



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 22, 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 our ICAD Task Force meeting. Of our members, we have Sheryl Turney, Alix Goss, Alexis Snyder, Denise Webb, Gus Geraci, Jim Jirjis, Ram Sriram, Rich Landen, Sasha TerMaat, and Tom Mason. I thought I heard Jocelyn. Are you on as well?

Jocelyn Keegan

I am here.

Lauren Richie

Perfect. I think Anil Jain is going to be joining us a little late, and that's all I have. Are there any more members on the phone?

Alix Goss

Mary Greene just chatted in the box that she has joined us today.

Lauren Richie

Perfect. Welcome, Mary. Okay, with that, I'll turn it over to Alix and Sheryl to get us started.

Summary and Action Plan (00:00:52)

Alix Goss

Fantastic. I believe that we can go to the next slide because I'm going to cover a bit of our summary and action plan for today, followed by some discussion around the broader intersection discussion and review some comments on our synthesized prior authorization work, so Sheryl and I are going to be tag-teaming today, as we're going to be fairly fluid as we move through a number of working documents. I'll be displaying and capturing notes as we go.

So, first things first, let's go ahead and set some context from last week's meeting. We discussed two major items last week. The first one was Sheryl's overview and recap of our presentation to the HITAC itself. We delivered an overview of our recommendations, building on our prior work to talk about guiding principles. We also had a good amount of positive feedback and a couple suggestions from our HITAC members, as well as the public, who commented at the conclusion of the event, so we were able to bring back that feedback and give an update at our last meeting before we moved into the broader intersection discussion.

As you may recall, we have been working on pivoting from our prior authorization exemplar to the larger conversation of how we intersect clinical and administrative data, and we want to really figure out what are the areas that we haven't yet tackled and need to incorporate and address as part of our overarching work product, which is the report that we will deliver to the HITAC federal advisory committee.





And so, there were a handful of issues that we tackled last week, and we had initially discussed this opportunity area on September 8th, and then we synthesized that into a themes document, which we presented last week and started to get validation on that body of work, as well as capture additional thoughts and considerations. And so, today, we're going to continue building on that work, jumping into synthetic testing data needs and price transparency and calling for some additional concepts areas that folks think we need to tackle. As we know, we have a very clear trajectory, which is to deliver a report to HITAC on October 21st.

So, that provides an overview of what we covered at the last meeting. Are there any questions on that? If anyone is not speaking, we encourage you to put yourself on mute. I'm getting a little bit of background noise. Hopefully that's not distracting to others on the call. So, without seeing any hands raised at this point, Sheryl, I think I'm going to move on to our first discussion area today. Can we go to the next slide?

Broader Intersection of Clinical and Administrative Data (00:04:32)

Alix Goss

We're going to dive into the broader intersection of clinical and administrative data themes and that working document, so I believe that we will now transition to a document that I have queued up, and I'm going to level-set a little bit about our approach, and hopefully, folks are able to see my screen, where I'm indicating that our approach today will be to build on our prior discussion results. We want to continue the discussion around synthetic testing data needs. We want to have a conversation around price transparency, as well as call for additional concept areas.

We have been capturing notes along the way. First, we've been recapping themes, and then we've been honing those themes to identify if there are guiding principles, ideal state impacts, or specific recommendations that we may want to capture. We understand that as we are advancing the synthesized content from the prior authorization exemplar, we have introduced an editor into the mix, and so, that editor has come on board. Her name is Susan, and Sheryl and I, along with ONC staff, have been working with her to get her oriented and up to speed. We met for several hours last night, walking through the document, so we'll be talking a little bit more about that body of work in our next agenda item.

But, what we also know in parallel to that editor work is that we need to transform our themes discussion around the broader intersection topic so that we can get that body of work woven into this new report that we're going to be generating. So, I just wanted to give you guys a little bit of context that Michael Wittie, who is a lead staff member to the task force, is going to help us with synthesizing the notes that I've been capturing during these calls so that we can then get some content merged into the overarching report. Any questions there about a little bit of the big picture that I've tried to paint? I'm not seeing any hands up, so I'm going to move along.

Please don't get dizzy. I'm going to skip us down to the part that we haven't talked about yet, which is these new topic areas. So, what I want to do is start with the synthetic data and testing conversation. During our last call, we talked about the – built on our prior discussions of this testing and concept that we know is important and that we need to make sure we're having pilots and testing efforts as we advance standards for adoption, but we took another lens at that from the idea of the synthetic data that might be needed in that testing environment, talked about an example, like Synthea, which is an industry effort to build synthetic





testing data, and also, we have a similar approach that we've noted from Aegis in that they've got testing mechanisms that are used heavily within the HL7 Connectathon environment.

We wanted to talk about whether we needed to include a recommendation related to this synthetic data, but also the built-in players and testers to make sure that everything works correctly, so we talked a little bit about testing protocols and use cases, and really trying to look at the holistic, end-to-end testing mechanisms that might be needed, recognizing that there's a commercial market in all of this that we might need to think about, and it wasn't necessarily that the feds needed to provide this as an ecosystem, but maybe needed to enable the marketplace to have a new approach to how we would really advance testing and piloting using some synthetic data, and we sort of left it off at that point, with FAST, the FHIR At Scale Task Force, specifically looking at the testing and piloting arena, but they're not specifically focused on administrative and clinical areas. So, we needed to continue the discussion for ourselves to see if there was something we felt was going to be needed, either as a guiding principle or a recommendation, for the broader intersection discussion. With that set up, I'm going to pause and ask for comments and questions.

Sheryl Turney

Alix, I think this is an important recommendation, and I think it really should be part of our guiding principles that whatever ecosystem is put in place, app developers have the ability to test against a synthetic database because already, as we're looking at interoperability from a payer perspective, we're getting approached by third parties who are looking for test accounts to be set up, and it's very time-consuming and also, I think, somewhat risky to have various participants in the ecosystem try to create data because you need that data – when we're talking about health data, you need that data to be set up where if there's a network, it has to be established if that is in-network versus out-of-network because with any type of thing that you're looking at that's going to have to deal with cost, you're going to have to deal with some of these things, so there are so many interrelationships that may not be present in other types of environments.

I think the need to have an ecosystem with a synthetic test data bed that allows apps and partners to go in and test against it without every participant having to create their own data is going to provide a better environment for more consistency and greater capabilities that they're going to be able to see and model with any testing and pilots, and I think it's going to make it a much more robust experience because what we're finding now, even with trying to implement the interoperability rules, is that things are only tested to a certain degree, and now, as we're all trying to go to the next degree, there are a lot of things being discovered.

So, if there is that capability to have some sort of synthetic test bed in the environment that's available to all the participants, I think it makes for a much cleaner, smoother, and hopefully much more rapid capability for adoption when you have a test bed there that you can already use. I don't know what other people think about that, but I see that as really part of the ideal state as well as the recommendation because it currently doesn't exist. I'm not seeing any hands raised right now, but I think we need other task force members to weigh in on this.

Ram Sriram

This is Ram here. I agree with you totally.

Alix Goss





All right, it looks like we have –

Lauren Richie

Sorry, we do have one hand from Alexis.

Alexis Snyder

I was just going to say that I totally agree too because trying to get a test, like you say, on the payer end – providers calling in, trying to push a test to see what the potential outcome is going to be – is really difficult, and if that was already embedded on all levels for all of the actors, then I think it makes a big difference, and I agree that it's an ideal state as well as a recommendation.

Alix Goss

So, it really has to be woven into all three of them. Thank you, Alexis, for clarifying that. I think we have other hands up.

Sheryl Turney

Yeah, there are. Denise has her hand up.

Denise Webb

I just wanted to say that I think this makes total sense. I agree.

Sheryl Turney

Okay, and then, we also have Rich with his hand up.

Rich Landen

Yeah, thank you. I think in this day and age, we've learned our lesson, and we know that we're really doing national standards. We really need some national test beds, so the idea of coming up with common test data as a public service rather than having individual industry actors create their own limited test data beds is a common service. We should have a national approach to this, so I'm agreeing that Sheryl's points are important to include.

Alix Goss

Thank you. It sounds like we've got a lot of support for this. I'm not seeing any other hands up, Sheryl, so what I feel like is that we need – we're agreeing to an ecosystem test bed, and we agree that there's a guiding principle aspect and there has to be a way to capture this in an ideal state perspective, so I think we need to craft a specific recommendation, and so, I think the recommendation – if I heard correctly, Rich mentioned a national approach. I'm seeing Alexis agreeing with that in the chat box, so I'm thinking that's the recommendation. So, the guiding principle would be to have the test bed, and the recommendation would be to create a national approach.

Sheryl Turney

Yeah, I agree with that, Alix. This is Sheryl. Do you want someone to write out a recommendation?

Alix Goss





Yeah. I think what I want to do is – I know we have Michael Wittie of ONC staff who's willing to take these notes and synthesize them into something that we can put into this new report format structure that Susan, the editor, is creating for us, so I'm going to hold off on asking for a member volunteer on that, especially knowing that in our wrap-up today, you're going to talk about the upcoming presentation summaries, so let's hold off on that direct ask today.

Sheryl Turney

Thank you.

Alix Goss

You're welcome. We got a pretty straightforward kumbaya on that one. I'm going to scroll back up, and what I would like to do is to pivot to the next discussion topic, which we identified last week – gosh, that was just a week ago – which is the link to price transparency, and this is a really big issue for the patient, whether it's a prior authorization situation where they're going for approval before they have a procedure or in the case of a retrospective authorization that often occurs in a lab situation.

We didn't really get to introduce this topic last week, so **[inaudible] [00:16:59]** in addition to this dynamic of pre-event or post-event authorization consideration, there's also the breadth of costs that needs to be considered in that if you're going to something more – if you're going to have a colonoscopy, you may run into a situation where, if you have a biopsy done during the test, you may come out the other side of that procedure thinking that it's a preventative service and it's all good to go, but then you find out that the coverage requirement or coverage dynamics may not have included that pathology test, so you may be incurring out-of-pocket coverage. That's just an example.

Another example was the dynamic where you have multiple providers involved in rendering a service, and you might have different coverage rules that you don't always know, and I think the classic example is your anesthesiologist is out of network, though your surgeon is in network. Another example of the price transparency challenges that we've heard about is that the coverage is verified, but the facility billing unit causes a different portion of your coverage to be engaged. For instance, you may think you're in an ambulatory setting for a test, but it is billed as a facility setting, which can then trigger a different deductible category.

And so, these are four examples of challenges with price transparencies in the marketplace, and so, I wanted to throw this out there to cause us to have a discussion around – in the intersection opportunity where clinical and administrative data are going to become much more integrated, how do we support the price transparency objectives, what are those things we want to speak to in our report, and how do we tackle some of these issues or examples that I've just showcased?

Sheryl Turney

So, there is one person with their hand raised, but I did want to add to this, Alix, because the challenge we got from the HITAC member was "I want to be able to shop my services just like I would shop for a blouse on eBay." So, regardless of whether it's a prior authorization or not or a contracted provider or not, I should be able to see what that price is, and go out, and shop and choose the provider that I want who will either do it for that price or a lesser price. We've all said that's kind of a challenge with the way healthcare currently operates, but if that's what the vision and goal are for some people – and, that's good; it's generating more





hands being raised – then how would we make that happen, is there a possibility to make that happen, or is it desirable to make that happen?

I think the question we need to ask is if we foresee in the future that with the intersection of clinical and administrative data being brought together, will we actually be able to create an ecosystem where people can shop for their services regardless of the networks that they're in? That's one of the challenges that's been given to us. With that question out there, I don't know if people would have sufficient data, but it would mean that a physician who has to perform a service would have to be able to say for a typical provider of that service, you're going to go in and have XYZ done, you will need a facility, an anesthesiologist, and a pathologist, so you're going to get all these bills.

Quite honestly, the way things operate today – I just had two surgeries this year. I didn't get the total list of things that were going to be needed in either one, and none of them were surprises. No one told me about the lab, no one told me about the pathology that was going to be needed, and they told me those are done every single time. So, if that's the case and that's what always happens, then why wasn't it presented up front? So, there's that challenge that we have to deal with in addition to what the price that they're shopping includes. So, with that as the setup between Alix and me, I see we've got at least three hands raised, and Rich was first.

Rich Landen

Sorry, I had to get off of mute. I think it's an issue, and I'm not sure the solution is within us, but I think the approach that's in my head is something simpler that's patient-oriented. It essentially says if there's a network involved – in other words, if part of the process involves a payer's network, or even a provider's network – then the patient should have a safe harbor or a hold-harmless, and the onus of ensuring that all the adjutant services – anesthesiologist, pathologies – are within the network would fall on a primary actor, be that the health plan or some other owner of the initial key step. So, in other words, assuming a health plan is responsible – the patient wants a surgery, goes to the surgeon or the hospital as the first step – as long as that provider is in network and is coordinating the care and responsible for the care, then it is really between the health plan and that initial provider to ensure that all other in-network services are available, and if not, the financial burden then rests on the contract between the health plan and that initial provider, not with the patient. That may be a bit radical, but...

Alix Goss

Hey, we are here to make a difference, so let's push the envelope, folks. So, I think the next one in the queue is Alexis. Is that right, Sheryl?

Sheryl Turney

Yes, Alexis.

Alix Goss

Alexis, are you on mute? Maybe she took her hand down.

Alexis Snyder

No, I'm here. Can you hear me now? I wasn't on mute.





Alix Goss

I can hear you now.

Alexis Snyder

How strange! I have to switch back to where I had my notes now on my phone. So, I was starting to say that that made one of the biggest points on the list. I've been jotting down notes while listening because all of the examples were perfect and then some, and the overall piece that I would give – and, I love whoever at HITAC said the thing about shopping for a blouse because the example that I always like to use is that the healthcare industry is pretty much the only industry where the buyer – in this case, the patient – goes in unknowingly and is charged unknowingly for pieces. So, you would never walk into, say, a card store, pick a card up off the shelf, and then not know the price of it, and even if you are told the price of it, nobody would say, "Oh, that costs \$2.00," and then you expect to hand over \$2.00, and then they charge you \$5.00, and you say, "You just told me it was \$2.00." "Oh, that's because there's a bag fee, a printer fee, a receipt fee, and a facility charge for the facility where the card was printed, et cetera." You get my point.

So, there are so many hidden pieces, and it's not fair – it's not fair to the patient in the end at all – and I think it goes back to our transparency guiding principle. It's a huge piece of being transparent, whether it's prior authorization or not, because sometimes, the prior authorization is a little bit clearer because you're getting that ahead of time, but again, there are lots of hidden pieces in there that you're not aware of at all, such as facility charges. As Sheryl mentioned, you can go in for a surgery and think it's going to cost you – you have your deductible, your coinsurance, and you're done, and then, lo and behold, you get a bill with things that say "ancillary services." You call up and say, "What was that?" "Oh, that's because a nurse came in and put a bandage on your back," and another \$400.00 later, you have an ancillary services charge.

I definitely agree with the pieces you spoke about where some providers were covered, but not everyone in the room, and I wholeheartedly agree with what was just said about how this needs to start with the payer being very clear and transparent. It goes back to embedding the testing piece that we talked about earlier, and even if it's transparent up front, there's a way to still test it to make sure that everyone's on the same page, it's clear in writing, and we know what's going to happen. When something goes differently and goes astray, it's sort of a contract now. "This is what the patient was told, this is what they should have to pay, and no more." If you make a mistake, then that's between the payer and the providers.

That's huge, and I'm not sure how we fix it either, but there needs to be an intersection of this testing embedded and an easier way to get that data. Now, many payers are easily providing access to looking up how much your prescription costs ahead of time and how much it costs at various places, whether you go to CVS, you get it at the hospital, or you get it through mail service. Most of those are getting much clearer and more transparent, so it would seem that that same type of technology should be embedded into the EHR systems and the patient portals, et cetera to work the same way now. There's no reason why you should go into anything without knowing exactly how much it's going to cost.

The last thing I'll say about that is that even those pieces – and again, this comes from the payer side, I think, in how you deliver the information electronically to the patient and to the provider – because we don't have national healthcare and there are many different contracts out there between providers and health facilities, it's different for everybody. So, again, that's where it becomes really unclear and looks to that testing because breaking it down for just the individual patient is a huge job depending upon whether you





have an HMO, a PPO, what your deductible is, how much of it you met, how much the coinsurance is, how much of it you maximally paid out of pocket or not out of pocket, if your family met some of it for you – it's almost impossible, so there's a lot of work to be done there. I don't know if that's helpful, but I gave you a lot more examples of the problem.

Alix Goss

Well, thank you for that. I'm going to – I've tried to capture the notes, and hopefully, I've gotten the key themes. If I've gotten that okay, I'm going to move on to the next in the queue, Alexis, and I think that's Gus.

Gaspere C. Geraci

Thank you. Can you all hear me?

Alix Goss

Yes, I can.

Gaspere C. Geraci

Okay. So, all of the comments to date are absolutely correct. I've been in these kinds of discussions multiple times over the years, and I want to pull us back a little bit to say that our primary charge is to facilitate prior auth, and I support the idea of having transparency as a goal, but I think it would be very difficult to implement, and I don't want that implementation to become a barrier to smoothing prior auth.

Having said that, there is a difference between this and going to the store and buying a blouse or card. Nobody insures you for those services, and you don't sign a contract – which very few people read – that says that you basically agree to the terms of the insurance company that you sign with. So, there is a third party involved, and transparency has to be a very delicate dance between the provider, who, if they're a hospital – and, this is a true example – a hospital provides an echocardiogram for \$2,000.00 which is read by the same cardiology group that does them privately in their office for \$400.00, and they are both par with the insurance company involved. So, you can go to the hospital because your doctor works for the hospital and says, "Go to the hospital to get this echo," for which you're charged \$2,000.00, or you can go to the private cardiology office and get it done for \$400.00, and the same group of cardiologist reads them, so there's not an issue of quality here. But, that's one example.

So, your copay under Medicare going to get it at the hospital would be what it would cost you to get it at the cardiology office, and it depends on who's sending you. So, the provider sending you to the hospital has a vested interest because they're paid by the hospital to take care of patients. The private cardiology group is not. So, those are some of the complexities, and I agree with the goals, but I just caution that as a statement, I think what we need to do is say something along the lines of "Transparency should be a goal in this," but I think to make anything stronger than that may be a real challenge because as has already been said – Alexis, you said it – who is responsible? Is it on the provider or the insurer to say, "This is how much this costs you?"

What if everybody's approved and Dr. Jones, the participating anesthesiologist, is signed on to do the case, he's late, and the case is on the table and they pull in Dr. Smith, who does not participate in that insurance company? And, that happens. So, that's the kind of stuff that is – who's responsible for that? Not the





insurance company. Maybe the provider. That's the challenge, and I would be cautious about saying anything much stronger than a recommendation to continue price transparency. Thank you.

Alix Goss

Thanks, Gus. Jocelyn?

Jocelyn Keegan

Can you hear me?

Alix Goss

I can.

Jocelyn Keegan

I love this conversation, and I think it's such an incredibly important conversation, and I think some of the insights in the text box – how many people are going to actually price-shop in reality if given this opportunity? – and I think that if we look at it from a pure, humanistic approach, price-shopping is a luxury for some people and a necessity for others between being able to get a service or not, so I think the onus is on us to improve this for U.S. healthcare, but I very much echo Gus's – I don't want to say "concern," but his point that at this point in time, we're really focused on PA, getting this report across the ground, and figuring out how this whole set of recommendations and macro process of making recommendations is going to work, but I do think that as a concept, price transparency is something that would be well served to be looked at at this ICAD level because there are so many factors that feed into it.

So, I can speak briefly to what we've been doing in Da Vinci. Patient cost transparency has been a use case for us – really, for over two years now – and as folks know, there are political and legal policy issues wrangling around on this topic out in the industry, but we continue to see a lot of support from the membership and the FHIR community in general about spending time here, and I would say there are a couple themes that have come out of the early discovery work that we did. I think there are so many people spending time on this topic – we're actually leaning heavily on the folks from the American College of Surgeons with the work they're doing out of Brandeis and with PACES, and if we're going to dive into this topic, it would be good to get a briefing from that group about the research they've been doing. I don't think it's the end-all, be-all, but I think a lot of man-hours have been invested in this.

The key is really getting to patient-specific information, which is one of the major challenges around many of these workflows that we see today. It's not about which plan, it's about a particular patient at a particular point in time in a plan year in a specific location, and what we've seen is – I think we can all make the references to retail shopping, but there are a number of things in our lives that have unknowns in them. If you think about what happens when you undertake a home renovation project, build a new house, buy a new car, or go shopping for a pair of eyeglasses – things that aren't covered by your health insurance, the extra stuff that shows up on your hotel bills, your ticketing when you buy a flight someplace, or when you get in a taxi in an unfamiliar town or city.

We're not special and different, but I think because we're talking about people's healthcare, it's incredibly sensitive and important that we solve the problem, but what we see when we're looking at this is there's essentially an equation when we're looking at it from the patient's perspective. What is the payer willing to





pay, and what is the provider willing to pay? And, in a very simplified view because I think Alexis did a great job of talking about what happens in reality when the service is actually provided and extras get added in, but even getting to price and cost up front before you choose where you're going to do, what we found was there's really a continuum.

If you think about it as a funnel, when you're initially investigating something and you have lots of unknowns – you don't know where the site of service is going to be or what the exact diagnosis is – there's more variability and less precision to what that answer is going to be, and you might be able to offer more of a range to a patient.

The more you know about exactly what needs to be done for the patient, especially when we talk about bundled-service types of offerings, that you can get some more precision in that location and coverage, and plan design – what actual plan somebody's on, especially if it's a high-deductible plan – becomes more critically important to really understand at the location level what the provider side of the equation looks like – which doc is actually laying hands upon the patient, what types of nursing care they're going to get – so, really, exposing that in a way that's got some level of confidence, there's really an opportunity to look at categories of services and, just like we're talking about with prior authorization, look at places where you could create more consistency, more known information for more straightforward binary types of services, and when you get into things more complex that would require more coordination and standardization, not just of the data transport, but of the actual events and the activities themselves. So, I think it's a big, hairy ball that we need to tackle, but I do think it deserves and merits its own discovery process, like what we've done with prior authorization. That was a little bit long; I apologize.

Alix Goss

Jocelyn, I want to synthesize that down to point back to what I copied out of the chat box, which was that you think we should set up a recommendation for HITAC to take a look at this as an exemplar unto itself on patient cost transparency and stop short of going any further than that.

Jocelyn Keegan

Yeah, and I think that that is the recommendation that we need to make, and not to put too fine a point on it, I think it's a critical pairing to the work that we're doing with the first exemplar and the goal of bringing these two worlds together.

Alix Goss

Okay. I hope I captured that right. Thank you for those insights. Anil, I see your hand up.

Anil K. Jain

Okay, great. I apologize because this may have been covered. I missed the first 25 minutes or so. But, I think when you look at the intersection of clinical and administrative data, one of the areas that needs further investigation – and, I think I heard that the topic we're discussing right now is around price transparency, but I think what patients and consumers really want is value transparency. They want to know what kind of outcomes they're going to get for what kind of prices. A poster child for bringing clinical and administrative data together could simply be to go to the next level of what we as a community have been discussing, which is price transparency, and simply ask that by bringing in and harmonizing additional data, can we finally get to that Holy Grail of understanding what we're getting for the money we're spending?





I would rather spend a little bit extra on a colonoscopy if there's a lower complication rate, but right now, I have lots of tools that tell me what different gastroenterologists and colorectal surgeons might charge, but I don't have a way to combine all that information into a coherent way for consumers to understand. So, the point I'm making is that by bringing these two different, siloed datasets together, we can start to get at something which is the next level of transparency around quality outcomes as well as price, which we don't have right now.

Alix Goss

Thank you, and hopefully, I'm capturing this correctly, Anil. It looks like Alexis has her hand up.

Alexis Snyder

On the one hand, I have a pushback to what Anil said, but on the other hand, I'm going to agree with a piece of it. So, I'll first say that I don't think the value and outcome is solely the most important thing to the patient. It depends on the situation, who you are, and what service we're talking about, so the pushback I'll give is if we're talking about specialty care and you can only go to a provider who's out of network, or even if they're in network, they're only in one facility where it could cost you more to see them versus another facility, then if this is the only place where you can get your care, you already know what type of care you're going to get, and that you absolutely need to go there, then that value piece in knowing why you should go somewhere else for less isn't really helpful.

But, I will say that it also goes back on the positive side. In agreement with what Anil said, it goes back to our discussions around the transparency of all these pieces to help that shared decision process when you're in the provider's office or you're on the phone with them, following through on something on where you need to go and follow up for testing. So, for the example of an MRI, you could be in a situation where your payer – and again, there's usually not transparency in this to begin with; it's very difficult to call up a facility and find out exactly how much it's going to cost and/or ask them to test bill it for you so that you will know. It's very difficult. You will probably spend 14-20 hours on the phone trying to do so, and pull your hair out by the end of it.

If you're able to get that piece of information when you're in the provider's office clearly and transparently, it helps the decision process because if you go off on your own – and, the example I'm going to use is a specific brain MRI or another specific part of the body that they're looking at, but let's talk about a brain MRI looking for something very specific – there are times where it will be read differently within a hospital versus the way it is looked at outside of the hospital, and so, yes, to Anil's point, you will pay less times in that ambulatory setting outside of the hospital, but you're not going to be getting what you need in the hospital, and that's a whole other piece of transparency that does not exist unless it comes up in conversation and you ask about it, so I don't know where we solve that piece, but in the end, the consumer does not have this available to them, so it goes back to the pieces we talked about early on with prior authorization of knowing all the information up front and transparently while making decisions with your provider.

Alix Goss

Anil, I think you're up. Sorry.

Anil K. Jain





Okay. I just want to make sure I clarify. When I say “value,” I don’t simply mean price. When I say “quality,” I don’t simply mean what we measure. Whatever the consumer, patient, and provider are interested in – the value equation being quality over cost or experience over cost – it could be how close a provider is versus the price. But, it’s that shared choice between a patient – or, maybe their individual choice. I just wanted to make sure I didn’t get anyone confused. I’m thinking of it more broadly as what’s important to that patient. Is it the complication rate? Is it the convenience of being that close by? Is it the only choice I have? Those are all things that have to be considered.

I think just simply bringing the different types of data together gets us a little bit closer. We don’t have a healthcare system; we have a bit of a cottage industry, so we’re not going to be able to solve every problem by bringing all this data, but we get a little bit closer to it because we’re able to start making comparisons that we haven’t been able to make today.

Alexis Snyder

And, I would agree with that, so that comes down to saying that it needs to be transparent to be patient-centered so that the patient is able to make the choice that’s best for them.

Anil K. Jain

I would just also say provider-centered because sometimes, docs actually make referrals based on half the information, and so, having more transparency could actually help the providers make referrals, and help the patients make their decisions, and help them have shared decision-making process in a combined way, so I just wanted to **[inaudible – crosstalk] [00:46:40]** physician out of it.

Alexis Snyder

Agreed, but I wouldn’t call that provider-centered. That’s the provider being enabled to make it patient-centered so that they can work together and make it centered around the patient in the end, so I don’t know what we call it, but it’s not “provider-centered,” but I’m on the same page as what you’re saying.

Anil K. Jain

That’s a good point. I think you used the right phrase earlier. Maybe it enhances the shared decision-making.

Alix Goss

Thank you. Jim?

Alexis Snyder

Alix, the only other quick – oh, sorry.

Alix Goss

No, I moved too fast. Alexis?

Alexis Snyder

I was pretty much done, but I just wanted to say back to the comments of how buying a blouse or a card is very different than healthcare, when you’re looking at it from the consumer side, it shouldn’t be. All those other factors that go into it don’t make a difference to the consumer at the end of the day, who may be





making \$10,000.00 a year and paying \$500.00 a month for health insurance – those are just some numbers off the top of my head of a more disparate family. None of what's behind it makes a difference to them. None of that is patient-centered. The patient needs to know what the procedure is going to cost them, period, and yes, it's different, but in the end, it needs to be that simple for the patient, so of course it's different if it's only an analogy. I don't think anybody on this call is going to buy a car tomorrow, sign a contract for a price, and then say, "Oh yeah, there are always surprises. I'm willing to give you a couple thousand more dollars when I come to pick up the key." So, that's a better comparison.

Alix Goss

Got it. Okay, I'm hoping I captured that point correctly in the notes. Thank you for making sure I captured that point. And, I'm going to out –

Alexis Snyder

It doesn't need a specific note; it was just commenting on comments.

Alix Goss

Okay, thanks. Too many different thoughts happen in these meetings that I'm just going to capture it so that it will get synthesized in wherever we go. Notes can be helpful for that retrospect of synthesizing. I think Jim is up next.

Jim Jirjis

Thank you. Listening to all this, I just want to make a comment in support of the shared decision-making because I think depending on the service, there is a difference between buying a sweater where you suddenly have a bunch of charges and healthcare, and one of the main differences is the information asymmetry. Over a sweater, the customer knows what they want and can make decisions. They don't need somebody with eight years of schooling. But, part of the value of the doctor/patient relationship is the expertise of the provider. I think it was mentioned earlier that it's not just about the hard outcomes and the price. Those are important inputs, but who is the team that's used to working together on this?

And so, there's a heavy reliance on the provider. "Who should I go to? Where should I have this done operationally?" And so, I just wanted to say that if our recommendation is to ONC and it's about the data, then our making the data transparent, fluid, and externalized will allow the ability to support the shared decision-making. My question is how many patients are – is this theory, or do we have solid data on whether 2% versus 80% of patients are going to want to decide based on just price? Is that theoretical, and should our focus just be on delivering the data so that we can create opportunity for different potential solutions to support the patient or the doctor? Do we have solid evidence that a significant number of patients are going to make decisions about surgeries like they do about a sweater, or is it more 80/20 helping the doctor understand the cost structure so that when he guides the patient, who has a trusting relationship, that the provider is, in fact, more informed on counseling the patient, but now, it's including real price data? I don't think it's as crisp as a sweater. That would be my take.

Alix Goss

Got it.

Sheryl Turney





Well, this was a good point. It generated a few more hands raised.

Jim Jirjis

I try to be controversial.

Sheryl Turney

That's okay. When you're ready, Alix, we'll go to Anil.

Alix Goss

Okay, let's go there.

Anil K. Jain

Okay. I was just going to – and, I think Jim said it, in a way, but I think we need to differentiate between services and very objective things like pills, devices, and things of that sort. Just to give you a simple example, getting a price for a colonoscopy – if the gastroenterologist finds a polyp, that's going to dramatically change the price of that colonoscopy, and telling a patient that their colonoscopy is going to be \$1,600.00 or \$2,000.00 may not make sense.

So, I think services versus device – if we think about transparency around pills and devices, it makes perfect sense. “This is how much your pacemaker is going to cost. This is how much your Lipitor is going to cost when you go pick it up.” I think we need to differentiate between that. And then, the idea of a sweater is an object, but if I were to get a custom-made sweater – I would never do that, but if I were to go get one, there are a whole bunch of different transactions and dialogues that need to happen, so I want to make sure we're thinking through this in the way that healthcare is delivered. It may be transactional, but there are differences in the way that services happen and that objects and very concrete things that we can touch are given, and maybe we ought to be thinking about those a little bit differently.

Alix Goss

So, Anil, if I may, the example of the colonoscopy was actually something that could have revealed because the scenario was told to be a preventative service that was fully covered, but what happened was when the processing of that colonoscopy occurred, it was a self-employed – and, there is a plan, basically – a self-insured plan basically said they put a cost control measure into place that said that even though the colonoscopy was a preventative service that's covered fully under the plan, there was a carve-out provision that was put into the actual contract between the employer and the insurance plan that says, “Yeah, but if you take a polyp, we're not going to cover that, and that pathology is going to be completely on the patient.” That should have been revealed, and it wasn't in this situation.

Anil K. Jain

Yeah. It's a common scenario where you might be thinking something is a preventative service, but if they find something – and, good for the doc for finding something that benefits the patient early – then that's not a screening colonoscopy, it's now a diagnostic colonoscopy.

Alix Goss

I'm sorry, Anil, but when you look at it from a patient perspective, it's still a colonoscopy.





Anil K. Jain

It is, and I understand that. As a consumer, I completely understand it. I've had my fair share of interactions with family with the hospital, so I get it, but what I'm trying to get at is we don't want to give the entire community that we're going to be advising – the ONC and people that read it – the impression that our group – and, I've not heard this, I'm just saying – that our group somehow is going to start equating everything that happens in health with going to the grocery store or going to buy things. In some cases, it is exactly the same – sweater and Lipitor – but in many cases, for the benefit of the patient, it is much more interactive and much more designed to look at the overall health of a patient.

No colonoscopist is going to say, "Okay, we're going to conclude the colonoscopy since the patient only paid for a screening colonoscopy. We'll do another one later to take the polyp out." There's an understanding that we do it at the same time and deal with that difference later, and I'm afraid that we're going to create a – go ahead. I think I made my point. The transparency we're trying to ask for in healthcare is needed for sure, both on the administrative side and the clinical side, but what we have to make sure that as a group, we differentiate that to other consumer choices that are made for objects, and maybe there are examples of consumer choices around services that we can use as metaphors for what we're trying to do in health, but I really worry when we start to boil it down to widgets and paying for things that are very tangible and very effective. That's not the way health is delivered, and it worries me a little.

Alix Goss

I agree, and I think it comes down to how we shouldn't surprise people. If you know those rules – it was clearly a rule that was coded that could have been communicated. That's my point. So, it's the surprise aspect that they could at least put a caveat for somebody that they know. But, I think you and I circled the wagon on that, so if it's okay with you, I'll jump to the next person in the queue. Thanks, Anil. Jocelyn?

Jocelyn Keegan

So, I think this is a really great dialogue, and I think it's really important. To me, maybe to help folks that don't live on the plan side of the world, we could think in terms of – I think one of the things that's made this incredibly more complicated in why this needs to get back to the availability of patient-specific information is really the complexity of plan design and how really, today, you don't understand unless you understand that particular patient, and especially with people with high-deductible plans, where they are in a given plan year will affect where the impacts are going to be to the out-of-pocket cost for that patient, so it creates a lot of variability that didn't exist even five or 10 years ago.

I think Anil is really zoning in on that point that I was trying to make earlier, which is that we can segment, and analogies are really powerful – I think they're important for us to look at. I think we can segment the types of services so that you can start to ask where can you get to formulaically, where can you get to a range of possibilities, and where is something that is going to take a lot more work by the industry to get to a higher degree of unknown. But, when we talk about the lottery that we all play when we use our health insurance, if you've ever been in a high-deductible plan, there really is this trust fall that you do – and, we're hearing people's personal experiences – about what your out-of-pocket cost is going to be, and today, we live in a world where no one can clearly give you that answer no matter how awesome your provider and payer are.





And so, I think that we can do better and should do better, but I think that if we look at it as a range and where we can make initial improvements and significant improvements in getting to a formula – because, Anil, what I was hearing Alix say, which I agree with, is this idea that we know that things change if you find something in the middle of a diagnostic test that’s preventative, but we know that, and so, there should be the equivalent of a price sheet that says, “Here’s what could happen if we find stuff while we’re in there,” so everybody goes in with their eyes wide open as opposed to having that sticker shock that happens with a patient afterwards when the type of service changes because of what’s found during that diagnostic event.

And, I think that part of this is that that is increasing the complexity of how payment and plans work as plan design has evolved and the tech to support it hasn’t necessarily moved along with the complexity of the plan design, and I think the second point is that we can carve out and start to get better where we can get better today, but everybody here can acknowledge we’ve got work to do on the things that are more complex and have a lot more unknowns.

Sheryl Turney

Well, this is really generating a lot of great input for our broader intersection. We have another hand raised from Alexis as well.

Alexis Snyder

I think Jocelyn just made a whole bunch of good points that I was going to make, so I’ll just quickly say that I think we need to get off of pinpointing what analogy has been used – so, somebody at HITAC brought up something about a blouse, and then I repeated it, and then it turned into a sweater, and then I told the story about going into a store, picking up a card, and being surprised after being told how much it cost, so I think we need to take a step back, and I think people are misunderstanding what I am saying from the patient side. It’s not about getting the cost – and, going back a few comments, maybe when Anil was talking and Jim asking if it was realistic and how many people wanted this information to pick their service and level of care based on the price, and that’s not when it’s about. Alix touched on it for me already too.

It’s not about knowing the price and the comparison solely so that you can decide where you want to go if you want to spend less money or you’re willing to spend more money. It’s about not being surprised so that you cannot be told – especially under a prior authorization – “Yes, we authorize you to have this, it is going to cost you X, Y, and Z,” and then have a bunch of extra surprises afterward. This is the only industry where that happens, and there’s no reason why – to the point that Jocelyn was making – that if we go back to what Alix said about, for example, the colonoscopy, you are going to be told that all of those other pieces are involved, and if they find something, they’re going to take it out. You need to sign off on those things. “If this happens, that’s what’s going to happen.” And, you should know how much all of those ifs cost.

Again, back to my point that nobody in this room is going to buy a car and say, “Oh, surprise costs are no problem; when you give me the keys, I’ll write you a second check” – similarly, if you want to bring the analogy to medicine, I also believe there is probably nobody on this call that is going to take their pet to the vet’s office and be told a bundled price for a service – surgery, what have you – and then come to retrieve their pet, and be given a bill for more, and be okay with that.

Sheryl Turney





I think that's a good analogy, Alexis. I do think, though, there's another thread here, and I tried to outline it when I was first talking – this is Sheryl – and that is that more and more patients are getting bills for things that are not necessarily prior authorizations, but some health plans are implementing things related to the waste calculators. So, I know a patient in my family went and got bloodwork, and there was a whole panel that was requested, and then they got a bill for \$5,000.00 because the company decided they were no longer going to pay for a certain test that they'd paid for in the past. So, that patient would have no idea that it was no longer going to be covered since it had been covered earlier in the year, and there was no insurance change and the plan didn't change, and then they quoted some policy that said, "In our opinion, it's not medically necessary." That has nothing to do with a prior auth. The patient would have no knowledge that tests that were ordered before would no longer be approved, so those are the types of things where the patient is never going to know until after the service.

Again, there is data available that says, "We're not going to pay for these things," but it's not data that anyone would understand because it's in those words that they add to all of these documents that indicate normal and customary and what is medically necessary, et cetera, and the patient would have no idea of knowing what that is. So, I just don't want anything we're saying here to preclude those types of things as well because that data should be available, and if someone is being sent for something like bloodwork, which normally gets paid for, then they should be able to know before they go what is and is not going to get paid, and not find out afterward, similar to the example that Alexis gave.

Alix Goss

So, Sheryl, as you're bringing this up, I'm thinking about the – I'm seeing a chat from Gus about how we probably don't – it's not necessarily within our scope to take a deeper dive on this, and there had been an earlier suggestion that we recommend to HITAC that price transparency is something that needs to be evaluated and they should go forth and look at it as their own, and that they should maybe put a group to look at this because this is the next generation of complexity that they need to dive into.

There's this basic set of recommendations around prior auth and that broader intersection discussion, and that broader intersection discussion needs to say that price transparency is complex and challenging and warrants its own task force. That's what I think I'm hearing from the membership, and I think we've got lots of good examples to help maybe a task force framing to occur, but I'm looking to see if that's how we button up this particular discussion today, and I'm seeing some comments indicating that other folks are agreeing with this.

Sheryl Turney

Yes, I'm seeing that also, and Alexis has her hand raised again.

Alix Goss

Thank you. Alexis?

Alexis Snyder

I agree that price transparency – and, I have sat on task forces in Boston for price transparency – is a whole separate issue, but the pieces that are attached – we definitely need a different task force altogether just to tackle this. But, the piece I think we still have the responsibility to is that underneath our transparency guiding principle, this is an important concept, and you cannot just get transparency to an authorization and





not transparency to knowing how much it's going to cost you, and I think that's where we need to go with it.

But, the one quick point that I wanted to make that I had lost sight of before is that for whatever it is, on the other side of it, there's always the whole value-versus-volume piece and patient-sharing piece, and without the information, patients are not informed for that decision-making to happen, and someone might be wanting to do something elective that they may be able to hold off on, and it may prevent them from doing it and actually spending more insurance dollars in the end if they know how much it costs up front, or they may go somewhere it costs the payer less money too because it costs them less money to know where they could go get a CAT scan or an MRI versus a more expensive place. So, these are all pieces on both sides of it – payer, provider, and patient – that make a difference to having transparency, and again, I can't say it enough: There's no other industry that isn't transparent with price and gets away with it.

Sheryl Turney

It looks like we finally went through the queue of hands, and I think that everybody's points are very important and very valid. I do think we have enough information now on this where we can go back and focus on beefing up our guiding principle for transparency and recommendations on transparency, and then maybe make that recommendation for a separate group to focus on price transparency as one of our recommendations.

Alix Goss

Okay, cool. I think we've got about seven more minutes until public comment, so what I'm going to suggest, Sheryl, is that we do the callout for – we talked about a lot of issues. What other things do we need to consider in the broader intersection discussion so we can queue up topics that we need to dive into next week? I have this feeling like we did a lot of great work on prior authorization, and some of the stuff that we tackled was broader than just PA, but I want to make sure that we don't miss the golden opportunity to discuss and consider other things related to that real intersection between clinical and administrative data.

I really want to make sure that if you have something, let's capture it right now. Otherwise, I will infer that this group – this task force – believes that we've tackled all the major topics and that if so, we could pivot into more of the content synthesizing review and getting us into the report review efforts, and we're now going to receive more of a traditional report draft as a result of working with our new editor. Every dream, every "I want to see fixed" concept that you came into the task force with has been addressed. Jocelyn, I see your hand is up.

Jocelyn Keegan

So, I haven't been to all the meetings, so I don't know if this is covered or not, but one of the things that I do feel would probably be worth a deep dive for us – but, if I were going to do order of operations, which I know you love, I would say we should get our PA document across the finish line and revisit this for a deeper conversation – is really the policy and regulatory barriers that are in place or could support us improving the synthesis between all these different worlds. So, I don't know if this is covered somewhere else there and I am just not interpreting that way or if we've really covered that as a topic.

Alix Goss

I think we've talked about it a little bit, but I think we need to come back to that. I think it's a good one.





Sheryl Turney

Is there anyone from the group that has information that they would like to bring forward on this particular topic or an additional topic?

Alix Goss

Off the top of my head, I think that we started to look at some of the opportunities for ONC leadership, but I think we need to take a fresh look at this, and I think we probably need to do a little bit of framing of this to help in the discussion. Yes, Jocelyn?

Sheryl Turney

Jocelyn has her hand up again.

Jocelyn Keegan

The only point I'd make there, Alix, is I think since we started, HHS created Mary's team – the burden reduction team – which I think is looking at synthesizing and how to better coordinate between CMS and ONC in general, so I don't think I would limit the ask of what ONC can do. I think I would make them more broadly to what the burden reduction function in the leadership in both ONC and CMS can do to help move us forward here, and I swear I'm not getting paid to make that comment.

Alix Goss

Okay, great. I think there's something there we need to look at. As you're talking, I'm thinking about the authority conversation that we had very early on about what happens here with the reports of – when we produced a set of recommendations, why did we bring together NVCHS and ONC's HITAC task force to tackle this? Because we knew we needed to engage industry and we needed to be efficient in how we did that, yet we had respective authorities we needed to feed these recommendations back into, so I think it's worthwhile to take that approach when looking at this. Are there other thoughts of what people might want to see?

Sheryl Turney

The only one that I wanted to bring up, again, Alix, was the one that I brought up – I think I started on it last week – whether or not we would want to make a recommendation related either to some standard or enabler that would make available the ability for a patient to get a third-party credential to help them utilize that for all of their data access because today, it's still pretty onerous and burdensome for them to manage that access, and there has been a lot of talk about it in the industry, but I think there's concern that without some sort of industry guidance from ONC, it won't happen, and it could be something that would make it a lot easier for the patients to access their records. And, that's going through that whole patient access picture that I've talked about, but haven't shared with this group.

Today, if you go into an app – let's use the Apple Health app because it's currently live, but if you go to five health systems, you have to provide credentials to each of the five health systems in order to get access to the data, and in many cases, people haven't completed it because they either forget their password, which then needs to be reset, and if you have the ability to go to a third party to create a credential, then the hope would be that each one of the healthcare participants would need to be able to use that, and that becomes your credential instead of the information you'd need to log on to each individual application.





Alix Goss

Okay. I notice that we're at 4:20, and that's the magic time for public comment. I want to ask you a bit more about this topic, Sheryl, so maybe we can pause for a moment and turn it over to Lauren.

Public Comment (01:17:18)

Lauren Richie

Thank you, Alix. While we pull up the phone number, we'll ask the operator to open the public line.

Operator

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

Lauren Richie

Okay, thank you. Alix, I'll keep you posted if we get any.

Alix Goss

Thanks very much, Lauren. So, Sheryl, let's come back to this idea that you put out there for third-party credentials. So, what we're thinking about is Patient Suzy Q – let me call her Citizen Suzy Q – needs to be known in the digital world, and we need to know that Suzy Q is truly Suzy Q regardless of where she goes – payer or provider of some sort – and that when Suzy Q wants to have her health information from one organization, whether it's payer or provider, passed to another place, whether it be an app or an entity, that you feel that there's industry guidance that needs to be generated to help the patient maintain their patient-at-the-center aspect, and that from the patient-at-the-center design concept, there's a challenge with credential documents that the credential aspects, like what I typically refer to in my techy world as an X-509 certificate, let me know that Citizen Suzy Q is really Citizen Suzy Q, and that if we had a centralized hub for managing citizen credentials, it would make it easier for the patient and everybody else. Did I summarize that appropriately?

Sheryl Turney

Yes, and I'm not saying that everyone would have to use it, but what I am saying is that for those patients that want to use it, it's going to serve as a place where potentially, that's where they get their credentialing, and it makes it easier for them to access their data, and also, it provides a greater assurance, if you will, that Suzy Q is really Suzy Q. So, when it comes to security and access, they have developed this approach to try and address some of the concerns that people have about patient matching.

So, that's the two parts, and then, in my head, I've actually said this would also potentially solve some of the issues in the ecosystem for consent and revocation because I've been asking a lot how, on the current interoperability rule, we would handle somebody who wanted to revoke the consent on an app that they've given their authority to, and in today's world, most people delete the app, but that doesn't revoke their authority, and when it comes to health data, we want to have a record that you've said, "Yes, I approve this, and now I'm revoking it," an deleting the app – if you read all the fine print, which no one does – doesn't revoke authority, and they still are allowed to use your data unless you specifically revoke it, and usually,





the revocation process is something very complicated that people don't even know how to find, and it's not usually a choice for something that they have. So, to me, it's all part of this whole access and consent process, which still seems to need some help. That's all. And, I see Alexis has her hand up also.

Alexis Snyder

Yeah, I'm a little bit confused now. I thought I followed it when you said it, and then I thought what Alix said sounded different, but now that you're talking about it again, it makes a little more sense to me, and anything that makes it easier and more secure is patient-centered in the end. And, it made me think of something that I brought up a while back at a HITAC meeting about some privacy and security loopholes in sharing information electronically between hospital systems, and I think that's another additional topic that could be considered going forward that I'm glad I just thought about.

So, the example would be a patient who gets most of their care at Hospital A, and then may have received care at Hospital B for something as simple as the fact that the ED was closer, so they went to the ED, or they saw one specialist there once and then went back to Hospital A. So, there's sort of a loophole in the electronic access system between Hospitals A and B – and, hopefully, I'm explaining this clearly – Hospital A being my home hospital, I don't really care to have them see my records from Hospital B, so I have told Hospital B through the electronic systems and portals and through the choices I can make for how I share and who can see what that I don't want it shared, and that they should not be traveling the medical highway, so to speak – literally in Massachusetts, there's a Mass Highway – and I check off "No, in Massachusetts, I do not consent to the Mass Highway. If I want to give Hospital A something, I will pull it and give it to them myself."

So, the loophole in that becomes that because you have been seen in both facilities, you are now known as a shared patient, and so, regardless of the patient's choice to have an intersection of the information accessible between the two, regardless of what the patient wants, it's done anyway because they're considered "a shared patient." And, to me, a shared patient is where you're getting numerous services that have been coordinated between the two hospitals, you've been referred back and forth, or you've chosen to coordinate the two for your care, but not something where you've gotten a small, ancillary service, per se, or see a specialist that you're never going to see again. That shouldn't be considered shared. Hopefully, I made that clear enough – that example was clear – but there seems to be this loophole to the privacy piece of how much shared electronically, between whom, when, and under what circumstances, and some of that may go back to some of these policy and regulation barrier pieces that we talked about earlier.

Alix Goss

So, Alexis, in consideration of time, I've tried to capture this scenario. I did follow you, and I understand the dynamic of the shared patient data flow, even in an opt-out situation, so what I'm hopefully going to do is queue this up so we'll talk about it in our debrief and figure out how to bring this back to the fold as we move forward, but we're at the end of our call, so I need to turn it over to Sheryl to cover some very important next steps, and a heads up to the task force – we have an ask.

Alexis Snyder

Yeah, that was the end.





Next Steps (01:25:27)

Sheryl Turney

Thank you so much. I appreciate everybody's time today. So, for next steps, we're going to be sending out to the task force the writeups and summaries that were done related to all of the presenters who came to the Intersection of Clinical and Administrative Data Task Force and presented, and we would like you to provide input or feedback on those summaries, so that's going to go out either later today or first thing tomorrow, and we would need your feedback on that by the 28th if possible, before next meeting.

And then, what we're doing offline is we are working with Susan, the new editor, and we're hopefully going to come back next meeting with this topic that we will hold over and continue discussing if we need to, but then, also, an update on the current draft of the report, and then start working through that to see how we're going to weave in these broader topics that we've discussed, and then discuss if there are any additional broader topics. Please don't wait. If you have additional topics that you thought about because of our conversation today or that are top of mind, send them to Alix or me after the meeting today because we need to have them on the agenda for next week. If they're coming after next week, we may no longer have time for that.

So, the way it stacks up is we have next week's meeting, where we're going to try to finish off this broader-topic conversation, then we're going to start looking at the final draft report, and we're going to be vigorously editing that for the next several weeks, with the goal to get that final report to HITAC by the 15th of October. That's what we have on the task force. Now, at this point in time, we're also going to tell you that any comments to the Google doc are now going to be closed because we have the editor working, so if you have any final questions, comments, or input to that Google doc, send them via email to Alix, me, and Michael so we can make sure they get to Susan and get incorporated into the final draft. Alix, is there anything else you want to add before we close?

Alix Goss

I just sent a message to Rich. We want to make sure he and Arien are all set with the purple text cleanup and closing the recommendations loop. We think you are, but we just want to make one last call to ask you to verify that because otherwise, we are going to strip it out because we are going to move towards actually have a more structured report-looking document to which we can all review and comment in a new set of processes. Thank you for double-checking, Rich. I noticed your response. I'm all set.

Sheryl Turney

All right. So, we have a meeting for next week, and then we're good to go. Thanks, everybody.

Lauren Richie

Thanks, everyone. See you next week on the 29th.

Anil K. Jain

Bye-bye.

Adjourn (01:28:50)

