way a doc might see the care of their patient, and what we ought to do is recognize is that we have potential for great harm, and that we ought to be working at closing that gap that's going to exist. We see it today in a limited way, but when you have more data, it's going to be worse.

Alix Goss
Thank you, Sheryl, because I think that really helped me further wrap my arms around what Anil was saying, and I think part of my challenge here is that this could include addressing gaps in care was an example that was brought up. The main category here was around the data flow for the care specialty continuum or long-term care more in the transition so that you would – I would hope that in the situation you explained, if my PCP is doing preventative care maintenance and they send me a reminder while I'm in rehab that I need a colonoscopy, I see it, and I look at my rehab doctor and say, "Hey, I'm supposed to be getting a colonoscopy," that there would have – what would have really happened is that there would already have been communication because my primary care and the situation of being in rehab – because I may have just had knee surgery or am recovering from a fall – that there would have been care coordination there so that the rehab would say, "No, she can't have one of those, she's on blah blah blah right now, she has to wait," and that that would never have come into my sphere of awareness from the backdrop conversation other than my interaction to be able to say, "Hey, somebody made me aware of this."

I could then say to my rehab doc that I was made aware of it, and the rehab doc would say, "Yeah, we've clarified. You're good to go for right now. We're going to let you just continue do what you're doing, no colonoscopy for you right now," and leave it at that unless I ask more questions.

Anil Jain
Yeah, in an ideal situation, if the "rules" for how you're identifying all those needed services and all those gaps in care were known to both parties at the same time, absolutely. In an ideal situation, it could be right, but in a nonideal situation, the patient could be left wondering, "Do I go with what my doc is telling me or with what my health plan is telling me?" And so, all I'm suggesting is that we try to find ways to start – just like what Steve was saying about the information model for how observations are made, we need to start thinking about how we're going to exchange the information about how one is determining what needs to be present at a transition of care or what determines a "care gap" because we would all have different opinions about what a care gap might be for different types of patients and get the community at large to start to think about how we move closer to that so that we're exchanging these knowledge nuggets that can help us identify these care gaps so we're all on the same page and the patient is not being given two different answers by two different siloed folks, if you will. Does that make any sense?

Alix Goss
So much more.

Sheryl Turney
Yeah, I think it does.

Alix Goss
Yeah, it really did help me get my arms around that better. Thank you. Are there other comments on that topic? I'm not seeing any raised, Sheryl, but I just want to do a shout-out in case I missed something.

Sheryl Turney
Yeah, I don't see any either.

Alix Goss
Okay. So, let's tackle another one before we go to public comment in just four short minutes. So, haves and have-nots onramps. So, there are these haves and have-nots in the world – folks who have technology stacks and resources to help them with those technology tools in the toolbox and who are all at different levels of maturity, and it needs to be possible to integrate data at the individual patient level. So, we've discussed this in a variety of ways already with prior authorization, but it merged last week, and it'll be important to start identifying system needs for common interactions and then expand to develop a base template with an idea towards it being reusable and extensible that not everyone is on FHIR yet, but moving in that direction by common conceptual frameworks moves us in that direction, and that incentivizes somehow – if we have incentives, they'll move us through a stepwise approach. I'm not seeing any hands up. I'm hoping that made sense to everybody, and that's what the silence means.

I'm going to introduce the last topic that we discussed last week, which is USCDI administrative data – what are the USCDI data concepts and elements that need to reflect – I'm sorry, I'm not that we wrote this sentence very well. So, I think it should ask what concepts and elements have to be reflected in USCDI – that's what we were trying to get at – and we need a review of current administrative transactions and associated value/code sets to ensure USCDI supports downstream and clinical/administrative functions, so to me, this becomes a recommendation that we need to have created and bolster out what we already have in prior authorization. I think that's what we were hearing last week.

Sheryl Turney
Yeah, I believe that's what we heard. I don't know. I don't see any hands raised.

Alix Goss
Okay. Well, I'm not going to start the next new topics because I believe we are seconds away from going into public comment, if I remember the timeline correctly. Oh, it's 4:20, so I have five more minutes. I apologize for not remembering correctly. So, let's go ahead and introduce the next topic, which actually gets into – I'm going to skip over price transparency for a minute because you got a nice teaser and setup for that from Sheryl, so I'm going to set up the synthetic data and testing aspect.

One of the things that we have discussed extensively is the piloting and certification aspect, and so, one of the things that we wanted to talk about was the idea of the fact that historically, we've not had testing or the synthetic data to support a testing ecosystem in the administrative side of the house, so we struggle mightily when, at NCVHS, we receive a request to upgrade a standard vocabulary or a transaction standard, and we always want to find quantitative and qualitative information to pass along to our federal colleagues to support the regulatory impact analysis and cost estimations that they have to create to justify – I'm sorry,

they have to create to fulfill the **[inaudible] [01:11:23]** Act and to help justify the reason why the rule should move forward.

So, we have some tools in the ecosystem – as examples, there are Synthea and the Aegis testing mechanism where we have synthetic data – but thinking there might need to be a recommendation to have an ecosystem with built-in players, synthetic data, and testers to make sure all this stuff really works. So, that would be a topic that I'd like to hear back from folks about, and maybe we could do a couple minutes' round robin on that before we go to public comment at 4:20.

So, Ram sent us a note in the chat box. "What is the process you will have in place for verification and validation?" I think that's a part of testing something before it gets advanced, and there's another part of verification and validation. Are you looking for compliance after the fact, Ram? Ram, can you come on audio with us? I know you're typing in the chat box, but would you like to…? We don't know that he's on audio today. Sorry, he's just on – I apologize that we can't have that interaction because that would be fabulous to have. He's not able to connect video/audio. Please send us some additional thoughts or weigh in on this when we are able to merge some more robust contact into our Google doc. Are there thoughts from anyone else? I see that Ram's typing, but I want to see if there are any other hands raised – there aren't. I'm inferring that this is either not of interest, it's straightforward and you agree with it, or you're all multitasking.

Sheryl Turney
Okay, I'm not multitasking. I would have to say that synthetic data and testing – I can only liken it to what we've done with trying to do the testing with some of the pilots – not really the testing, but I guess I'm thinking about the pilots. With the Da Vinci testing, obviously, there's really more focus on passing back and forth the connections and the capability rather than the actual data itself, so I can't say that I know enough about what the requirements are for the creation of this synthetic testing. I know that trying to use synthetic data organizational-wise has been a difficult challenge, quite honestly, because of all the connections where you have to have some providers with networks and others without, and then you have to have members who are assigned to different products, so they have to be valid products. So, all of the different connections make synthetic testing a challenge. I guess that's all I can say from a health plan perspective. I don't know about a provider perspective.

Alix Goss
Okay, I think we're ready to turn it over to Lauren at this point, if she'd like to go ahead and… I see Ram has now raised his hand, so I think he may have gotten on audio. We'll come back to you after public comment, Ram.

Public Comment (01:15:40)

Lauren Richie
Okay. Thanks, Alix. Operator, please open the line.

Operator
Thank you. If you would like to make a public comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 if you would like to remove your

line from the queue, and for participants using speaker equipment, it may be necessary to pick up your handset before pressing *. We will pause for one moment. There are no comments at this time.

Alix Goss
Thank you.

Lauren Richie
Thanks.

Alix Goss
Ram, are you on audio now? He is not, okay. I see his hand raised, so I'm a little challenged in understanding if he's going to send us a chat message or…

Lauren Richie
It doesn't look like he's on audio.

Alix Goss
The support team has confirmed that in the chat box to me.

Ram Sriram
For some reason – can you hear me?

Alix Goss
Hi, Ram.

Ram Sriram
Yeah, I'm sorry. For some reason, I can't speak through the WebEx system, so I had to dial in. So, my comment is kind of generic in a way because once we have this whole ecosystem, we should also have a mechanism or a protocol for testing it – test protocols, samples, some use cases, and those kinds of things. How do you test the whole thing? So, we need to have some kind of mechanism for that. For example, in EHR, for meaningful use, we have some tests – we test them before anyone can buy the EHR. Similarly, do we have some kind of a strategy here? That's the question.

Alix Goss
I think that's what we're looking to craft to identify what it is that we think we need to thoughtfully recommend an ecosystem in the future that can meet our testing needs, so it's a blank slate.

Ram Sriram
I was just wondering if anyone has any ideas in terms of the testing process that's involved, so that's why. Otherwise, I will think about something.

Alix Goss
Yeah, because I think there's also not only just – so, what is really needed to look at – especially if we're going to start to bring together the administrative and clinical data – we're doing some Connectathons and testing, such as Sheryl discussed, but if we want to design something that has clinical administrative, you're

right, we need to have an ecosystem, an end-to-end testing mechanism, and a platform, but I think it's also going to take an investment of money and an investment of somebody to own it in the feds and to help move it along, and this might be something where we say what we'd like to have, but we don't necessarily say how it has to happen, and I suspect Jocelyn has a suggestion because I just saw her hand raised.

Ram Sriram
Okay, thank you.

Jocelyn Keegan
I was just going to share a little bit of perspective from the trenches, and I think what we're seeing are a number of commercial opportunities where folks are really seeing themselves playing that role of being the place – the sandboxes where people can come and validate and test, both from the testing tool vendors and from both for-profit and nonprofit entities, so it might be worth understanding what's happening out in the market. For instance, I know we work closely with MiHIN, a deployment member of Da Vinci. They joined specifically to help us get our implementation guides up to scale, and they've got text beds, sandboxes, and synthetic data, which are part of the solutions they're offering to implementers. And then, we have folks like what used to be HSP. It's Logica now.

Alix Goss
HSPC.

Jocelyn Keegan
HSPCA, I think, is what it was before. And, they're providing free sandboxes for folks to come implement and get up and running with FHIR resources, but fewer services available for that free service, and so, organizations like what we're doing with Da Vinci – we come with our test data and essentially work with Logica to use their sandboxes, and we bring the data that go along with the implementation tests for building, and I think other accelerators are doing similar work like that.

I think there is a need to really understand and look at what the base minimum set of test data across these data sets and these standards needs to be and who needs to fund that and make sure it's available because I think that's the point above this – this idea of being unequal access depending on how much capital someone needs to bring to this type of innovation work is incredibly important, and so, being able to meet people with the right tool at the right place for their available technology capabilities is incredibly important, and the free market will supply some of that solution, but there needs to be some sort of floor, and I believe the feds need to help us create it.

Alix Goss
So, what I hear you talk about are the attributes of this recommendation, and what I'm hearing is we don't necessarily need all of our tax dollars to go do this, but somebody has to get the wheel cranking, and the feds could possibly help us do that. We have the chapel environment, we have the certified product environment, they've come up with ways to have the marketplace jump into the mix of that, but still have that oversight to make sure that we're staying on the path that was intended in the beginning and orchestrating some of those resources and tying up the pieces together. So, did I synthesize that?

Jocelyn Keegan

Yeah, I think so, and Alix, I think it's probably also worth calling out that there is a discussion – at least, on the FHIR side of the world – around this entire topic in the ONC staff group, and so, there are folks looking at this for FHIR, but I think that our vector is really where the three worlds or four worlds collide around administrative data and clinical data, and I do think that any one of us that implements understand the licensing challenges around just getting some minimal datasets allowed to be available for folks to test create. It's not impossible, but it does create burden and time and coordination effort to make the more proprietary data sets available for folks that are actually trying to do early adoption and implementation of where these roads are starting to dive together.

Alix Goss
Yeah, I have some thoughts about the things that we did in evaluating 6020. The Division of National Standards actually put a big contract out there for at least one organization, maybe multiples – I can't remember, I think it was just one – to take a look at doing the testing and evaluation so we could get that ROI assessment done beforehand, and I don't think it turned out quite the way everyone thought it might, but that is a tale for another day to explore because Sheryl, I believe you're up to talk about next steps – or is that me today? Okay, it is me today.

Next Steps (01:24:04)

So, I mentioned earlier that we had hired – ONC had retained an editor to assist us. We are needing to get that person up to speed in parallel to our task force efforts. We have the Google document that has a number of items in it, and we've been working our way through comments. A shout-out to Arien, who may have already dropped, and Rich Landen for any hanging portions of your recommendations work. There was purple text –

Arien Malec
I'm aware.

Alix Goss
Okay, thank you, and I'm hoping that maybe we can get you to look at that so we can figure out if there's anything you want to bring back for us to discuss to wrap up some of the prior authorization work. That would be great because we're also going to be figuring out the next steps with the Google doc and starting to take the work we're having here in the broader intersection and merge that into that. So, we want to make sure we wrap up the recommendations work and also the rest of the comments, so we're hoping to do some of that work on our call, and then to consider our discussion, so we probably need to finish up this synthetic discussion, and then, we'll need to discuss the transparency aspect as well.

So, we encourage everyone – not encourage, we ask all of our task force members to go in and review the content that's out there so far for prior authorization synthesis work so we can get that cleaned up and buttoned down a bit as we start to move into needing to craft the next set of contents so that we can actually have a comprehensive draft report. Sheryl, do you have any parting words?

Sheryl Turney
Thank you, Alix. Yes, if you could please make a comment by the end of the day on Friday, that would be very helpful so that Alix and I have a few days, and we're meeting with the editor next week, so it's very important that we get the rest of your comments on the existing draft this week. Thank you.

Alix Goss
That's a refined point there. Thank you, Sheryl. With that said, have a great rest of your day. Thanks for participating and listening in on our task force efforts. Take care, everybody. Lauren?

Lauren Richie
Thanks, everyone. Bye-bye.

Steven Brown
All right, bye-bye.

Sheryl Turney
Thank you.

Adjourn (01:26:42)