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 (ICAD TF) MEETING

March 3, 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
Jim Jirjis	Clinical Services Group of Hospital Corporation of America (HCA)	Member
Anil K. Jain	IBM Watson Health	Member
Jocelyn Keegan	Point-of-Care Partners	Member
Rich Landen	Individual/NCVHS	Member
Leslie Lenert	Medical University of South Carolina	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
James Pantelas	Individual	Member
Abby Sears	OCHIN	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

Operator
All lines are now bridged.

Lauren Richie
Okay. Hello, everyone, and welcome to the inaugural meeting of the Intersection of Clinical and Administrative Data Task Force. This is a subcommittee of the ONC Health Information Technology Advisory Committee. We are glad you all took time to be with us today. I know it's been a while in the making, but we are excited and ready to go. We want to thank our co-chairs, Sheryl Turney and Alix Goss, for agreeing to be our fearless leaders on this effort, and I will officially call the meeting to order starting with roll call. Sheryl Turney?

Sheryl Turney
Here.

Lauren Richie
Alix Goss?

Alix Goss
Present.

Lauren Richie
Aaron Miri? Okay, not present. Abby Sears? I think I heard from her –

Abby Sears
I'm here.

Lauren Richie
Alexis Snyder?

Alexis Snyder
Here.

Lauren Richie
Andy Truscott?

Andrew Truscott
Present.

Lauren Richie
Anil Jain?

Anil Jain
I'm here.

Lauren Richie
Arien Malec?

Arien Malec
Good morning and/or afternoon. It's all afternoon, everyone.

Lauren Richie
Hello there. Debra Strickland? Okay, not yet. Denise Webb?

Denise Webb

Present.

Lauren Richie
Hi, Denise. Gaspere Geraci?

Gaspere Geraci
Present. Hello, everyone.

Lauren Richie
Jacki Monson?

Jacki Monson
Here.

Lauren Richie
James Pantelas – I believe he's going to be absent today. Jim Jirjis? Not yet. Jocelyn Keegan?

Jocelyn Keegan
Here.

Lauren Richie
Les Lenert?

Leslie Lenert
Here.

Lauren Richie
Mary Greene?

Mary Greene
Here.

Lauren Richie
Great. Ram Sriram?

Ram Sriram
I'm present.

Lauren Richie
Rich Landen I believe is going to be absent as well. Sasha TerMaat?

Sasha TerMaat
Hello.

Lauren Richie
Steve Brown?

Steven Brown
Hi.

Lauren Richie
Great. And, Tom Mason.

Thomas Mason

I'm here.

Lauren Richie
Great. So, we may have a few others join us a little late. Before I turn it over to the co-chairs, just a couple of housekeeping items. For the task force members, you will notice in the upper left-hand corner, if you will, the "raise hand" function. That is what we will use to indicate if you have a question or comment. Please just remember to select and unselect when you have finished your question or comment. We will also ask you to please state your name before your question or comment until we get to know each other and recognize voices, especially for members of the public who are following along. We'll ask that you state your name first. And then, for the members of the public, you are welcome to participate by dialing in during the public comment period. The phone number is in the lower left-hand corner, and we will have the public comment period toward the end of the call. Alternatively, there is a chat feature in which you may weigh in, but please just keep in mind those comments will be captured as a part of the official record of the meeting. So, with that, I'm going to turn it over to our co-chairs to get started.

Sheryl Turney
Thank you very much. This is Sheryl Turney, and I appreciate all the work that you folks have done at ONC in order to help us get prePAred for this meeting. I want to welcome everybody today, and in a moment, we're going to have some introductions. This is a combined effort between HITAC and NCVHS, so Alix, who comes from that organization, and I, who represents the HITAC here, are coming together so we can collaborate and achieve our objectives. The agenda that we have for you today is to do a little bit of introduction, and since it is a combined effort, we did want to go over a brief introduction of each person so we can get to know people a little bit better. Say who you are and where you come from. We'll do that in a moment.

Then, we're going to have an overview of the task force charge and the timeline that we're expecting to experience to accomplish this. We're going to review the task force procedures, and then we're going to have a little discussion about potential work streams. This meeting today is really to bring the scope and objectives, if you will, and then define our overall timeline, and then we're going to go into a little bit of our background and level-setting in the next meeting, and then hopefully have a more fruitful discussion about how we want to set up and move forward. Then, at the end, we'll talk about next steps. The cadence of the meetings that we have currently set up are at a weekly occurrence for an hour and a half. Are there any questions about the agenda? Alix, do you want to add anything?

Alix Goss
Thank you for that setup. This is Alix Goss, so you can all learn my voice. I will hopefully remember to announce myself as we move forward. This is a really important day as we launch the conversation to take the deep dive into how to converge clinical and administrative data with a focus around prior authorization. I'm very excited. It's been a long time coming, and I'm very grateful for the task force members' willingness to volunteer their time and their thought leadership in helping us figure out these important next steps.

Sheryl Turney
Thank you. Okay, great. I'm just going to go down the line, and I'll start with myself for the roster. Again, just to level-set, tell us a little bit about who you are – your name, organization, and title. My name is Sheryl Turney. I come from Anthem. My title there is Director of Data Use Enablement. Essentially, I'm responsible for our data use policy as well as interoperability programs, our APCB reporting, and our BCBFA reporting. And, from there, I'll turn it over to Alix, and she can tell you a little bit about herself.

Alix Goss
Thank you. My name is Alix Goss. I come from Imprado, which is the consulting division of DynaVet Solutions. In addition to my private sector consulting role, I do wear a federal advisor hat, sitting on the National Committee for Vital and Health Statistics, where I am the co-chair of the standards subcommittee and review committees. We at NCVHS are the gating step for the administrative HIPAA-related transactions, code sets, privacy, and security matters, and I'm looking forward to working more closely with

the clinical side of the house.

Sheryl Turney
Thank you. Let's go to Anil next.

Anil Jain
Hi, guys. I'm Anil Jain. I'm one of the VPs at IBM Watson Health. I also serve as the Chief Health Information Officer and have a little variety of responsibilities, including setting the tone and direction for some of our data efforts, including parts of what we're going to be hoping to focus on in this task force around the use of clinical – especially clinical EMR data, along with the administrative data that comes from a variety of different sources. I'm a member of the HITAC as well, for those of you who aren't part of the group, and I'm really excited about focusing on what I think as a part-time – very part-time – practicing primary care physician at the Cleveland Clinic. So, I'm very interested to see how we can start to combine some of this to push the ball along, if you will, in some of the work that we're doing.

Sheryl Turney
Thank you, Anil. Arien?

Arien Malec
Hey. I'm Arien Malec, SVP of R&D for Change Healthcare, where I run our large administrative processing networks as well as clinical networks. We process eligibility in claiming volumes, are now doing clinical attachments into claims transactions, and we're the service provider for CommonWell, which does clinical interoperability, so I'm incredibly excited about this task force because I've been sitting at the intersection of clinical and administrative interoperability, and have been using administrative data for clinical quality measurement, and now clinical data for administrative efficiency, and I just think there's a huge amount of untapped promise for better efficiency and quality in the U.S. healthcare system.

Sheryl Turney
Thank you for that, Arien. Andy?

Andrew Truscott
Thanks, Sheryl. Hey, everybody. It's Andy Truscott here. I've probably got one of the more distinctive accents on this call. I won't repeat all my aspirations for the group, which seem to have been effected by others already. I'm with Accenture. I'm a managing director in our health and service business, and I have worked with clients both in North America and around the world for the last couple of decades embracing health information technology to make the jobs that they do faster, better, cheaper, higher quality, better patient outcomes, et cetera. I also chaired the Information Blocking Task Force along with Mike Adcock from HITAC last year – we actually kicked it off about this time last year – and we've just seen that come to fruition with the emergence of the regulations, fingers crossed, and we're looking to see how we can actually go forward with this as well under Alix and Sheryl's excellent supervision.

Sheryl Turney
Thank you so much, Andy. I really appreciate that. Leslie?

Leslie Lenert
Hi, I'm Leslie Lenert. I'm a professor at the Medical University of South Carolina and assistant provost here. I do work on learning health systems and population health systems and represent the public health perspective on the HITAC as a voting member there. I'm particularly excited about this idea of being able to streamline prior authorizations both from the perspective of being able to introduce clinical data and the ability to really learn what the outcomes of prior authorization are as far as its impact on health and wellbeing.

Sheryl Turney
Wonderful. Thank you so much. I believe Ram is not here today –

Ram Sriram
No, I'm here. My trip got canceled because of this coronavirus issue.

Sheryl Turney
Sorry.

Ram Sriram
Yeah, it got canceled last night. Again, this is Ram Sriram. I am also adding to the accents around here. I am the program manager for the NIST Health IT program. I also serve on the HITAC committee as a federal government representative. The NIST Health IT program is deeply involved in developing tools for the testing infrastructure – for example, for the meaningful use testing, we developed most of the tools that are used for testing EHRs in stage 1 and stage 2, and some of stage 3. I'm also involved in the NITRD, which is, again, the Networking Information Technology Research and Development that is part of – all the federal agencies get together under this umbrella, and there is a health IT working group, and I work closely there. We also work on medical device interoperability and the coordinator of the National Academy of Medicine's report on procuring interoperability, which came out last year, as some of you know. My primary expertise is in computer science, mostly to deal with artificial intelligence, where I've been working for the last four decades or so. That's about it.

Sheryl Turney
That's quite a mouthful, Ram. Thank you very much. Sasha?

Sasha TerMaat
Good afternoon. This is Sasha TerMaat. I work at Epic, an electronic health records company, but I also work with many other developers of electronic health records in the Electronic Health Records Association. I'm a former chair of the association and a current member of the executive committee there.

Sheryl Turney
Wonderful. Abby?

Abby Sears
Hi. I'm the CEO of OCHIN, and I'm also on the HITAC committee as well. We're an organization that hosts electronic health records all across the country for safety net organizations, so we have built the largest database of underinsured or Medicaid patients around the country, and we also are a huge advocate for the movement of data, and pretty much will pilot almost anything that moves our patients' data to wherever it needs to go.

Sheryl Turney
Wonderful. Jim?

Jim Jirjis
Yes. I'm Jim Jirjis. I'm the Chief Health Information Officer for HCA Healthcare, and I've been there for about seven years. I've been in health informatics for 20 years. My primary interest is in – we've had the meaningful use, we have interoperability coming, but the burden on providers and the interference with the patients' continuity of care due to delays make the prior auth task force of particular interest to me because there's endless frustration between the provider, the patient, often the pharmacist, and the insurance companies, so we're excited, and we have 185 hospitals, numerous clinics, and we're interested in scalable solutions that take out some of that frustration. I'm also a member of the broader HITAC committee.

Sheryl Turney
Wonderful. I think Denise is not with us today.

Denise Webb

Oh, no, I'm on.

Sheryl Turney
Oh, you are. I wasn't seeing you on the list. Go ahead, Denise.

Denise Webb
Hi, this is Denise Webb. I have about 20 years in heath IT. The first part of my health career was at the Department of Health Services in Wisconsin, and I worked primarily on the policy end of health IT, and most recently, I was at Marshfield Clinic Health System as their CIO. I have been on the HITAC committee from its inception, and I'm very interested in making progress in the area of clinical and administrative data integration, particularly around reducing provider burden and making things better for the patient so they can get their care right away around prior authorization, and I'm glad to be on this task force. Thank you.

Sheryl Turney
Thank you. Glad to have you. Is James Pantelas on? I don't see him on the list, but I'm not making that assumption anymore.

Lauren Richie
No, James is not on, and neither is Rich Landen.

Sheryl Turney
All right. How about Debra Strickland? I think I heard she was on.

Debra Strickland:
Yes, I am here. I am a program manager at Conduent Services. I am also on the standards subcommittee and the full committee of NCVHS. I have worked as a volunteer at X12, co-chaired the remittance advice Workgroup for over 15 years, and held a number of other leadership positions in the standards community.

Sheryl Turney
Welcome. Jacki Monson?

Jacki Monson
Good afternoon. I'm Jacki Monson. I am currently the Vice President/Chief Privacy and Information Security Officer at Sutter Health, and I also have the privilege of serving on the National Committee for Health and Vital Statistics. My expertise is all things privacy and security, so I'm looking forward to this committee.

Sheryl Turney
Thank you very much. Do we have Gus on?

Gaspere Geraci
Yes, I'm here. Hello, my name is Gus Geraci. I am from the dark side. I've probably spent the last 20-25 years on the insurance side. I'm a physician, family doc, and ER doc by background. I'm one of those evil people who does prior auth, and I've done that for close to 25 years, but did practice medicine through most of my career. I can't list my current employer for various reasons, but I am a chief medical officer for a large Medicaid insurance plan in Pennsylvania and have served at both the state and national levels in similar roles. In the past, I have had an interest in IT and health IT for many years. Alix and I worked together to try and implement an HIE in Pennsylvania, which was successfully launched, and prior auth is a huge problem on both sides, and I can speak to both sides of the issue, having both practiced and been the evil guy on the other side saying no.

Sheryl Turney
That will be very valuable to the group, so thank you. Do we have Jocelyn Keegan on?

Jocelyn Keegan

Hi, this is Jocelyn Keegan. I work for Point-of-Care Partners, which is a small consultancy focused on where standards and the industry strategy matches up. I am currently our payer practice lead, and I spend my days working around the space of value-based care, standards and strategy, prior authorization both on the pharmacy and medical sides, and specialty medications and how we improve the workflows and automate specialty just in general with the fact that it's stuck back in the '90s. In addition to that, I spend about half my time these days as a program manager for Da Vinci, which I've gotten to meet a number of you through – that, and my work. We're uniquely positioned in the market in that we work with everybody, so we enjoy this sort of Switzerland status.

Similar to Gus, we've been on all sides of the conversation around prior authorization. I actually helped bring the ePA standard that's live with NCPDP and has gotten tremendous traction in the market to help reduce that provider burden by automating prior auth where possible, and co-chair the ePA task group over at NCPDP in addition to my Da Vinci work. I really believe that with the tools that are out there available on the market and really looking at this holistically across pharmacy, medical, administrative, and clinical that we can find ways to reduce, remove, and, where necessary, automate prior authorization to make everybody's life better. I'm excited to be here.

Sheryl Turney
We look forward to your input, and I appreciate all that you've done with Da Vinci, having met you previously, so thank you. I don't see Tom Mason, but is he on?

Thomas Mason
I am.

Sheryl Turney
Wonderful.

Thomas Mason
I'm Tom Mason. I'm Chief Medical Officer at ONC. I'm also a general internist with a background in EHR implementation. I co-lead our clinician burden reduction efforts as required under the 21st Century Cures Act, and I'm looking forward to working with the group here.

Sheryl Turney
Wonderful. Thank you, Tom. All right. Aaron Miri?

Aaron Miri
Hello, I'm Aaron Miri. I'm the Chief Information Officer for the University of Texas at Austin for the entire medical district, which includes the Dell Medical School and UT Health Austin. I'm also a current member of the HITAC and a prior member of the Health IT Policy Committee. I also co-chair the Annual Report Workgroup and work with many of the esteemed individuals on this call today on a number of different task forces. My passion is really around privacy and security, as well as research, data, big data, and how we can really leverage data into artificial intelligence, hopefully in the near future, and to the degree of it, I'm excited to work on this task force to see how we can move the ball forward collectively and really advise a number of emerging fronts on the technology space that need to be addressed.

Sheryl Turney
Wonderful, thank you. Steve Brown?

Steven Brown
Hi, I'm Steve Brown. I work for the Department of Veterans Affairs in the Office of Health Informatics, where I run an office of knowledge-based systems. We're sort of the slide rule club of informatics in the VA, with responsibilities for terminology, standards, interoperability, decision support, and their integration. I'm also an associate professor of informatics at Vanderbilt, and have been doing standards bodies like this at the federal level since the days of the Consolidated Health Informatics Initiative, the first beauty contest of

standards back in the early '00s.

Sheryl Turney
Wonderful. All right. Mary Greene?

Mary Greene
Hi, I'm Mary Greene. I'm a senior advisor in the Office of the Administrator at the Centers for Medicare and Medicaid Services. I'm a pediatrician by training. I lead our CMS agencywide burden reduction initiative called Patients Over Paperwork, and our top priority happens to be prior authorization, so the timing of this task force is perfect, and I'm absolutely happy to participate.

Sheryl Turney
Thank you very much. And then, last but not least, Alexis Snyder.

Alexis Snyder
Hi. I'll try to make it quick and short, since I'm last. I'm Alexis Snyder. I am an independent patient/family advisor and engagement specialist. I work with a number of healthcare systems and researchers to ensure the patient and caregiver voice is always present and well-represented across many areas of healthcare, such as process improvement, patient-centered outcomes, and patient-centered outcomes research. I recently joined the HITAC in January, representing patients and caregivers. I'm very excited for this task force to be able to represent that patient and caregiver voice and how the infrastructures and policies for prior authorization affect patients, patient burden, and their outcomes.

Sheryl Turney
Wonderful. Thank you very much. As you can tell, it's a great roster; we have a great cross-section of people from different aspects of the healthcare spectrum, and I think that working together, we're all very excited to approach this topic. So, let's move on to the task force charge. Essentially, the vision is to focus on how clinical and administrative data, viewed together, we can improve the interoperability, which supports clinical care. Today, there are so many things that have been done to automate the collection of information, but that information is still in very disparate systems, and they don't communicate together, they don't even communicate within the same EMR systems, or even the same claim systems, for that matter. I think if you look at multiple payers, you will see that they are not even on one claim system, so we can't look at just the clinical aspect; you have to look at both administrative and clinical.

So, the idea is really to look at the data and the efficiencies, and try to see what we can do where we can record once and reuse. That's really the optimal goal that we need to focus on, and all of the mechanisms that need to be in place or the framework that supports that "record once and reuse" scenario. Our charge is broken down into an overarching charge as well as a specific one, but essentially, we're going to look at the landscape of what currently exists, what the problems are that have been reported related to burden, and how the framework can be improved so that we focus on the most important aspects, and then define what those recommendations are for standards and interoperability improvements, and hopefully even prioritize them. So, the idea is to look at administrative data, clinical data, the transport structures, how we move data from one place to another, the policy, administrative, and clinical rules that go along with those data captures, and also, the data sharing.

And then, the privacy and protection of that data is of utmost importance as well. And so, we want to leverage the good, hard work that both NCVHS and HITAC have already done to collect this information. Hopefully, this information is going to be presented to us in future meetings. And then, from there, we will move forward and look at how we want to organize and how we want to work on this. If we look at specific charges, again, we want to design and conduct research, but essentially, we want to look at the landscape and identify what works and isn't working from the perspective of the framework and the opportunities. There have been a lot of recommendations made by a lot of different groups who represent their own specific interests, and also, it will be up to us to look at that landscape and say, "Which of these are we going to move forward? Which are the ones that are going to help us move the needle in a way that's going

to be positive and hopefully can be implemented over time?"

And then, we'll identify what is currently present, what is emerging, and we won't lock ourselves into things that are rigid, but we'll allow for the opportunity to grow and mature into a framework that will be able to respond to that. And then, we'll look at identifying patient- and process-focused solutions that will remove these roadblocks, and that's really the key objective here. How can we remove the roadblocks and increase the ability for data and processes to be supported through electronic means? Maybe there's some standardization that could occur or some elimination of that work that could occur. And then, also, maybe we share some of that information. In some cases, clinicians say they don't know when all the cases exist for when a prior auth is required. How do you standardize that across many payers, and how do you make that data available within an EHR system that has to be able to communicate with multiple administrative systems? And then, what are the rules associated with those, and how do you make those available?

So, what we have been asked to do is no easy task. We will be culminating with recommendations and, I believe, priorities for those recommendations that will be submitted to HITAC and NCVHS, and hopefully, the task force will share these deliverables in a collaborative way, and we will both be recommending that they be implemented and moved forward. The goal is to establish this set of recommendations by the September timeframe. Any questions on the charge? All right. And then, we put this very rudimentary, one-page timeline in there, but essentially, what we're going to try to do is, with a cadence of one meeting per week, be able to accomplish this very lofty goal. Obviously, this is going to be adjusted, and the goal is that we might want to break up into smaller teams. Alix is going to talk about that in a minute, but essentially, the goals between both of our groups will be to come up with combined recommendations.

So, those of you who are on HITAC understand the way this works. I'm going to repeat this because for those of you at NCVHS, I don't know how you've done it, but what we've done in the past – and, I was part of the Information Blocking task force that Andy mentioned before – is we've gone through, we've had preliminary recommendations, we've presented those to our committees, like HITAC and NCVHS, we've gotten input, we've come back, and we've updated based on the input that we've gotten so that we have some final recommendations. So, understanding the nature of how this works, we really need to have some sort of preliminary recommendations fairly well developed in the July timeframe in order to meet that September date. Any questions about the timeline? All right. I'm going to turn it over now to Alix, who's going to talk a little bit about the task force structure – actually, this is going to be Lauren who's going to talk – no, I guess this is Alix.

Lauren Richie
No, this is Lauren. I can take it from here. Thanks, Sheryl. I'll try to be quick. I'm sorry if this is a little repetitive for our HITAC members, but since we have a large blended group, as a reminder, the task force is going to meet weekly, as Sheryl mentioned. All of our calls are open to the public, and they will include a public comment period at the end, so we do try to honor that time period, so if we're getting a bit off schedule, we will take a break per the agenda, see if there are any public comments on the phone, and then, if there is any remaining time, we'll come back to our discussions. Primarily, the process is deliberation concerning all points of view, resolving differences, and asking our chairs to keep us on track in identifying areas of agreement and disagreement. Next slide.

So, just as a reminder, again, to those who are not familiar with FACA procedures or with ONC's HITAC, the task force does not provide recommendations directly to ONC. Those recommendations are submitted to the full HITAC for final vote and approval, and then from the HITAC to the national coordinator for consideration either for ONC policy or program. In this case, those recommendations will also advance to the NCVHS standards subcommittee for consideration, and finally, once everything is approved and transmitted to the respective agencies, you can find all final recommendations posted on healthit.gov. Next slide.

So, just for the awareness of all the task force members, you have a cell of solutions, who you probably have heard from already and who has peppered your calendar with meeting invites. Michael Wittie, who is

from ONC, will be the staff lead for this particular task force, with me serving as the DFO. Cassandra Hadley also supports me and the broader HITAC. So, you'll probably hear from any number of us throughout the life of the task force, and if all else fails, please refer to healthit.gov for meeting materials, and that's where we also encourage you to forward to your colleagues who are interested in joining the meetings. That is where the public access information is that we give to the public. Your personal invitations are only for you, and you will only be given access to the VIP line as a task force member. I think that's my last slide. Any questions on the general structure or process? Hearing none, I am going to pass the baton to Alix to jump into the discussion for today.

Alix Goss
Thank you. This is Alix. I'm not surprised that we haven't had questions so far from the task force members, as they're a pretty seasoned group of individuals who have participated in a variety of federal advisory committee meetings, and I think it's really fantastic that NCVHS and HITAC are able to garner input from the industry and thought leaders to advance the overarching work of intersecting clinical and administrative data. And so, let's talk a little bit more about the landscape, if we could go to the next slide, please.

There has been tremendous work to date by ONC and NCVHS, and that means that as Federal Advisory Committees, we have engaged industry along the way to understand the challenges for payers, providers, patients, and the vendor community related to the prior authorization activities that are essential in the process flow for healthcare delivery. Most recently, ONC has released the burden report. There are a smattering of prior authorization references, and we dive deeper into the front matter in the middle section, ultimately culminating with a set of recommendations on about pages 46 and 47, so if folks haven't had the pleasure of being able to read that from front to back, I encourage you to take a look at the strategy on reducing regulatory and administrative burden relating to the use of health IT in EHRs, and give some good framework.

From an NCVHS perspective, we have a longstanding set of initiatives that have taken a look at prior authorization – not just prior authorization, but also including the concept of attachments. I've been on NCVHS for about seven years and worked on the attachments topic back in the early 2000s, when I was a representative of X12 leadership in collaborating with HL7 on some solutions. We've seen challenges with prior authorization beyond attachments, especially related to the NCPDP transactions adopted under HIPAA, and have had a number of attempts at influencing federal regulations to resolve some industry needs and disconnects with Part D versus the HIPAA regulation for ePA.

We also did a deep dive in NCVHS-land related to the review committee work in 2015 and 2016 that really called out the need for convergence and predictability in our national standards framework, and there's a lot of historical information that we're going to be able to leverage. I believe that ONC is currently compiling a set of key artifacts that will help us get our arms around the extensive history that really speaks to transaction standards, especially on the medical side of the house adopted under HIPAA, that have not met the industry where they're at in their workflows, and that we have a number of challenges as we move forward with thinking about clinical and administrative data and the various flavors that we have with medical, pharmacy, or devices.

So, one of the things that I would like to do is really help get some structure for how we're going to operate, so we're going to talk about that in a minute, but we really need to get our arms around how to transform the paper-based genesis of our national standards that often have tried to solve a one-size-fits-all approach, and that really has not worked from a usability perspective and the products that have been rolled out. We have an opportunity to address the lack of automation and templates that proliferate across the different payers with different roles, but ultimately, we've also got to improve the day-to-day efficiency of the administrative staff supporting the clinical delivery, and faxes, portals, and phone calls really aren't efficient, and ultimately, this is all about the patient services being delayed and the patient outcomes that we're trying to achieve, so as a task force, we have a really great opportunity to kick the tires on the great work that's been done before, and to roll up our sleeves and think about what we can propose to move the dial, as someone said earlier.

So, to that end, I'd like to first ask if there are any questions about that current landscape setup before I move to the work streams conversation. Hearing none, I suspect we'll get chattier as our calls advance, so let's go to the next slide, please. The first step we need to do – and, please understand I'm trying to paint a picture, and I'm really going to expect the feedback and dialogue to help us think about how we're going to organize ourselves and get our work under way so that we can accomplish the timeline that Sheryl spoke about, which is really to advance weekly to the point where we can have draft recommendations in the July timeframe.

To that end, we need to examine our landscape, as I mentioned earlier, and ONC's going to be bringing us some additional framing of a synthesis of that historical information. We're probably targeting that for March 17th, our next call. That's going to help us hone in on the specific gaps and opportunities so that we can really achieve that end-to-end better electronic flow of information where we're recording once and reusing. We really want to figure out the availability and use of appropriate harmonized standards, and when I'm using the word "standards," I'm doing that in air quotes because standards not only talk about the way we transport the data, but also the business rules about what data we put in there and how we use those transport mechanisms. We need to make sure that we're protecting the data and understand the risks of electronic health record data extraction and exchange with payer systems back again, and what the best practices are that we need to be thinking about as we move forward.

Part of our objective is not just prior authorization, as that is the exemplar, the primary, shiny object in the middle of our table, but there's an overarching issue that we need to tackle as a nation, and that is how we're going to converge clinical and administrative data. We have HIPAA, we have HITAC, we have MMA, we have 21st Century Cures, and MACRA – I can't forget that – and we need to figure out how we bring these closer together in our nation's journey toward more efficient information exchange, and that may also include taking a look at barriers in existing regulations to support the care delivery and system efficiencies that we're ultimately looking to achieve.

So, we think that we want to start out with getting ourselves rounded around that holistic big picture, and if we think that that's the right place to start, then that would lead us into a second set of activities, and the first holistic view would inform how we want to organize and structure ourselves in the next steps, so I think it's important to understand that this is a journey, and we're going to learn along the way, and we're going to stay in communication, and we can tweak our approach, but we have to agree on how we want to get started and how we want to focus ourselves.

One of the things we may need to grapple with is the overarching – the big picture is one thing, but we probably have some dynamics between medical services, pharmacy, devices, and other specialty prior authorization processes, so we may want to think about how we tackle the nuances within those categories, and then bubble the input up into our overarching consideration. With that setup, I'd like to open it up for questions.

Sheryl Turney
Alix, before we do that, I wanted to throw something out there as I've been thinking about it. This is Sheryl, and I did raise my hand.

Alix Goss
I'm sorry, I wasn't looking.

Sheryl Turney
No, nobody was offering anything. One of the things that makes it – so, this is hard work because it's conceptual, and so, I think getting started is always the toughest part because how do you begin a path, and which path do we go down? One of the things we might want to do, which, if we can do it quickly, might help us understand how we want to organize, is for us to really have in mind what our goal is, and to me, because I think I do think a little bit conceptually, I try to look at what my desired end goal would be for this

effort. To me, as a patient, I would want to be able to walk into a doctor's office, I would want them to be able to look up my plan, and based on which insurance I have, know when they would need a prior authorization, what's required for that prior authorization, and when I'm going to get an answer on whether that device, medication, or test can be performed.

With that in mind, there are a lot of things that have to happen in order for that to work. Today, we know there's a gap in the EMR system. They don't all connect to all the payers. They don't have the data at the line-of-business level, or at the plan level, or maybe they need to be at the employer group level because a lot of the plans are now based on ERISA groups that have customized health plans. So, what level of data is really required in order to know what prior auth is required?

To me, we should start with a picture like that of one set of things, and then, in the background, what's the other set of goals? We would want to be able to send a message electronically when a prior auth is required, or maybe we want to say, "Hey, 99% of these procedures for this thing always get approved, so why do we even need to do a prior auth? Why can't we do a trust-and-verify for this one?" Maybe there are some criteria that can be recommended that would allow more consistency amongst those things. So, again, I'm just throwing these out to ask what the concept we want to start with is that's going to help the discussion get started so we can figure out how we want to work on this. Does that help spur some conversation?

Alix Goss
Well, we already have some hands up, so I think Arien was first, and then Leslie was second.

Arien Malec
Thank you, Alix. What I'd note is we should probably start with critical metrics and definition of delight on each of the actors. So, if I'm a patient, what does delight mean for me? As I think Sheryl mentioned, it means that I come in, a treatment recommendation is made for me, and I leave with approval for that treatment recommendation, or if there's denial for that treatment recommendation, I leave with clearer approval for an alternative treatment recommendation. If I'm a provider, then the amount of office, administrative, and clinical staff time is minimized. If I'm a payer, I've been able to manage appropriateness of care and drive efficient use of healthcare without driving my members crazy and driving inefficiency on my side. So, I've got some member and provider issues, and I've got total cost of care issues.

At the end of the day, I think we believe that there's a benefit to all of us as individuals and as taxpayers, so we do need to bring this down to total cost of care relating to ePA or relating to activities that require prior authorization workflow. So, I think starting with clear statements of not incremental improvement over the current state, but what great looks like, would be really useful.

And then, Sheryl, I think you hit some of the key needs. I need to discover if there is prior authorization needed for some prospective treatment that I'm offering to my patient, and if there is prior authorization needed, I need to efficiently provide the supporting documentation to adjudicate that prior authorization, and I need to do that adjudication either in real time, or if there's a wait time, the level of wait time and the SLA around that wait time need to be very clear and transparent so that I know exactly what guidance I can give to patients.

And then, if I'm a payer, I need to be able to collect the information needed to adjudicate and maybe – there are a whole lot of shenanigans sometimes in these systems. Do I provide transparency around my rules and make sure that I've got an evidence basis for the rule sets that I'm using? I need to be able to make sure that I'm collecting the information necessary to adjudicate that prior authorization. So, maybe there's a set of workflow needs at a high level that we can treat before we get down into the messy bits of all the transports, standards, and workflows that are necessary. Maybe we can think about the decomposition of the key actors, what information needs they have, and what workflow drives the end customer benefits.

Alix Goss
Great input. Thank you very much, Arien. I think Les was next.

Leslie Lenert
I second a lot of what you said, but I want to take this a few steps further in laying out a good foundation for going forward. In the current system, there is a lack of transparency from the patient's perspective and the provider's perspective. Let us come to some agreement as to what the gold standard is. That gold standard should be the consensus of experienced physicians using appropriate rating technologies for procedures that have already been developed by RAND and other approaches for looking at whether procedures are indicated or not. This needs to be fully transparent, and not just publication of the rules, but to understand the tradeoffs, the sensitivity and specificity of those rules, and what the edges and brittleness of those rules are when they fail before this starts. There should not be the right to impose any rule that potentially impacts health outcomes in the prior authorization process.

As Arien suggested, it has to be evidence-based, and the tradeoffs have to be clear and transparent, but better still, it'd be better if these rules actually mimicked the judgments of a consensus of physicians. Again, this notion of transparency needs to be very clear. It would be good if we wound up with a process where insurance companies had to make those criteria transparent so that when people were buying insurance, they could see at least there was a process for this that they could endorse through their consumer choices.

Secondly, I'd like to say that physicians and patients are not always on the same side in a prior authorization decision, and it's important that this decision be shared, and that patients have a route for exploring what is and what is not authorized by a company independent of the physician because oftentimes, physicians recommend treatments that they're either skilled or experienced in, or sometimes, regrettably, that they benefit from because they provide the procedure and receive additional remuneration through that route. This doesn't always happen, but it happens enough of the time that it's important that the patient's autonomy is preserved in this.

I think that the past is a guide for how these things could be done, but in the past, this process has been excessively based favoring the insurance companies, and it's time to create a more equitable process through these policies that balances the needs – as we've heard from other commenters – of the insurers for efficiency with the rights of patients and with the needs of providers to be able to do the most good for the greatest number with the limited time and resources they have to aid their patients. And so, I really urge, as Arien said, looking at the goals for the overall process with this kind of equitable consideration and transparency that allows the market to be able to play the role that it should in these types of business processes and decisions, that we not repave the cow path with the standards, but consider how we might leap ahead with newer technologies, such as AI, to a much better vision of what prior authorization could be: Rational, cost-effective, and transparent, as well as advocating both for patients and providers equally to insurers.

Alix Goss
Thank you very much, Les. I believe next in the queue is Jim.

Jim Jirjis
Hey, thank you so much. I have a question and a point to make. There's a lot of politically challenging – there evidence basis, there's efficiency of workflow, and there are misaligned incentives, where the insurance company wants to keep costs down and keep margins high, and may have instituted delays because they know the numbers. The patient will end up getting the service or will end up filling the med if they just wait. How much of that are we trying to solve in this group? It seems to me that we would want to start with mapping out the workflows and starting with a platform where at least the data, information, and content rules are exposed, and at a later time, CMS and others could then decide to regulate what the requirements are of insurance companies.

For example, if we look at hospital prior authorization, this notion of time being an important element – not only do we need APIs and not only do we need to identify what rules and data have to happen immediately in an automated way, but there are issues of timeliness, for example, not just timeliness of pay, but let's

say, for example, we use CDS Hooks in our EMR when a patient is admitted, and the CDS Hooks don't allow enough time for the data to accumulate in order to have all the data necessary to get an approval or denial. Well, that can lead to unnecessary denials that then have to be reworked through an appeal process, right?

So, I guess what I'm asking is whether the charge of this task force within HITAC is to define the process and what kinds of APIs, timeliness rules, and types of automation need to be a part of each of these four use cases. Or, is the job of ONC to solve the political issues about evidence-based medicine versus the insurance companies' misaligned goals? Which is it that we're supposed to deliver in September?

Sheryl Turney
Alix, I don't know if you want to respond to that or if you want me to try and you can chime in, but we can certainly get the folks from the ONC to help weigh in as well. But, I believe the focus of our task force is really to look at what recommendations we can make in order to clear some of the hurdles. To the extent that transparency of rules and what's required to submit a prior auth and which procedures or medications, et cetera require a prior auth, and for those to have supporting documents – I think all of those things are within the scope.

When it comes to AI and decision-making, I would certainly assume we could make recommendations related to using evidence-based, but I would be very cautious in that regard because a lot of us in the healthcare sector are still talking about the fact that there is no single standard for AI decision-making, and particularly, what the patient rights of access and knowledge are regarding the decision made with AI, and whether the AI data is direct – I'm going to call it direct or circumstantial, similar to what you see in a court. Is it a direct observation? Is it a test? Is it something that you can show evidence of, or is it referential because it's some social determinant of health, or something that was self-reported, or a social media or a wearable type of reporting, where there might be assumptions that have been made around it? I personally would not feel comfortable extending to that degree, other than maybe to make statements that say where it makes sense. AI should be looked at as an option to help support decision-making, but Alix, maybe you can weigh in, and then folks from the ONC can weigh in as well.

Alix Goss
I think you summarized a lot of my thoughts. In consideration of time, I'll let Lauren weigh in if she wants to, and then, in the queue, I have Jocelyn, Gus, and then Arien.

Lauren Richie
Thanks, Alix. Nothing else from my end, but I know Dr. Mason has been working very closely with the NCVHS team, so I'll see if he has any additional response to that question.

Thomas Mason
Sure. Just briefly, I would say I think we should be – and, sorry, I'm a little under the weather as well. I would say we should be thinking about what our ONC authorities are and what the areas are where we can make an impact through the regulatory process. Also, at some point, it would be great to hear from Mary Greene in terms of some of the things that CMS may be thinking about, but I think it is important for us to initially focus on recommendations that'll go to the national coordinator that we can work on collaboratively with NCVHS. I know Alix will eventually talk a little more about that process and make sure that we understand the way the administrative standards are changed and how we eventually will think about a process that will cover the convergence of both administrative and clinical data, but I would say that as the guardrails for us to at least start thinking about the things that we have the authority to make changes and impacts through our recommendations.

Alix Goss
I think you made a shoutout to Mary Greene. I don't know if she wants to weigh in on that topic before we move to our next commenter.

Mary Greene
I can do that. I would say right now, as we're looking at prior authorization, we've really been focusing more on the process itself to try to make the process more efficient and more transparent. "Standardize," too – although people interpret the term "standardize" in different ways, some plans are unwilling to standardize, even on exactly what's needed for certain prior authorizations, for certain services. Many plans don't want to do that. But, on the actual data transmission standards and that sort of thing, the elements of it – the general elements of what to choose from and whatnot – they would be willing to standardize on that.

We've been shying away from addressing anything that is in the purview of making decisions about when prior authorizations should be used, although we've collected a lot of information about that, but we're not focusing on that right now. The issue about the basis for prior authorization, though, comes up among the clinicians all the time, and whether the plans should at least be transparent about what guidelines they're actually using when they're making the prior authorization decision. That sounds like it's a little challenging because as multiple people have been pointing out, it's a combination of guidelines and business decisions for the companies themselves, so that's a little bit more key there. So, there's plenty to do just to deal with the process of prioritization, and some transparency into at least what resources are being used to make decisions is really important.

The other piece here is part of that process is things like the appeals process or having to go through peer-to-peer discussions or like clinicians, supposedly, on the plan side and vice versa to talk over the case. Those kinds of things are also a little bit challenging to do, but we should remember that they're a core part of the process that kind of transcends that technology. It's more the interaction between the plan and the clinician when that's necessary.

I do want to ask a quick question. In the context of prior authorization, step therapy and formulary changes come up all the time, especially formulary changes because that triggers whether somebody gets to continue with their prior authorization in the context of drugs. But, when we're talking about prior authorization, are we talking about a straight particular product or service, or is step therapy for medications, for example, part of that conversation?

Alix Goss
I think it's the whole kit and caboodle. We haven't figured out if anything is off the table when it comes to the specific flavor. I think everything is in scope for us at this point in time, and that's part of what we're going to need to struggle with as far as getting going so that we can figure out if we do need to break ourselves into discrete Workgroups to tackle the deeper dives in order to make the July timeframe.

Jocelyn Keegan
Alix, it's Jocelyn. I was actually going to head there a little bit. If you don't mind, I'll just jump in.

Alix Goss
I would love you to because you're next in the queue, and after that is Gus, Arien, and then Jim.

Jocelyn Keegan
I love this conversation, and it really incorporates a lot of the challenges I've dealt with over the last five or six years living between medical and pharmacy. If I were going to say it, there are two ways I would look at the whole domain, and I really the love the theme of transparency because I think both in the work that I get to do at NCPDP and the work that we're doing at Da Vinci, just in medical benefit in general, I think it's the unknown, the lack of clarity, the variability, and the lack of clear information/source of truth for provider organizations that really make prior authorizations so painful.

So, I would challenge this group to think about prior auth as more than just the act of submitting a 278 and getting an answer, but really, what that workflow is that is involved and trying to understand a patient-specific benefit at the point in time of care that is right for that specific domain or that specific care setting because I think that being able to get a source of truth – even if people use different methodologies or

technologies, being able to surface at the right point in time in workflow so that a provider and a patient can actually have a real conversation about that particular patient's options, including cost, including service areas – where they can get this done, who is actually in their network – and that's way bigger than just PA.

On the pharmacy side, we deal with it in formulary and benefit. To Mary's point, in the work that CMS and Mary's team are actually sponsoring under Da Vinci, we're doing something similar to formulary and benefits called coverage requirement discovery, which is just giving people one place to get an answer to see if they need to do a prior auth or not and what they need to know about this patient specifically. There's so much variability in the market around plan design, and I've heard people speak to that. I think if people speak about what we can do in the short term to increase transparency way upstream in the workflow, and then have that ability to take the guesswork out for anyone on the physician's team, and then give places to queue the work and pause the patient or pause the process, because the data isn't in real time today. It's just not. And then, how do we create a vision toward how that would happen in real time in ways that we could really unleash the data that's in the EHR today to fully automate?

But, to me, it's about the workflow opportunities to get involved, to get better data in place. What's the transport to do that? There are a lot of tools already available today that can be sewn together, and we're seeing really good progress. Where the data quality is good, the physicians really can reduce a tremendous amount of burden with their pharmacy prior authorization, but if they've got bad data about whether a prior auth is needed or what their therapy is for this particular patient, the physician does what they've done forever, which is to send the script to the pharmacy, and the pharmacy figures out what needs to happen. We can do better than that.

So, I think we can learn a lot from what we've learned in pharmacy, which is that it's not just about the PA, it's upstream, and if we look at it – and, I'm a product manager by training. If we look at it from a workflow perspective, then we'll be able to show those best practices that tie together existing standards, and where we can – and, I'm going to hone on this a lot – where we can allow the industry to experiment with emerging technologies to really figure out the right way to get to that long-term solution where you can take things like AI and put them to work so we can unleash the data via FHIR so we can make real progress.

Alix Goss
Thank you, Jocelyn. Gus, I think you're next in the queue for the first round of commentary, and I just want to make sure that folks are aware that at 4:20, we're going to make sure to take public comments, so that gives us a good seven minutes before we take a wee break, and then we can resume conversation. Over to you, Gus.

Gaspere Geraci
Thank you, Alix. I'll try and be very brief. One of my favorite things is the concept of definitions and unintended consequences. One of the challenges is how things happen and why things happen, and there's been a lot of discussion about cost, and the last speaker mentioned a fact about formularies changing. Sometimes, formularies change simply because the manufacturer changes their discount, price, or rebate, and it has nothing to do with FXT in quality, which leads me to my second comment, which is that before we talk about prior auth, we have to define the basis for prior auth, which is medical necessity.

So, you have to define what you mean by "medically necessary," and then add to that the concept of trying to provide some kind of definition of "quality" because the definition of "medical necessity" and the definition of "quality" are intertwined. I'll give you a very brief example. If I want to go to the Walmart that's about 1.2 miles from my house, there are a number of ways of getting there. They all get me there, but do I walk? Do I take a bicycle? Do I take a used car? Do I drive my own car, or do I get driven by a limo? To me, the best quality there is for someone to pick me up in a limo and take me there, but walking gets me there equally well. So, defining quality in our basis for discussing medical necessity is an important point. I'll just say we haven't mentioned quality, but is it better to walk there or take a limo?

Alix Goss

Thank you. Arien?

Arien Malec
Hey there. Sorry, this is round two, but with regard to the conversation on incentives and all that, I think we ought to proceed with the notion or perspective that we assume good intent, that we assume that there is an issue with overutilization or inappropriate utilization, there's a reasonable interest in putting safeguards in front of overutilization, there's an interest in getting the patient the right, most appropriate care, and there's an interest in all the actors in spending as little time, energy, and effort on getting to the right care that is at highest quality and the most appropriate cost. So, there is clearly a range of issues where all of those things are true. We might speculate as to areas where that's not true, but there's enough in that realm of good, reasonable intent that we can solve for those cases.

Alix Goss
Thank you for that, Arien. Jim, you're up, unless you took your hand down.

Jim Jirjis
No, I didn't. Thank you. I just wanted to give an example. If you have these four different areas – meds, hospitalizations, medical services – the thing they have in common that we don't have right now – the chassis we don't have is a workflow where they're all similar. For example, knowing when someone's ordering a service or med that might need prior auth, knowing if they need prior auth, knowing what data they need to fulfill to adjudicate it – that's just half the battle. It's transparent, but there's a whole other iterative piece to that: When it's not approved. I might submit to the group that shouldn't alternatives, whether they are meds or inpatient versus observation – shouldn't denial be required to also include substitutions or alternative where they're available? Shouldn't there be an ability to adjudicate rules, for example, in a hospitalization if there's an argument over inpatient versus observation? That's a highly iterative peer review process that could be automated. The same goes for meds.

But, we could also get agreements around automatically converting to an alternative, and to me, if you look at the workflows of hospitalizations, med services, and meds, there are a lot of parallels in those workflows. I submit that it sounds like the authority we would have would be to start with mapping out those workflows, figuring out what "good" looks like from a transparency perspective, prioritizing the iterative nature, and then defining what the standards would be to reduce some of the friction and burden between the payer and provider that the patient gets caught in, and it sounds like that's what the ONC's authority is. Is that correct?

Sheryl Turney
Is there someone who can speak to the ONC authority? I don't want to speak on behalf of that. This is Sheryl.

Lauren Richie
Sure. First off, is Tom still on the line? Maybe not. This is Lauren Richie. I would say that Cures is very specific in the charge and outline of the committee, and so, I'm happy to review those, but I would say anything that's within the purview of this particular committee is an option we can explore, but I think where it's a little interesting between this is that we have authority under ONC, and we also have authority under NCVHS, so just making sure that we're keeping those lines drawn clearly, we have to sort out under which authority we want to proceed.

Sheryl Turney
That's wonderful, Lauren. I do think that helps. We didn't really discuss this as much in the beginning, but the ONC's authority is really focused on one aspect, and NCVHS on another. Maybe we need to reset that for the next meeting and just have a one-pager on that to come back to this group so that they can see what the differences are.

Lauren Richie

Yes, I'm happy to do that. So, at this point, it seems like we're at a natural break. Alix and Sheryl, I think we'll go ahead and open it for public comment at this time. Operator, can you please open the public line?

Operator
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. For participants using speaker equipment, it may be necessary to pick up the handset before pressing *.

Lauren Richie
Thank you. Do we have any commenters in the queue?

Operator
There is nobody in the queue.

Lauren Richie
Okay. Sheryl and Alix, I'll hand it back to you.

Alix Goss
Okay. So, let me do a callout to see if there are any other comments from the task force members around this approach to the work streams discussion. While you're thinking about that, I can indicate that I think there's some very strong theme around transparency and a strong theme around getting the workflows mapped out. Jim, I think you might have called that the chassis. We want to make sure we understand what the workflows are, and as Arien put it, I love these critical metrics of delight, that we really want to know what "great" looks like, and that really intersects with the workflow conversation and some of the transparency aspects. I think that there's some commentary around having good definitions of what we're trying to achieve and the interplay of medical necessity and quality aspects. I think these are thoughts that we'll take away from today's call, and the co-chairs will be working with ONC to figure out the materials for the next call and the structure that will help us continue this journey, but having recapped that, are there any other thoughts from the task force members?

Sheryl Turney
I just wanted to add to that, Alix, that I also heard that with the definition of the workflows, perhaps it'd be helpful if we could find the information requirements related to each actor and how they might be different, and also talk about what happens when prior authorizations are denied, and maybe some techniques and alternatives or standards that could be put in place for how that is handled to reduce the burden around that aspect.

Alix Goss
Great additions. Thanks for catching that. I wasn't sure how much conversation we were going to have, and I'm really pleased with the thoughts and the input. We will definitely be producing some perspectives on where we've come from, maybe factoring some clarifications relating to NCVHS versus ONC, although I think it's pretty clear to see that we've got ONC running down the clinical path and NCVHS going down the administrative path, but we are definitely holding hands, skipping our way to the end to make it better for all. I think we have some additional slides. I want to make sure we get through all of those today.

Sheryl Turney
Yeah, we have one more slide, about the next task force leaders.

Alix Goss
I'm not seeing any hands raised at this point. We are planning to meet on March 17th. I believe, Sheryl, that unfortunately overlaps with a vacation – probably a very well-deserved vacation – so I don't know that we'll see you or hear you on March 17th. Certainly, you'll be helping to guide the work between now and then. For everyone's awareness, because of the intention for HIMSS next week, we have canceled the March

10th meeting, but we will be resuming on March 17th to discuss the various topics that I've just summarized and to solidify a few more of our next steps for organizing our work. With that, we've actually come to the end of our presentation and intended dialogue. I don't know if there are any final words from ONC.

Lauren Richie
This is Lauren. From this end, I want to thank everyone. We've captured all the notes and action items from this discussion, and we'll bring that to the next meeting.

Sheryl Turney
Thank you, everyone, for participating. We really are excited to get going on this topic.

Andrew Truscott
You're welcome. Thank you for leading.

Arien Malec
Thank you. Goodbye.

Lauren Richie
Thank you all. Have a great day.