The Office of the National Coordinator for Health Information Technology

Meeting Notes

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

March 17, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

EXECUTIVE SUMMARY

Alix Goss welcomed members of the Intersection of Clinical and Administrative Data Task Force (ICAD TF) and reviewed the task force's agenda for the meeting. **Lauren Richie** and **Tom Mason** from ONC covered some of the authorities related to Federal Advisory Committees for ONC, and **Rebecca Hines** from NCHS covered those related to NCVHS. **Alix Goss** presented the current landscape and led members in a discussion and analysis of it and a compendium of artifacts in this area. **Jim Jirjis** shared sample workflows for prior authorization (PA) that he developed following discussions held at the previous meeting, and members discussed the workflows at great length.

Several members volunteered to create more examples of workflow prototypes to be presented at a future meeting. **Alix Goss** thanked members for their thoughtful participation and feedback, and she summarized the main themes from the meeting, including trust and transparency around the PA process, patients being at the center of everything with their caregivers, helping patients to be an integral part of a future happy path, and the idea of metrics for delight.

There were no public comments, but there were several comments written in the public meeting chat via Adobe Connect.

AGENDA

03:00 p.m.	Call to Order/Roll Call and Welcome
03:05 p.m.	FACA and ONC Authorities
03:15 p.m.	Landscape Discussion and Analysis
03:30 p.m.	Workflow Examples and Discussion
04:00 p.m.	Discussion and Next Steps
04:20 p.m.	Public Comment
04:30 p.m.	Adjourn

CALL TO ORDER

Lauren Richie, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the March 17, 2020, meeting of the ICAD to order at 3:03 p.m.

ROLL CALL

Alix Goss, Imprado/NCVHS, Co-Chair
Gaspere C. Geraci, Individual
Mary Greene, Centers for Medicare & Medicaid Services
Anil Jain, IBM Watson Health
Jim Jirjis, Clinical Services Group of Hospital Corporation of America (HCA)
Jocelyn Keegan, Point-of-Care Partners
Rich Landen, Individual/NCVHS
Arien Malec, Change Healthcare
Thomas Mason, Office of the National Coordinator
James Pantelas, Individual/Patient Rep
Alexis Snyder, Individual/Patient Rep
Ram Sriram, National Institute of Standards and Technology
Debra Strickland, Conduent/NCVHS
Sasha TerMaat, Epic
Denise Webb, Individual

MEMBERS NOT IN ATTENDANCE

Sheryl Turney, Anthem, Inc., Co-Chair

Steven Brown, United States Department of Veterans Affairs
Leslie Lenert, Medical University of South Carolina
Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin
Jacki Monson, Sutter Health/NCVHS
Abby Sears, OCHIN
Andrew Truscott, Accenture

WELCOME

Co-chair **Alix Goss** welcomed members to the second meeting of the Intersection of Clinical and Administrative Data Task Force (ICAD TF). She noted that a robust discussion around the task force's workflow examples would occur to set the focus for future workstreams to achieve the end objective of making recommendations for the merging of clinical and administrative data, its transport structures, rules, and protections, with a particular focus around electronic prior authorizations.

To set the context for the meeting and to follow up with the ICAD TF's discussion from the last meeting, she explained that **Lauren Richie** and **Tom Mason** from ONC and **Rebecca Hines** from NCHS would cover some of the authorities related to Federal Advisory Committees, ONC, and NCVHS.

FACA AND ONC AUTHORITIES

Lauren Richie noted that in response to several questions received at the previous ICAD meeting, she would present more detailed information on the respective authorities between the two Federal Advisory Committees (FACs) represented on the task force. Also, the ICAD TF would discuss the additional authorities around ONC's clinician burden reduction work.

She gave an overview of the HITAC, which was established under the 21st Century Cures Act (the Cures Act) to "recommend to the National Coordinator…policies,…standards, implementation specifications, and certification criteria, relating to the implementation of a health information technology infrastructure, nationally and locally, that advances the electronic access, exchange, and use of health information." She noted that the HITAC essentially replaced the previous HIT Policy and Standards Committees that were in place at ONC.

The HITAC's specific charge is as follows: "Such recommendations shall include recommended standards, architectures, and software schemes for access to electronic individually identifiable health information across disparate systems including user vetting, authentication, privilege management, and access control." She noted that the three main HITAC priority target areas include information exchange, privacy and security, and patient access.

Rebecca Hines gave an overview of NCVHS and noted that it has been in existence for 70 years. It is charged by Congress with advising the Federal Government and HHS on the information needs underlying national health policy. The main areas are health data, statistics, privacy, and data standards. She stated that its scope expanded in 1996 when HIPAA called on the Committee to serve HHS as a key advisor in the implementation of the law's administrative simplification and privacy protection provisions.

She explained that advice and recommendations regarding health data and statistics, privacy, administrative simplification, data standards, and health information policy are submitted directly to the Secretary of Health and Human Services (HHS). The office of the HHS Assistant Secretary for Planning and Evaluation provides oversight to the NCVHS, and, historically, it has been staffed by the National Center for Health Statistics (NCHS), which used to be housed in HHS but was later moved into the Centers for Disease Control and Prevention (CDC). The Cures Act calls for ONC coordination with NCVHS, which finds them looking to the HITAC for recommendations and comments that can be taken into consideration.

Tom Mason gave an overview of ONC's role in clinician burden reduction and authorities under the Cures Act, which, he explained, did not give ONC any new authorities but tasked them with creating a report in collaboration with the Centers for Medicare & Medicaid Services (CMS). He noted that the Reduction in Burdens Goal states that the Secretary of HHS shall establish a goal, strategy, and recommendations concerning the reduction of regulatory or administrative burdens (such as documentation requirements) relating to the use of electronic health records. It states that this should be done in consultation with providers of health services, health care payers, health professional societies, health information technology developers, public health entities, States, and other appropriate entities.

He presented the goals of the report, which were meant to address the following items: actions that improve the clinical documentation experience, actions that improve patient care, actions to be taken by the Secretary and by other entities, and other areas, as the Secretary determines appropriate, to reduce the reporting burden required of health care providers. He noted that the report is mainly focused on actions HHS could take through regulatory actions to reduce clinician burden. The report focuses on ONC's current and existing authorities in terms of rulemaking that centers around their certification program, U.S. Core Data for Interoperability, and ONC's convening authority.

He emphasized the importance of the fact that the report was exempt from the Federal Advisory Committee Act. ONC was asked to reach out directly to the stakeholder groups that were identified in the statute. From an ONC perspective, from a CMS perspective, and from the industry perspective, there are recommendations that call for the industry to move forward without ONC having new authorities and regulations in areas over the industry. He clarified that this is a report that Congress asked for through the Cures Act, and it was meant to leverage ONC's existing regulatory authority in terms of reducing burden.

LANDSCAPE DISCUSSION AND ANALYSIS

Before beginning the presentation, **Alix Goss** noted that task force members should have received a preliminary version of a compendium of information related to historical artifacts, and she invited them to share suggestions to make it a full, complete compendium.

Then, she began her presentation by directing members to the slides. She noted that the separation of clinical and administrative datasets and systems has been leading to a burden, particularly with regards to prior authorization. She explained that there are many outdated and complex workflows from its original paper-based genesis of technical standards and policy approaches and detailed some of the challenges across the marketplace.

From the meeting slides, she presented a table that was included in the 13th report to Congress, in which the NCVHS community compiled information on the percentages of industry implementation of seven transaction standards from across the years 2013, 2018, and 2019. She emphasized that the table drove home the point that existing standards are not fully implemented, despite a longstanding mandate for the HIPAA transaction sets. Prior authorization (PA) lagged far behind the other standards, at only about a 15% industry implementation rate in 2019.

She noted that the landscape of the industry has continued to understand that the PA transaction adopted under HIPAA was not meeting all of the industry's needs. She highlighted some ways in which the industry has responded to the need to ease the prior authorization burden by developing Fast Healthcare Interoperability Resources-based (FHIR) standards and market-based solutions, forming new industry working groups, and holding hearings with NCVHS and HITAC. Then, she asked members to look at the compendium and to share any additional or missing information that they have related to the compendium.

Discussion:

- **Jocelyn Keegan** inquired if the National Council for Prescription Drug Programs (NCPDP) was mentioned in the compendium. Also, she inquired if it included the scope of both pharmacy PA and medical PA.
    - **Alix Goss** responded that it was not an intentional omission, and it is meant to be the landscape of the challenges on the medical side of the house. She thanked **Jocelyn Keegan** for the question, because, she said they not only want to tackle medical PA and pharmacy PA, but they also want to think about any of the specialty dynamics related to prior authorization as they move forward.
    - **Jocelyn Keegan** mentioned that workgroups, of which she is a member, are actively talking about related items, including specialty medications, and she said she would reach out offline and figure out who or what sort of data would be helpful to include in the compendium.

WORKFLOW EXAMPLES AND DISCUSSION

Alix Goss noted that **Jim Jirjis** shared some sample workflows developed after the previous meeting and that the task force would work with them later in the meeting. She noted that the models might be over-simplified, but they are meant to build a baseline for future work. Then, she asked him to walk everyone through a high-level model. She asked members to think of this as a general prototype that is a base to be tweaked over time to get to medical services, inpatient services, durable medical equipment, and pharmacy-related types of prior authorizations. The goal for this meeting, she emphasized, is to review this initial model and then discuss how it can be leveraged to define and drive the work as they move forward.

Jim Jirjis suggested that the group focus first on the simplified steps, realizing that tweaking them would be necessary, from durable medical equipment PA versus medical service PA versus hospital services PA. He emphasized that if they all understood the steps, however simple they may be, they can work together from that point. Then, they can go back to specific steps to determine what the opportunities are in the process, and this would happen through the lens of the authority each of these two organizations have around PA.

He presented a general prototype of the PA process and noted that the potential areas of focus were standards, data models, workflow integration, and transport methods. He shared some questions for task force members to consider while evaluating the workflow, which were:

- Missing elements: are there any high-level components that are missing from the model?
- How can we use the model to establish a ‘north star’ or ideal state result?
- How can we use the model to reflect the benefit to providers, patients, and payers at each step?
- Who are the major actors that should be considered/consulted that are currently impacted or would be impacted by alterations to the sample workflow presented here?
- How do we represent the work that has already been done within the model?
- How can we use the model to define and drive workstreams to accomplish our deliverable?

Then, he presented a slide showing potential opportunities for improvement between steps in the workflow. He reminded members that the list of opportunities is not meant to be exhaustive but, rather, a way to ground the task force into working with a shared lexicon. He presented a list of questions to consider, which included:

- How do we ensure no major step is missing?
- How do we begin to add a more exhaustive set of opportunities at each step?
- How do we represent the work that has already been done (HL7 Da Vinci Project, etc.) on this model?
- How do we process those opportunities and organize them into action items for HITAC?

Discussion:

- **Arien Malec** inquired if a step was missing that covers discovery and the potential sharing of procedural codes or other criteria for which PA is required. At the minimum, they need to know that payer's coverage. Then, he suggested that they might also want to think about a process for discovering from the payer what procedures require PA or may require PA, so the PA check can be done.
- **Anil Jain** thanked **Jim Jirjis** for the overview. Then, if PA is the test case, he asked how this model and some of the steps would look in a reimagined state in a world where clinical and administrative data have been aligned to reduce the burden. He asked about the overall scope and if the task force is trying to recreate the current workflow in a more data-enabled way, or if its goal is to reimagine how a more efficient process would look in the future, and, possibly, to eliminate multiple steps along the way. He discussed some example scenarios.
    - **Alix Goss** stated that the task force should figure out how these workflows would function with more data flowing and more real-time options and not be limited by the existing process steps.
    - **Tom Mason** agreed with the approaches described by others, and he supported both improving existing workflows and reimagining ways to be more efficient with data and technology.
- **Jocelyn Keegan** voiced her agreement with **Anil Jain** and asked to continue discussing the point that **Arien Malec** made earlier. She emphasized that the concept of transparency of information is critical. She discussed some relevant PA situations and noted that, today, the quality of the data available upstream drives what kind of technology someone in a physician's office uses to initiate the process. She emphasized that, even before the first event in the workflow, there is a decision to understand the patient's benefits, and if a non-digitized format is used at that time, she lamented that she is stuck using a certain workflow.
    - She explained that in her experience providers do not do PA unless it is a single doctor shop. When a nurse or MA is doing the PA (signing for the doctor based on set procedures), the smart practices have created cheat sheets to back out of all of the existing rules in their particular market as general rules. She gave some examples of how this can be a difficult process due to variability in the market, patient-specific situations, and more.
    - She noted that the upfront idea of data, transparency, and trusted information that matches the current patient has to be the thing that they "unlock" before they talk about how to automate the workflow. In response to a request from **Alix Goss** for clarification on "unlocking data," she said that there are many places where data can degrade, depending on storage and sharing methods, so moving to real-time application programming interface (API) access back to the payer or product data management (PDM) as a source of truth are both important.
    - She explained that the concept of what is paid for by a patient's insurer is completely separated from what happens while they are sitting in their physician's office, because the other part of the team is doing the PA administrative work. She said the ability to bring those two worlds back together is what she meant by "unlocking" it.
    - **Alix Goss** responded that she sees this as a need to have a pre-step, possibly called the discovery state, which comes before the workflow.
    - **Jocelyn Keegan** said she thinks that an understanding of the patient's benefits must come first. She said that the way plan design works with payers, the process has to be patient-specific.
- **Arien Malec** noted that the coverage discovery and benefit discovery piece of the workflow had been belabored by the task force, though he stated it is incredibly important. Next, he emphasized that they need to put the patient in the diagram. He echoed **Anil Jain's** statement that there are several places

where mechanical steps in the workflow should be replaced by processes, and he shared examples. He stated that there should be an implied state machine in the process.

  - Also, there are areas where they risk automating an inefficient manual process. Instead, they should be seeking to design a process that has all the information required at each stage of the process, and, in doing so, the task force could collapse many steps into one.
  - He said that for each of the major steps they should plan to design around the concepts of "happy path" vs. "degenerate path," and in the "happy path" case, they should be thinking about what delight looks like and what metrics are associated with delight. He said that they should make sure the standards are set up to be able to handle real-time inline adjudication or near real-time adjudication in the context of the patient encounter.

- **Alix Goss** summarized many of the points made and the themes highlighted in the meeting thus far. Members discussed the state machine keeping track of the status concept.
- **Alexis Snyder** agreed with the points **Jocelyn Keegan** and other members made earlier.
  - She opined that Step A in the workflow should be when a provider orders a medication, test, treatment, or durable medical equipment for the patient or caregiver. This ties to the idea that there is not universal awareness of when a PA is required because of differences in insurance processes. She explained that determining a universal plan for when a PA is required is likely an undertaking for a different task force.
  - She noted that Step B is when a patient or caregiver returns to the doctor's office to explain what they need, and, often, they do not have contact with a provider but someone else (medical assistant, nurse, or another administrative person). She explained that the reason for many denials is that these staff members are not properly trained in how to enter PAs and get denials right away in the process.
  - In her opinion, the patient or caregiver is in the middle of the workflow, as they are the one who hears from the pharmacist, the durable medical supplier, or another special provider that the PA has been denied. The patient is the one who is burdened. She gave other examples of how pieces or other burdens might be missing from the workflow. In response to a question of clarification by **Alix Goss**, she explained that it would be useful to have prototypes of workflows based on the identity of the actor in the process (patient, clinician, or payer). ICAD TF members discussed several ways to approach these different prototypes.
- **Jim Pantelas** stated that the piece that is missing is the patient/caregiver in the situation, because they end up getting a denial before they see any documentation or extra information. Then, they have to correct what was initially submitted so it can be submitted again. He gave the example of trying to obtain a wheelchair, which took over a year to be processed, and the patient (a child) had grown out of the size ordered by the time it arrived. He emphasized that nothing should be submitted for PA without also copying the patient or caregiver. He highlighted the need for financial price transparency.
- **Rich Landen** noted that if the ICAD TF is thinking at the highest level, the prototype is fine. However, it begs the question of how the prototype will be used; if it will be used to test ideas, validate things, and talk about the workflow, it is too high level. He echoed others who requested that the patient be added as an actor in the prototype and listed several patient-centric questions that could help shape a from-the-bottom prototype featuring the patient.

- **Mary Greene** echoed statements made by other members and also highlighted the beneficiary as part of the process. She added that it might come as a surprise to many that some health plans also require the beneficiaries to trigger the appeal. As a result, there is an issue with delays and appeals because the beneficiary often does not know what to do. The providers have to step in on behalf of the beneficiary or offer to help, due of the complexity of the problem.
    - She noted that, if they think about the patient and the provider as a team during this process, there will not be as many steps, and the beneficiary might not get left out in several steps. Also, she mentioned the peer-to-peer process, which is triggered as part of the appeal process and discussed some of its nuances.
- **Alix Goss** noted **Mary Greene's** comments and stated that they would discuss how there could be some creativity applied with peer-to-peer reviews. Also, she reminded members that comments were being entered into the chat box in Adobe during the discussion. Feedback will be used to create another prototype for a future meeting.
- **Jim Jirjis** agreed that the input would be used in creating further versions of the prototype. He noted that, though it is not ideal, the current state of the PA process should be mapped out, as well. He suggested that outpatient versus inpatient medications should be teased out as a process.
- In response to the many comments received, **Alix Goss** took offers from the task force members to create a variety of prototypes, including a patient and caregiver focused one.
- **Jocelyn Keegan** explained that when she has used "happy path" scenarios with NCVHS in the past, the format of the UML version of the picture is good. Then, they could define how the next version of **Jim Jirjis's** prototype would look.
- In response to a prompt from **Alix Goss,** members discussed how detailed the future workflow prototypes should be at each level presented, given that they could choose to represent different actors, swim lanes, system workflows, or specific kinds of PA.
    - **Jim Jirjis** noted that some concepts would apply to all four areas, and some would not. He suggested separating the four different types, mapping them out, and, then, coming back together as a task force to find commons pieces.
    - **Alexis Snyder** agreed with this approach. Also, she added that if the situation is flipped to think about the outcome when things do not go right, it becomes apparent that the true burden is on the patient. When the focus is on the bottom line, people jump in to take steps, from the beginning to the end, to streamline a process that reduces the work burden for the provider and the burden placed on the patient or caregiver. Then, ultimately, this fixes the care for a patient who is at end of the line and has been waiting for something they need that insurance has been blocking.
    - **Jim Jirjis** noted that one different example is when the hospital is involved in calling in PAs, like when a patient is admitted to the ER. He said that it is a different dynamic and should be examined by the ICAD TF.
- **Gus Geraci** emphasized the key issue of transparency. However, he explained that the items requested for PA can be inappropriate, and this places the burden on the physician. The assumption that things are denied because of an "evil insurance company" ignores the fact that lots of denials are appropriate. In some cases, he noted, the provider asked for the wrong thing or is trying to do something that is not under current standards of care. He suggested creating a prototype that starts with the insurance company.
- **Jim Jirjis** commented that 62% of denials of PAs in the hospital are overturned, so there is an opportunity to do a better job. He referred to some other figures from the slides in his argument.
    - **Gus Geraci** noted that if they are getting 62% denials, they might not be submitting requests that are rich enough in information.

- **Jim Jirjis** responded that is often a timing issue, in which all of the necessary information is not available when PA is filed.
- **Gus Geraci** noted that it might also be a process issue, related to how insurance companies operate.
- **Jim Pantelas** stated that this could be an argument for including patients closer to the front of the process.

Alix Goss asked members to pause their conversations to open the lines for the public comment period.

PUBLIC COMMENT

There were no public comments.

Questions and Comments Received via Adobe Connect

Gus Geraci, MD: Gus Geraci, here.

Cassandra Hadley: Thanks Gus. Will mark you down.

Alexis Snyder: Yes! That is exaclty what I was just thinking, many times providers nor patinets are aware a PA is needed

Gus Geraci, MD: Agree with Jocelyn.

Alexis Snyder: Absolutley agree

Gus Geraci, MD: Most insurers have their requirements online, but for a provider that means accessing multiple websites for multiple diagnoses, and requesting PA multiple different ways.

Alexis Snyder: and many times that info is incorrect

Gus Geraci, MD: Just creating a single automated or even online process/gateway would be a good start.

Alexis Snyder: we need standartds across insurers as to what needs a PA or not to start

Gus Geraci, MD: That would be a challenge, as each insurer creates their own criteria/items requiring PA.

Alexis Snyder: I know but that is already a hugh part of the problem

Gus Geraci, MD: Absent a single payer system, doubt that's viable.

Gus Geraci, MD: The process shown is missing the actual first step- verifying insurance and any COB for the patient to be sure you're dealing with the right insurer/patient.

Jim Jirjis: Sorry . i lowered mny hand

Jim Jirjis: Some of these assumptions change if it is an outpatient clinic tryign to get prior auth and it is denied or if it is a hopsital authorization

Jocelyn Keegan: We have a UML format we've used on NCPDP for happy path

Denise Webb: Use swim lanes format for each actor

Mary Greene: Some plans require patients to trigger the appeal process as well. Another burden for them.

Jocelyn Keegan: Important to keep them together, because site of care is a big derailer :)

Ram D> Sriram: Last year Melanie Combs-Dyer gave a talk at one of the ONC's HITAC meeting on PA in the Medical Fee for service program. I believe CMS is using AI techniques to do PA. Might be useful to look into this.

Alexis Snyder: Also the prototype is missing a step between denial and appeal, and peer to peer review. We need to streamline a process that once denied can be re-submitted/appealed and given priority 2nd look before having to go to peer to peer reveiw while the patient waits and deterioates

Alexis Snyder: and to further that thought, the appeal is usalluy on the patient/cargegiver first, not the provider

Mary Greene: CMS is not currently using AI for prior auth but is including that potential in discussions

Alexis Snyder: I would be happy to help too

Carolyn Petersen: I am happy to help with the patient experience also

Jocelyn Keegan: Yes. to everything Alexis just said.

Alexis Snyder: :)

Gus Geraci, MD: Jim Pantelas, I am horrified to hear about a year to approve a wheelchair.

Alexis Snyder: unfortunately hat is not uncommon Gus, as is waiting for manuy other treatmentts, diagnostic etc

Alexis Snyder: *that not hat

Gus Geraci, MD: typos understood.

Alexis Snyder: Happy to send you the results of a reseach study that I was engaged in that sh ows the statitics on this ..it is happening way more often then you think

Gus Geraci, MD: Denise, most insurers have their criteria online.

Alexis Snyder: and often the critertia online is not updated in real time and not helpful

Gus Geraci, MD: That is a burden that needs to be overcome.

Gus Geraci, MD: Like prices in a supermarket, they need to be held to what they publish.

Denise Webb: Agree Gus but it is often vague and requires a phone call to the health plan. I know more about the process than the average beneficiary since I work in health care and I don't think it is that straight forward

Carolyn Petersen: Yes, I'm in

Jocelyn Keegan: i just dropped my voluntold offers :)

Alexis Snyder: correct but that is also very easier said then done

Jocelyn Keegan: into your email Lauren and Alix

Following the pause for public comment, the discussion continued.

Discussion:

- **Mary Greene** commented that the requirements need to be understood early in the process to try to avoid denials related to incomplete submissions. She shared an example of a beneficiary who understood PA very well but could not get herself inserted into the process to help to it forward. She seconded need to include beneficiaries, the importance of transparency, and peer-to-peer conversation. She asked about the plan's perspective if the patient or beneficiary were to be an active part of the conversation.
- **Gus Geraci** responded that he is a believer in transparency and the need to have the patient or representative involved in the process. He explained his personal experience with a time he had to attend a hearing, and the times he has had to overturn PA decisions. Also, he noted that once in a while, the provider is practicing medicine that is decades out-of-date and made the wrong recommendation; the patient should be notified of the PA decision, in that case.
- **Denise Webb** voiced her agreement with the comments from other members about the role of the beneficiary or the patient in the process. Frequently, she noted, patients are left out on the payer and provider side in terms of how they can be empowered and have a role, starting with the payer side. She stated that it is helpful to have straightforward, transparent information about what does require PA in your benefit plan and to have that easily accessible when going to an appointment or making a request. She would like to have the payer engage the beneficiary in a partnership, and it would be good if they illustrate the role of the beneficiary/patient in this process.

CLOSING REMARKS AND ADJOURN

Alix Goss thanked members for their thoughtful participation and feedback, and she summarized the main themes from the meeting, including trust and transparency around the PA process, patients being at the center of everything with their caregivers, helping patients to be an integral part of a future happy path, and the idea of metrics that delight. She noted they have a prototype that needs to evolve to have a full reflection of the common pieces that can then be broken down to add nuances related to specialties, and if the ICAD TF can get those happy paths and common pieces defined, they can work on the framework and can identify and mitigate possible failures. Also, she noted that they could develop a set of general principles around what they expect the new perfect world of PA would accomplish. The homework for the task force is to produce some additional prototypes, and she thanked **Jim Jirjis, Jim Pantelas**, **Alexis Snyder**, and **Carolyn Petersen** for volunteering to work on them.

She reminded members that the next meeting is scheduled to take place on March 24, 202, and that the team would meet after this call to think about all the input from today. They will create some discussion documents for use at the next meeting.

The meeting was adjourned at 4:30 p.m. ET.