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 24, 2020, 3:00 p.m. – 4:30 p.m.

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-ofCare 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
Josh Harvey	Clinical Services Group of Hospital Corporation of America (HCA)	

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Welcome to what is now the third official meeting of the Clinical and Administrative Data Task Force. We will go ahead and get started starting with roll call. Sheryl Turney?

Sheryl Turney
Here.

Lauren Richie
Alix Goss?

Alix Goss
Present.

Lauren Richie
Aaron Miri? I don't think we have him yet. Abby Sears?

Abby Sears
Here.

Lauren Richie
Alexis Snyder?

Alexis Snyder
Here.

Lauren Richie
Andy Truscott? Not yet? Okay. Anil Jain?

Anil K. Jain
I'm here.

Lauren Richie
Arien Malec?

Arien Malec
I'm here.

Lauren Richie
I believe Deb Strickland is going to be absent. Denise Webb?

Denise Webb
I'm here.

Lauren Richie
Gus Geraci?

Gaspere C. Geraci
Here.

Lauren Richie
Perfect. Jacki Monson is going to be absent as well. Jim Pantelas?

James Pantelas
I'm here.

Lauren Richie
Great. Jim Jirjis?

Jim Jirjis
Yeah, here.

Lauren Richie
Jocelyn Keegan?

Jocelyn Keegan
Yes, here.

Lauren Richie
Les Lenert?

Leslie Lenert
I'm here.

Lauren Richie
Mary Greene and Rich Landen will be absent. Is Ram Sriram on the phone? Not yet? Okay. Sasha TerMaat?

Sasha TerMaat
Here.

Lauren Richie
Steve Brown?

Steven Brown
Here.

Lauren Richie
Tom Mason?

Thomas Mason
I'm on.

Lauren Richie
Welcome. And, joining us today is Josh Harvey, also representing HCA along with Jim Jirjis. At this point, I will turn it over to our co-chairs to get us started.

Alix Goss
Thank you so very much, Lauren. This is Alix Goss. I'm happy to be here today. A number of my colleagues from NCVHS, as you heard in roll call, will not be present as they are carrying forward with today's full committee meeting, so I'm grateful for the opportunity to have such great attendance on today's call. I'm going to be kicking us off now that we've completed roll call, setting us up for a staging for the rest of today's call, and with Jim Jirjis's team's support and Sheryl, they're going to walk you through some of the work that's been done since our last productive discussion just a week ago, and then, hopefully, we will be able to accomplish a structure for the next call, and we'll start to get ourselves very much into a passive work stream by the end of this month. Sheryl, did you have any opening remarks before we jump to the next slide?

Sheryl Turney

No. I wanted to thank everybody for carrying forward while I wasn't here last week, and I'm very pleased with at least the initial workflow that they put together for the devices, so I look forward to getting into that discussion.

Alix Goss
Well, thank you. With everything else going on right now, I appreciate that you had time to read through the transcript and have volunteered to work with the workflow team as we move forward. So, if we could go to the next slide, please…and the next slide…all right, and the next slide. We're just kicking them out today. Let's start with a recap from our last meeting. It was really good for us to hear clarity from Lauren, Rebecca Hines, and Tom Mason about the authorities of the respective federal advisory committees and the work that we're doing under 21st Century Cures and the respective federal advisory committees. We are very much running within our own trajectory of responsibilities while maintaining a strong linkage between HITAC and the National Committee on Vital and Health Statistics. We all want to see the burdens and challenges from the separation of clinical and administrative datasets resolved so that we can better underscore interoperability and efficiency in the system.

As you know, we'd been focusing on high-level prior authorization workflow in the last call. The first cut from Jim and the HCA team was really fantastic and produced a lot of good discussion last week. I think we're clear that we want to focus on the happy path for the workflows, making sure that we're building them out with all the feedback that you provided last week so that we can have a framework of common understanding of the prior authorization pieces and start to then peel back the layers enabling us to look at the various flavors of prior authorization and how we might continue to take a deeper dive into those respective paths, and also looking along the way for the opportunities to reduce burden and promote efficiencies for patient care.

We talked a lot about trust and transparency in the patient focus last week. Those themes were picked up by the expanded workflow team – Jim had some volunteers come to the table, so we're grateful for Alexis, Carolyn, and Jim for raising their hands and working with him in the past week, along with some of the resources that Jim has brought to bear from HCA. So, what we want to do today is provide an opportunity for us to continue in this initial very fluid process of going through a new workflow that they've produced around durable medical equipment. We're going to have Jim and his team facilitate the discussion with Sheryl's support, looking for additional commentary and input today.

Ultimately, I'd love to see us get through this DME-focused workflow and have some clarity at the end of that discussion about what we've learned, how we need to mature that, and what that might mean as we move forward with other various flavors of prior authorizations. We know pharmacy is another big area; we're grateful to NCPDP for providing us with some implementation guide content that the workflow team can use, so that'll help us with that, but we have some other specialty flavors that we might need to take into consideration, but we can hold onto that thought while we pivot to the next slide and ask Jim and his teammate Josh, along with Sheryl, Alexis, and maybe a few of the others – Jim, I don't think Carolyn can make it today, but I'm looking forward to seeing the new workflow that you designed and seeing where it takes us.

Sheryl Turney
Great. Thanks, Alix. Go ahead, Jim.

Jim Jirjis
Okay, thank you. Thank you, Sheryl. Next slide, please. So, what we had talked about – well, just to back up and make sure we're all on the same page, here are some key points that we pulled out from the past discussion in addition to what we just covered. Defining the workflows in question for the four areas in sufficient enough detail to be useful was one of the goals, so the prototype of high-level – almost cartoonishly high – and, one other piece of the feedback – we'll get to another level of detail. I don't think what you're going to see is going to be – I think we're going to take one – there's going to have to be one more level of detail with swim lanes and workflow still, but I think we have gone deeper.

The second is that people have commented that we don't want to just hardwire a process that's horrible, but instead, isn't there an ideal state? And, the notion of this practical ideal state kind of emerged that we want to understand that, for example, there are some state requirements that constrain us in some ways, but how many different steps

can we eliminate via the current process if we just have the ability to get to the third bullet and say if we had standards data models, workflow integrations, and transport methods, and we had information really collected earlier in the process in an actionable way, how many of these ridiculous steps could we actually take out and simplify? As I understand the 21st Century Cures Act, the goals are interoperability, patient engagement and access, and reduction of provider burden, and this should hit all three. Really, the goal at the end of it is this workflow is only helpful if it's at the right level of detail to then tee up the ability to articulate and organize a set of recommendations for HITAC around the standards data models, workflow integrations, and transport methods rooted in the current workflows, but made far better than what exists.

Next step. So, our goal is the bottom button – I'm sorry, go back again. Our goal is to use this not just as an exercise, but to actually get a nice framework to allow us all to say, "Here are some cogent recommendations." So, cycle 2 – what we decided to do as a group last time is to go deep – take a deeper dive into a particular use case, see how far we can get, and then expand it to the other use case. We need to involve the patient or delegate far more deliberately in this next cycle, and then we need to develop this use case as a prototype to then guide some consistency around tackling the other use cases. If we can all agree that we've got the right level of detail in the workflow to lend itself to an ability to articulate recommendations, then would apply that technology to the nuances of the other use cases, the ultimate goal being to define the workflows with enough granularity to provide those recommendations. Next slide. So, before we walk into this, are there any comments on what we're trying to do or questions from the group? Okay, we'll march through this.

Alix Goss
Jim, to provide – I reviewed this, and I actually think the entire group did a great job in trying to express this out in understandable terms, both from the patient perspective and the real-life evolution of what someone has to go through. So, I liked the way it was represented, and hopefully we can build on this. I do agree the swim lanes with the actors will make it a little bit more understandable when we try to translate it to what standards we need, who those recommendations would rely upon, either for information sooner or et cetera, but I think this was a great start.

Jim Jirjis
Okay. And, I'm just going to walk through this slide, and together as a group, there's a lot of – even on this slide, Alexis, Jim, and others who are on the call, please chime in to make color commentary as we go through. So, this was going deeper in the prototype for DME. We talked a lot about whether we pick the most complex workflow. I think Jim brought up the notion of a particular device from his personal experience that involved all kinds of different middle players beside just a DME company and a therapist, but maybe getting an employer to understand why somebody needs it, or a school – there may be a cacophony of people who have to help make the case. We thought that might be too complex for our purposes, and we would start with something a little more straightforward, like a wheelchair. A wheelchair brings in several players: The patient, the provider, the notion of the therapist group that does an assessment, the notion of a DME company that would be fulfillment, and then, obviously, the patient and the delegates' activity in the process.

So, as we walked through, the first step was – please interrupt me, members of the team, to help with this – the patient determines that they have a need for medical assistant. They then visit either a therapist who they have a relationship with or a provider, and they indicate their insurance information to that provider. Again, this is not an ideal state. In step 3, the provider or therapist determines that a wheelchair is needed and writes a letter of medical necessity. In step 4, the provider writes a prescription for the wheelchair, sending the request to the durable medical equipment company. Step 5 is a meeting scheduled between the patient and the durable medical equipment company to evaluate the needs, options, and features for the wheelchair. Step 6 is where the appointment actually happens and the wheelchair is ordered. In step 7, the durable medical equipment company informs the provider that a prior authorization is needed, along with what information is involved in the submission. In step 8, the provider and staff begin the PA process to submit to the DME company. In step 9, the DME company submits the PA to the payer.

The payer then makes an assessment and responds either that more information is needed, in which case the provider, therapist, and DME company gather more information, perhaps starting the cycle over in this inferior model, or a PA is approved, but in this case, the DME sets up time to deliver the wheelchair, the patient receives it,

and in my own experience with patients – I have experience that it sometimes doesn't meet the patient's needs, it doesn't fit, or it's missing a cushion or a neck support, which means there may be modifications that have to occur even after it's in the patient's hands. The third possibility is that the PA is denied, in which case four possible things could happen. First, the payer recommends an alternative or, if duly insured, then information is sent to the second payer, or if it's partially approved, then what's not approved is then sent to the second payer to attempt approval. Or, the patient goes without or works with the provider or others on different methods to get the wheelchair – United Way, et cetera. Or, there's an appeals process that could be improved upon.

Go to the next slide, and then people can comment on it. So, we're not articulating that we should simply hardwire that tech – somewhat crappy workflow, if you would – but what I think the team can comment on as we walk through is just a few examples of opportunities that I think if we transfer this to one of the swim lanes, then we can actually begin articulating the data standards, et cetera that might support it. So, there are some opportunities here that we came up with as far as – of course, if you look at the green lower portion, there's this notion of the patient being more deliberately involved up front in opportunities B and A, where the patient's needs are collected more comprehensively, the patient's benefit design is understood in a machine-understandable way, and throughout the entire process, there should be a state machine that is actually keeping track of status and providing passive ways for people to log on and find out where it is in the process, and also active/proactive notification, including for the patient or any of these other actors that information is missing, where it's held up in the process, or what its status is. That is a sort of overarching assumption that for each of these steps, there should be transparency as to process.

A lot of opportunities on the front end were getting – I think someone on the last call mentioned getting the benefits right up front and collecting more information from the patient, maybe having the patient begin to articulate the letter of medical necessity and contributing opportunity E. Throughout here, there are a lot of opportunities to define datasets, make sure that they are either available earlier in the process or communicated as an automatic byproduct of an entailment. And so, we can walk through each of these, but I think there are patients being involved in the process through most of it, there's automation, there's making sure information is needed and benefits are provided earlier in the process, and then, at the end, when there are things denied or more information is needed, not having to start the whole process over, but instead, being able to simply provide missing information along the way.

So, one notion that came up is that often, the only way to get more information is to let the whole process fail through denial so that someone could be notified that it was denied so that they could start the process all over again, this time hopefully providing the information needed. Instead, there ought to be a system along the way that actually identifies early what's missing and is causing the denial before it occurs. So, Jim, Alexis, Josh, or others who are on the call, do you have any comments about this?

James Pantelas
Hi, this is Jim. I just have some thoughts. The opportunity levels are ones that I think are of significance, but I also think it's pretty significant that the letter of medical necessity – in my experience, that doesn't get finalized until after the DME, the patient, and the therapist meet because they have to justify every feature, and it's the justification of the features that's built into that notification that goes on to the payer that gets things hung up – the wheelchair has to have a certain set of abductors, or a specific head restraint, or things like that. Those all need to be justified, and they need to be tied back to the medical condition. That all gets done a little bit later in the process, so that letter of medical necessity that's outlined in step 3 really doesn't get completed until about step 6 or someplace in 6.5.

Jim Jirjis
Yeah, let's move that, Josh.

Sheryl Turney
This thing with the – this is Sheryl – so, I think you could look at many of these blocks and say they could be moved. I don't know if the order of events is really the thing that we should be focusing on at this point. I really think what we need to focus on is the data that's needed for that decision and if there's a way to get them that data sooner. My example for that – you were talking about some things that I might not be as familiar with, but my daughter had a femur removed and hip surgery. Well, they knew before she went in that she would have to have a wheelchair. Stupidly, we did not know that. It didn't dawn on this dense, messy head here that she would need a wheelchair

coming out of the hospital.

So, why couldn't a lot of that information be conveyed up front so that the decision could be made? Because we had issues. Because my daughter is very short and small, she needed this child-sized wheelchair, and they brought her an adult one, and it wasn't usable. So, that's a perfect example of not getting the right thing weighed in by everybody. So, information like that – I would be less concerned about where it appears in the step and more about what data is needed for the appropriate decision to be made. And then, in her case – and, I don't know about other people, but what seemed to happen with other durable medical equipment – there was a whole conversation about whether to rent or own, which she had no idea about, and neither did I. We thought we'd made a decision on that, and then later came to find out she was renting the wheelchair for two years after she no longer needed it, and they told her she owned it.

So, somehow, that was all involved in this prior authorization decision as well but wasn't communicated very well. So, to me, all of those parts of the information in terms of cost, et cetera, need to be conveyed up front in a way that's understandable to the patient so that they know what they're agreeing to, and then the doctor and the therapist have the information that's needed in order to move forward.

Steven Brown
This is Steve Brown. I might make a comment from a different direction. First of all, I'd like to thank Jim and his team for putting this together as a point of discussion, and I'd like to try to tie the obvious complexity of the slide that we're now seeing back to the initial slide, which was talking about having standards and stuff like that. One of the conversations – perhaps you had it last week when I was on spring break at the beach – is having standard notation for process modeling that's explicit and reproducible, and supports the flows that look like our PowerPoint-based here. So, I think there's another level of standards – not just data standards, but process modeling standards – that it would behoove us to consider before spending a lot of time making process models informally that are hard to reuse.

Specifically – I mean, I'm aware of work in OMG with something called BPM Plus. There's a BPM-Plus.org site where they're working to do healthcare modeling with American College of Emergency Physicians and, I believe, ACOG for some of their guidelines, but these are the same shape things and all that, so I'd like to add that to the list of things to talk about.

Jim Jirjis
That's a good point. I think that's the next level we have to get to – that level of professional process modeling.

Arien Malec
I just have a meta-process question. I think last meeting, we were trying to use the hand-raising features. This meeting seems to be more of an open discussion. Can we have clarity as to whether we should be using it?

Sheryl Turney
I was just going to say we need to use the hand-raising feature. If you'd like to make a comment or ask a question, please click the little man with the hand raised. It's sort of in the middle of your screen up at the top, and then, I'll try to keep track of the order of events in terms of who raised their hand. Thank you for that. Did you also have a question?

Arien Malec
No, I had one, but it was addressed on the letter of necessity and where that belongs in the process, but I definitely appreciate the perspective of the importance of all these steps and the information for all these steps, not necessarily the order.

Sheryl Turney
I think we can work on the ordering when we transfer this to a process model with the swim lanes, and we can take note of all those things, but I think at the end of the day, we could spend a lot of time moving things around because I think for various things, they all happen in maybe a slightly different order. The important thing is that we capture

all the steps in the process as well as identify the opportunities where we can make improvements, or even reimagine a recommendation relative to how we move forward. Maybe there's an opportunity when you're getting your authorization for surgery, and you know you're having hip surgery, and you're going to need a wheelchair that you get the measurements for a wheelchair or whatever is required in order to do that preauth, and it all goes in with the surgery recommendation. Those are the types of things I think we're looking for on how we could make that happen to streamline the process.

Arien Malec
That was actually going to be my comment, that there's an implied knowledge that X is needed – so, for example, a letter of medical necessity needed. For each of these areas where there's information needed, that's a really interesting callout for how we can provide that information at the right point in the process.

Sheryl Turney
Exactly.

Arien Malec
Not only what the inputs are, but also what the requirements are and how we communicate those requirements to the actors who are working through them.

Sheryl Turney
Exactly. I don't know that this certainly wouldn't apply. There are times when you need a wheelchair and you're not having surgery, so obviously, it's not going to fit every situation, but I think it makes sense to identify those situations where certain groups of data will be available, and then, in other cases, it may be that there's a problem with the wheelchair and the wheelchair has to be replaced, so that requirement is going to be a different focus, so what needs to happen in those situations? Or, if it's something that's a chronic condition that leads to the need of a wheelchair or some other durable medical equipment, at what point in the process do those chronic conditions then necessitate those needs? Again, I don't know if there are specific clinical standards that can be applied to those types of conditions because I'm not a physician, but those are things I think we should talk about if there's an opportunity.

Anil K. Jain
Sheryl, this is Anil. I've had my hand up. I'm not sure if you could see it.

Sheryl Turney
I can't see anybody's hands up, so how do I –

Jocelyn Keegan
I have as well, and I commented on that first, that we should hold up hands, and my hand has been up the entire time.

Alix Goss
Yes, actually, we've started out with Steve Brown up first. The order was Gus, then Anil, then Alexis, then Jocelyn.

Sheryl Turney
I don't know why I can't see those.

Alix Goss
Okay, it's in the participant list on the right-hand side underneath the active speakers and the presenters, so I'll help you if you can't see that. I'm happy to help out here, Sheryl. So, Gus, would you like to offer some comments?

Gaspere C. Geraci
Sure, thank you. This is less about data, but first, this is a great start because DME is probably one of the most challenging prior auth issues because there are so many people involved, and you've done a nice job with outlining it, and I agree with the comments that have been made so far. Because this is going to be a prototype for future

ones, I'm just going to suggest a wording change, and I know that doesn't have much to do with data, but "payer recommends alternative" under "PA denied" – there's a lot of sensitivity in the payer market about recommending or saying anything contributory to anything that smells or looks like the insurer is offering treatment. All the payer does is authorize or deny, and I agree with the intent of that sentence or that block, but I would just suggest alternate wording because most insurers do not recommend anything because they're not authorized to provide treatment; they're merely authorized to provide payment.

So, I would suggest a wording change from "payer recommends alternative" to "payer offers covered alternatives for the duration," and that's just – it's a minor legalese kind of thing, and I'm not a lawyer either, but I've had lots of discussions internally and externally about this particular subject, and we probably will need a lawyer to approve the final wording, but I do have a lawyerly objection to "recommends" because that suggests that the payer is offering treatment. They are not treatment renderers; they are merely approvers, and so, "offers alternative that may be covered" might be a better way of putting it.

Jim Jirjis
Yeah, I think that gets into step therapy. To your point, they're not recommending, but they're just identifying alternatives that are available.

Gaspere C. Geraci
I think "identifying" is a good way of saying it because ultimately, the decision is always the provider's. The payer merely denies or approves payment, so I think that's a great suggestion, but I do have a problem with the word "recommend."

Alix Goss
Thank you. I think the next person in the queue is Anil.

Anil K. Jain
Thank you. So, this might go back to something we discussed on the last call, but there are other groups that have looked at creating a template, if you will, of prior authorization within the context of using existing HIT standards or emerging ones, and going back to Steve's comment, with some pretty nice flow diagrams using conventional standards of representing information flow and things of that sort.

So, are we leveraging some of the work that, for example, Da Vinci has done around preauthorization starting from the work that's been done in the industry as opposed to spending what could be very good-quality time creating a sample prototype of a flow, but others have done this already, and I just would ask that we think about – and, as a clinician, I can tell you there are many permutations of this, so if we spend a lot of time focused on the perfect prototype, we're not going to get to what our group really needs to do, which is – as I've heard from others – focusing on some of the standards, the hooks, and the ways in which we're going to simplify the art of the possible for what a next-gen PA mechanism might be that's powered by open standards. And so, I'm just putting that out there. I'm not an expert on what Da Vinci is doing, but I've seen some of the work that they've done, and in many ways, I look at the sample prototype and I wonder whether we can just take something that's been done already and use it as a starting point.

Alix Goss
Thank you for that. I think we're trying to do exactly that, and leverage models and examples in the industry to create a foundation. So, I think the next person in the queue is Alexis.

Alexis Snyder
Hi. Going back to the discussion about ordering and steps, I was just going to bring up that I think a big piece of the problem, which is probably interesting for us to point out where systems fail, is that there are different providers of different DMEs working in different ways and in different orders, so this isn't going to be a fit for everybody, but I think as Sheryl was saying, getting the pieces from where the opportunities are to make it flow better and possibly take out the number of steps to get the approval in the end makes a lot of sense, but I do think somewhere, it would be interesting to be able to note the variations that happen in different health systems or with different DMEs, and I

think that not only is it not always "one, two, three, four, five," sometimes we were talking about step 3 possibly being moved, and in my experience, step 3 happens there as part of the beginning of the PA process, but it's not where it ends, and it gets revisited again along the lines later on where Jim was talking about.

And so, I think recognizing that it's not necessarily accurate every time for everybody, but that all of the steps are there, and knowing that they can be juggled around a little bit is actually a good thing to point out because there's so much variation in practice with it that that's also what is causing system problems.

Alix Goss
Thank you. Jocelyn is next in the queue, Sheryl.

Sheryl Turney
Thank you.

Jocelyn Keegan
Thanks, Alix. I love all this commentary because I think everybody's catching the problem from different sides. I wanted to come up with a thought that's between where I think Jim is and – this work is great, guys. I think that "doing one" and showing the complexity in all of the steps that are way beyond a simple PA submission and adjudication step that I think everybody thinks about prior auth as being and what makes it hard – I think this really illustrates it. To Steve's point, I think there are a lot of people who have spent time in this space, and we can learn from them. When I was watching you walk through, Jim, the notes that I made were that this is a great exemplar, and being able to show the variation – getting to the last speaker's point around how much this is varied when you move from DME, and from my experience, I think DME is one category, infusions and on-site dispense is another category, buy/billed, expensive medications are their own category, med-surg is a category, and then, PT and referrals are the last category. That's sort of the bundle to understand putting those – how they differ and where things are simpler or harder.

I think what you're laying out here is not just the pure submission of a prior authorization and the understanding of the rules for one specific thing. What you're laying out here is all of the steps, and I think being able to normalize the steps regardless of what order they happen in is what's critically important to start to show – to a couple of the subsequent speakers – where we're already making progress and where we're starting to look at things in that API/real-time interactive way to be able to get benefit information just in time with some of the work that we're doing in Da Vinci to be able to understand how to capture or pull the data out of the EHR to get somebody enrolled in something.

So, if I think about the steps and my own personal experience and work in this area, I think you're really looking at benefit identification – that transparency of benefit being the first step, the order itself – placing the order or prescribing something – being the next step, what I need to enroll somebody in this service, whether it's ordering – in this case – something that's really complex, like a wheelchair, or whether it's something as simple as just getting somebody a referral to a new doctor or a specialist, and then, the actual PA itself, which is, in some ways, a lot of the same data that's involved in enrollment, and I think it gets to that point around how there's patient data required there when you're talking about the enrollment and the PA step.

To me, the way to keep the patient involved in this whole process through clear communication and alerts is critical, and then, understanding what other activities – I love that point around the letter of necessity or patient source data really being – I don't know if it's its own step or if it's just making sure that the patient is aware of the process as it's appearing, and the power of the things happening in the market around smart applications and third-party integration through CDS Hooks into these workflows really enables us for the first time to be able to make this more seamless and not be these paper-driven, crazy facts processes because we can make things chattier than they've been in the past.

So, I guess my key takeaway is that I love where Jim is headed with this. To me, understanding all the categories is important, as I spelled out, and then understanding the step, because I think it's that ability to remove variability that's going to allow us to figure out where we can take current work that's happening in the market, propose it as

best practice, and then identify where we have no solution, like this idea of the chattiness and the patient at the center. I think we can look at what the solution should be in those scenarios so that we can really come up with something concrete and make real recommendations to the market in the next couple months. I'll write it up and send it as an email, Alix.

Alix Goss
Thank you, Jocelyn. Sheryl, I see that Jim has his hand up. I thought Steve Brown did, but it came down, so I think it's back to Jim.

Sheryl Turney
Thank you. I can see it now. I don't know why it wasn't – my machine wasn't letting me bring the attendee list up and down, but now I can see it. I still see Steve. Steve, do you have a comment you want to make before we go to Jim?

Steven Brown
I guess I could, sure. There are going to be any number of tweaks, variations, versions, and all that sort of stuff of anything anybody puts out like this, and one of the things that – if we pick proper standards and tooling, we can accommodate that and expect that we're going to go through multiple iterations, make changes, find commonalities, find differences in various process and process flows, and actually, it's not all that scary if you do it right. There's no way you could expect that anything in PowerPoint is going to stand up to real life, but there's a lot of experience in doing this sort of stuff outside of this area that I think we could really benefit from, and rather worrying whether it's step 7, 7.2, or 7.3, saying, "Well, it doesn't matter because it might be that or it might be this." We can model all of it and know what the common components are, what the common required data elements are, and actually run that on RedHat.

Sheryl Turney
Okay. I'm not that familiar with RedHat, but maybe there are others who are who could weigh in on it. Jim, I think you were next.

Jim Jirjis
Thank you. As I listen to all this and as our team – Jim and Alexis – dug into the complexities, a comment that was made earlier that attracts me – are we on a wicked witch hunt, finding the next wicked witch to kill by getting all these different workflows? I wonder if we just started with what information is needed to get approval and work backwards from that – forget what order things are done in. What if we set up what information is needed for a wheelchair? What do we need from the patient, the provider, the therapist, and the DME company, and what if we worked backwards and didn't get caught up in the complexities of these spaghetti workflows, but instead starting with what information is needed, defining standards around it, and then starting to define how that information can move and be defined? Would that simplify and land us in a place where we divorce ourselves from the nuances of iterative workflows?

Sheryl Turney
I personally would say yes, I think that will bring us – I think we needed the workflow to provide some context so we had a common footing of a way to look at it, but I think now that everyone's looking at the workflow, it does help to say for durable medical equipment, if we take different types – maybe there are classes of durable medical equipment that can be done or different life events that drive information or data requirements. For those purposes, this is information that's needed along the life cycle that would cause this particular thing – and, of course, that's a huge list, so we can't expect that we're going to go through every type of DME or every type of whatever, but I think if we take an example from each type of life cycle that we've already talked about, where we said pharmacy, or durable medical equipment, or medical authorization – that we take some samples from each of those and start with what information is needed, who we need to get it from, how we can ensure that it's complete, and if there's a way to standardize or normalize that data so that it can be acted upon. Is there a better way to gather it, and when is the soonest that data is available?

Because ideally, as everybody has expressed, if that data can be made available sooner in the life cycle and it's

shared as openly as we can make it happen, then that information will be able to be acted upon in a manner that's more expedient as well because everyone's desire is for the decisions to be made electronically in more of an immediate fashion. So, like the case of surgery, we know with every surgery for a hip replacement or whatever it is, the person is absolutely going to need a wheelchair and a walker, so why are we waiting for the end of the visit to make that PA go through? Why isn't it done up front? I think that makes sense. What do other people think? I see some more hands. Alexis, we'll let you go next.

Alexis Snyder
I agree. I had just been – a couple people were chatting and typing. I had put down before that I agree with what you're saying, as I mentioned before, about taking away the numbering of the steps, breaking it up into blocks or groups, and then listing under each group what needs to happen at that point or what needs to be collected and listed that way. I think that makes sense, so I agree with what you're saying. I just wanted to mention that when we talked in the smaller group when this was being put together as far as case sample, we talked about trying to start – it was first mentioned that perhaps we'd start with the simplest, and then, that way, it could be built up and go into more complicated PAs, and then, the more we all talked about it, we thought, "Let's start with something that's the most complex – being this wheelchair example for DME – and then, the more complex that we can solve something, the less complex would be able to trickle down with fewer steps." So, I just thought it was important to mention that and see what other people thought about that.

Sheryl Turney
All right, that's a very good point. Again, I'm sorry, I'm not catching the order of which, so I'm just going to go alphabetically. Anil?

Anil K. Jain
I don't have a question right now.

Alix Goss
I think it's the speaker. I don't think anybody has their hand up, so actually, I'm not clear how I raised my hand because I don't see an icon, so hopefully I'll get some instruction, so at some point, I'll just go ahead and learn that functionality, but for now, I heard Jocelyn talking about the categories, I've heard Sheryl talk about the classes of data and the examples for the major buckets, and what I'm hearing is that people are feeling good about the fact that we've started to prototype this, but are ready to jump to the next level, so I think it might be beneficial to have some discussion around the list that I saw Jocelyn put in the chat about the DME infusion, on-site buy/billed, dollar medication, med-surg, and PT referral as big categories, so I think that it would be good if we could think about what we think are the key categories, and then also think the classes of data and, as I'm seeing Denise Webb type, if there's any linkage with USCDI.

Sheryl Turney
I think that was a good summary, Alix. Are there any other comments or questions at this time? All right, why don't we go to the next slide? I think the next component was we were going to talk about where we go from here and what our next steps are, and I think this set us up for a good transition to that. So, at this point in time, we had talked about whether we need to put together some small workflow for the other types of use cases, but maybe what we can do is instead of doing that – I don't know if we can jump to this – sometimes, people need a picture in order to generate all the thoughts that they have around a particular subject. I know that I'm a little bit that way.

But, if there's a medical service like requesting the surgery prior authorization, for instance – if that needs to be expressed out in another workflow like this or if we could take this workflow and just adjust it, but maybe take it to the goal that we were just talking about, where we focus a little bit more on the information needs that we would need at any point in time in order to make that decision positive so that the prior auth gets decided up front without a lot of back and forth versus all the steps in the process that are needed – really focusing on what the information needs are and whether we even know what they all are. I do represent a payer, but I don't know that in every type of situation, I would know what all of the prior authorization rules are that are applied to every decision that's being made, but at least we can start categorizing or developing those classes of information that we need in order for those types of things to start being generated. What does the group think about that?

Alix Goss
You have Arien's hand up, and then Jocelyn's.

Arien Malec
Thank you. I think foundationally here, the first order – what you need to know – is whether PA medical necessity or some kind of preclearance activity is required for a particular procedure or equipment code. I have to admit total ignorance – I know how medications are ordered and how procedures are billed for; I don't know whether there's an equivalent of an RX1 code or an equivalent NDC code for DME, but first, you at least need some way of knowing whether the payer requires some level of preclearance for the procedure or product category UPC or other code, and then, again, at this second order is at least access to the relevant information for what's required – and again, I think we previously talked about not just by the payer, but potentially by a patient-specific, eligibility-specific requirement here. So, at the very least, we should be mapping the need to access that information. If we just got the ability to fill out the information electronically with a dumb paper form or a dumb electronic form, that would be a major workflow improvement above here.

We also talked about cost information, so if there are major cost-sharing provisions, any cost-sharing that triggers Medicare-specific rules relevant to patient payment, and there's need for prior notification ABN for patients, that would also be an important consideration. We talked about potentially some of the payment options that are required for things like DME. And then, we also talked about – again, this goes at greater or lower levels of complexity, but what specific information is required potentially by the payer, but also – and, this use case brings this out really nicely – potentially by one of the intermediaries. For anybody who's had to order special medication, there may be medication-handling and delivery requirements that are required by the patient to fill out.

So, again, at the first and second order here, access to information about whether preclearance activities, prior authorization, medical necessity, or other requirements are required, and information about what is required, where that information is patient- and planned-product-specific, and then, information relative to the source – so, what the payer requires, what the DME equipment or specialty firm requires, and what have you. And then, we get down to how we actually automate the workflows, and those data requirements are going to be somewhat different on a case-by-case basis, but at the very least, we need to get access to those up-front pieces of information. Thanks.

Sheryl Turney
Thanks, Arien. I saw Jocelyn also had her hand up, so I was going to go to her, and then we'll come back and maybe have a suggestion. Go ahead, Jocelyn.

Jocelyn Keegan
I really like the point that Arien just made. I think the complexity and the type of auth you're trying to get done can be greatly simplified based on the topic or the particular challenge that that patient and doc are facing, and there's another way we could cut through the types of authorizations and the types of these order workflows that we're talking about, and I don't know if it's as simple as bundling them into something very simple that can be decided based on an ICD-10 code – if you have this diagnosis, you get this thing – which we see a lot on the pharmacy side, but also on the med-surg side. Once you get to a certain level, this is the thing that gets approved based on your plan.

I think there are things that potentially require a lot more information from multiple sources or are more complex, and then, there are other authorizations, like the DME example, that are really iterative with multiple parties involved, so that's almost its own type of activity, and that's more to the point that Arien was just making, which is the superset of data you need so that you can collect that as soon as it's available, and as you learn more through a particular patient's journey that there things you can automatically approve that you may not need until later. I think the example of how we know that somebody who's having their hip and femur replaced is likely going to need a wheelchair when they get out, so why don't we approve the wheelchair ahead of time?

To me, that removes and reduces the need for prior authorization by – and, sometimes, the payer self-serving content they've already collected for other purposes about that patient and that particular situation. So, I guess if I were to summarize what I was thinking as Arien was talking, in the earlier conversation, in addition to cost, I think

there's a type about the level of data and the complexity of the actual prior authorization that's required that might allow us to divvy up what could be automated quickly versus what's going to take some time and some maturity to be able to get to further automation.

Sheryl Turney
So, those were both really great comments. Alix, did you want to say something?

Alix Goss
I would love to get Arien's thought process as a discrete bulleted list because I think there's a framework emerging with the list that Jocelyn started and Jim also added to for inpatient/outpatient so we'd have our categories. We know we have USCDI, but I think Arien brought together this methodology that we need to almost walk through, and I wish we could grab it and translate it into a document on the fly to see if we're all thinking in the same way because what it may do is take the work that we've seen from the prototype team and give us a glide path forward so that we can understand where we can find – if we're all in agreement on the commonalities, then we can start to look at the opportunity areas; we can start to then do the deep dive into whether the standards exist or not, and it's not just standards. It's vocabulary and policy that we also have to start to look at. So, I'm really curious if people feel like there are some key pieces that have been brought out by the team today that if we put them together, we can probably have a pretty good framework to affirm next week and hit the ground running in April as the result of a kumbaya.

Arien Malec
If it helps, I've got in mind a Venn diagram or a set of descending prerequisites, and it might be useful for me just to frame some of those up and think about the bulleted list and what you need to have at the deeper levels – what you need to have previously had in order to get down to the deep levels, because sometimes we jump to "How do I collect every piece of information?", but there's a ton of value that I can have by just knowing that this procedure requires X, and at the next level, there's a ton of information I can have about the specific requirements for X, even if I don't automate every piece of information. So, if you want, I can think about what that step-down category looks like.

Alix Goss
That's resonating for me. Sheryl?

Sheryl Turney
Yeah, that's a great idea. I agree, and I think it will help people visualize what we're talking about a little bit more, so I do think that would be great as input for our next meeting.

Alix Goss
And, realize that we're trying to move this – if you can get that to us, the sooner the better because what we want to do is start to pull these various pieces from the conversation and the worker bees that are willing to help us advance efforts offline because a week goes by really quickly.

Arien Malec
Understood. I've been in the chair role, and I know exactly how it works.

Alix Goss
Bless you!

Sheryl Turney
Yeah, exactly. So, I think that's a great next step from that perspective. Do we also want to take the DME workflow that we have and try to bring it into more of a bulleted list or something like that for the next steps, Alix? What do you think about that – if we were to take it and then say, "All right, what is the information that's required at each of the various steps?" – again, not assuming that the steps are in order, but if there are information requirements for each of those things, like trying to pull out so we have an example we can apply it to as we move through Arien's model, and we can see how it would apply to the DME.

Alix Goss
I think you may have a clearer picture in mind than what is coming to me at the moment. First, let's see if Jocelyn has a comment. I also want to do a check-in with Lauren about where we are in the public comment period. Is that at 10 after or 20 after? I don't have the agenda in front of me, so please keep us honest on the public comment.

Sheryl Turney
It's at 20 after.

Lauren Richie
In about 10 minutes.

Sheryl Turney
Jocelyn, did you have another comment?

Jocelyn Keegan
I did. I wanted to build again on Arien's point about – I think it's this idea that the data itself matures through a process. I think that's really important. We did some really great brainstorming last year on the concept of price/cost transparency in one of our Da Vinci working sessions where we really came up with this concept of there being a funnel, and depending on how precisely you knew exactly what it was you needed to do at any given point in time during a care journey, you could get a more precise answer about cost, but way up front, when you're really looking at all the options, having as much transparency and getting some rough ranges in itself had value to know what was possible or plausible with a particular patient, and then, also, knowing what options to look at.

So, I think that this concept of the idea of the data getting higher and better quality as you get through a process is a really important one for us to keep in mind, and also, often, unlike a simple pharmacy prescription for a generic drug that goes through and is very fast – this one-time event while you're sitting in front of the doc – many of the things we're talking about that cause real pain and cause delay are things that often aren't just being touched by one team, but are moving across teams so that what the primary care doc has for info versus the specialist versus the hospital – the repetitive number of times that we go through this data flow, and how that in itself triggers a lot of noise and pain around denials based on incomplete information or somebody changing a location.

Those are all things that cause that hair-pulling frustration that we have with prior authorization. I think it's important to understand that the patient isn't static, and is moving through a care system in order to get this service, this surgery, or this DME item actually in their possession. I think that's a really important concept that we need to keep in mind because part of the pain is that somebody gets a yes, and then, two steps down, they get a no because they're using different datasets.

Alix Goss
Jocelyn, in addition to having the buckets of high-level flavors, along with this linkage at some point to USCDI, along with Arien's bulleted list and the layers of the prior authorization onion, I also think I just heard you talk about the principles, goals, and assumptions that we need to capture along the way. Did I hear you correctly?

Jocelyn Keegan
I think so, Alix, and I don't want to sound like I want to get into the weeds here, but when we did enrollment, we made a decision to move enrollment out of the NCPDP standards and actually leverage FHIR to get the data out of the EHR in one of the task groups I worked on over the last couple of years. We went through this exhaustive exercise where we literally inventoried all of the data that was needed for a subset of drawn special data, and that in itself is sort of a heroic work. I think we need to be figuring out a framework so that everybody can pick up the framework, and then, for their niche area, bring their SMEs, because otherwise, it falls apart really fast if you're trying to boil the ocean of all the data, and really, the exercise we want to focus on is how much of the data – the types of data we need, the categories of data we need, when we need them – are going to be serviceable in USCDI and what's not, because I think that's something that can be acted on by the industry to say what the outlier concepts of USCDI are. I think patient source data is going to be one of the big pieces there, and some of the payer-related information.

Alix Goss
Thank you. Those are useful insights. I think Steve Brown is next.

Steven Brown
Hi. I'd like to make a friendly amendment on the next steps slide – the sub-bullet to develop high-level opportunity matrix for standards data models, integrations, transport methods to support practical ideal state – I'd like to add process models.

Sheryl Turney
Okay. I think that goes back to the thing that you brought up before with the process model reference.

Steven Brown
Yes, it does.

Sheryl Turney
It was there, and I did capture that, so we can definitely add that to the list. So, I think that where we are in the meeting, we need to figure out exactly what our next steps are going to be. We have convened the smaller workgroup that created this durable medical equipment process model, so we can either take that work and say we should go to the next step or define what type of data is needed within that process to then try to apply it to that Venn diagram that we're going to get from Arien, see how the two would match up, and compare those for our next meeting. Is that something that would be useful for the group, or not? Does anyone else have another suggestion for a next step?

Steven Brown
If I hear what you're saying, it sounds like the DME workflow pivots to what we're talking about – what data is needed by whom, the Venn diagram – is that what you're saying?

Sheryl Turney
Right.

Steven Brown
But, do that to the DME model? That makes sense. We'd need some additional expertise.

Sheryl Turney
Right. So, to me, we would go to that picture of the model with all the opportunities on it, take a look at that, and find the information requirements we need for each of the steps – again, knowing the steps may not happen in this order, but just understanding what the information requirements are, and then assuming that for most medical equipment of some sort, this type of information is going to be required so that decisions can be made, and then, we can look at how that lines up to what Arien is going to propose as the data categories in the Venn diagram, and then, further, how that would then look when we go to say what Da Vinci activities occurred that would support this prior authorization that we're talking about.

Are there APIs that are being developed that require photographs, pictures, or things of that nature? If it's a wound that we're talking about and somebody needs a wheelchair because of whatever has happened – I don't know what the expectations are because I really don't know what the requirements are going to be for these types of things, but we can at least assume the types of data that might be needed, and then determine at what point that data would be present in the process, and whether those data requirements are supported by USCDI and others. We can then take it to that level, but first, we need to identify the data that we need to make decisions. I can start with this prototype in the beginning and say that I need to know what all the instances are where a prior auth is needed for a wheelchair, and I don't know if it's always needed or if it's only sometimes needed. I don't know the rules, as I said, for every payer for those things, but that's what we would need to do and call out for each one of these bullets.

So, just to try to create the visual in my mind, we'd be talking about how we need to know what of prior auth is required, maybe there are certain types of prior auth where we need to know specific demographics about the

individual that make the difference in terms of what's going to be ordered or in what form the product is going to be delivered, and then, when is that information available? Who collects that information? Who provides that information? In some cases, like you said, with this more complicated scenario, the provider might provide some of that data, and yet, the therapist might provide some of that data. So, looking at who's responsible for providing that data as part of the process also – maybe those are things that we can try to simplify. Today, we can say this is what it is for some of the ones that are known, and then, maybe this is where we can make recommendations and say this is data that's going to be needed regardless of who provides it. Does that make sense? I'm just trying to make it a little clearer what my suggestion is, so I don't know if it's coming across.

Jocelyn Keegan
Sheryl, I think what may be helpful is to take the steps and put them in more of a table format so that we can look across the different types to see if there are steps that we haven't captured and if there is data that's not represented here that we can tease out of the work that Arien's going to do. I'm just visualizing in my head what I think a next iteration would look like. I don't know if people are in agreement that being able to map out across all these different types of areas will let us know what we've left on the table.

Sheryl Turney
Right. Unfortunately, we have to take a break for public comment, but let's come back to that point as soon as we get back. Thank you for bringing that up. Lauren, go ahead.

Lauren Richie
Thanks, Sheryl. Operator, can we open the public line?

Operator
Thank you. If you would like to make a public comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 if you would like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing *.

Lauren Richie
Great. Any comments in the queue at this time?

Operator
There are currently no comments.

Lauren Richie
Okay. Alix and Sheryl, I'll let you know if we get any additional comments from the phone.

Alix Goss
Thank you. Sheryl?

Sheryl Turney
Okay, I do see Alexis had a comment she wanted to finish.

Alexis Snyder
I was just going to say as far as – I agree with what Jocelyn was saying. We had talked a little bit earlier in the conversation about rather than steps, breaking it up into blocks of times and what's needed, and lists or tables under each one. I think that a Venn diagram is going to end up looking and being just as confusing, if not more, than the flowchart is reading now. I think it's confusing, and the diagram isn't going to necessarily help us tease out what's needed, who's responsible for it, and how to make it better.

Sheryl Turney
Maybe what we could start with, then, would be a table and outline from the process some of the opportunities and identify based on the table so we could structure the information a little bit to make it easier for people to read. Would that be helpful?

Alexis Snyder
I think it would be clear that way. When I think about seeing it in the overlapping circles of a Venn diagram, I don't see it making it any easier. I think a table would lay it out better.

Sheryl Turney
All right. Well, let's – we'll talk about that a little bit offline in terms of how we structure it, but would the group that was already working on the DME be willing to work – and, I'll volunteer to participate on that team as well – to try to translate what we've already done to map it into a table to start capturing what some of the information and data requirements would be within that process so we could try to model that out and see how that would map itself against the requirements of data that are currently in the USCDI? Would that be a good next step?

Jim Jirjis
Yeah, we'd be happy to help. Obviously, we'll need a lot more expertise on what that data is, but we're happy to help with that.

Sheryl Turney
Okay. We can bring forward what has currently been approved as USCDI version 1, which is what's in the current interoperability rule, because we have that well-documented, and then we can start from there to say what else we need that's not on this list, and then talk about how we need to bring that forward or accelerate those data elements to get them in the list. Again, we're talking holistically now, but we're not going to be able to do this and map every single piece of durable medical equipment. We're looking at trying to bring it up to a data class level or a category level.

Jim Jirjis
I think so. To me, what's daunting is all the different types of DME, and all the different meds and everything, and just the breadth of types of information and data needed to actually be collected from various stakeholders. It seems pretty daunting. I don't know if others – anything could make me feel better.

Sheryl Turney
I think it is, which is why it's been out here for so long, because I think so many groups have tried to cut it and slice it in different ways, and at the end of the day, you can't get away from the complexity, so if we could create a framework that complexity could be reviewed under so we could help accelerate, streamline, or reimagine, then I think that we're achieving the recommendations that we're being charged with.

Jim Jirjis
So, for example, if we're operating on a framework level, it says – like for the durable medical equipment, the wheelchair, there's information from the provider, there's information from the therapist, and there's information from the DME that all go into what's needed to approve, but also to fulfill, right? If we're just looking at "fulfilled," then are we back to simply what information is needed to justify payment instead of – and, is that a CPT code? Is that an ICD…? It seems like there are lots of different types of data that may not already be standardized.

Sheryl Turney
Right, exactly.

Jim Jirjis
So, you just say "high-level" – we'd start with patient-specific data, data about diagnosis, data in the USCDI, and then see what's missing, and then create a high-level framework and not necessarily try to solve it with terminologies that don't exist.

Sheryl Turney
Exactly. I think that's the best way to try to apply an example so we can see where we go from here.

Alix Goss
I see Jocelyn's hand up. This is Alix. If you want to go ahead, then I'm going to comment.

Jocelyn Keegan
I think this is exactly – that type of category information that you were describing, Jim, is exactly what we need to capture because I think that's – where I've seen progress in being able to automate quickly is where you can get to do really discrete data points that are already digitized, like an ICD-10 code, and if that code exists, then a lot of the other information becomes irrelevant, and I think understanding what type of data is required, and then understanding the players gets to whether it's an easy, multiparty, iterative type of prior auth, or users are in a patient journey that then lets us tackle it in different ways because it might require more chattiness and more support if it's something that has a long duration or is multiparty versus something that could be the low-hanging fruit that you could automate more quickly by just being able to get down to the four elements you need that allow you to automate and get to that perfect state. But, do we still want to do all that today?

Alix Goss
I want to check – Denise, I'm seeing the green check. I'm taking that as you're concurring and agreeing with what you're hearing others say, but I want to make sure we're not missing that you have a comment to offer.

Denise Webb
I was just going to reinforce this idea that I really think – when I think about prior authorization and the process we're going through here, it would be really helpful to work through the example we're on around DME and wheelchairs specifically, and really start with assuming a PA is required. I get it that every payer has different rules, and a PA might not be required, but if we would just assume a PA is required, then we start and go backwards to "Okay, payer, what data is needed to process the PA?", and then work from there, figuring out what of those data elements are already structured and available digitally, and who has them, when are they captured, can they be captured sooner – defining who has what role – and work through the whole example with the wheelchair, and then that creates a framework for a way we can look at other use cases or other types of DME. But, I think we really just need to work through one and start with the data first, and then start overlaying the roles, the steps, and the order of the steps, and so forth for the ideal state.

Alix Goss
I like that idea.

Denise Webb
I agree with a lot of what everybody said.

Sheryl Turney
All right. Well, Alix, I think we need to wrap up because we're at time. I do think this gives us a way to move forward. I do appreciate the group's – and, Alix, I'll give you time to speak as well. We're going to discuss a little bit offline on how we're going to organize the next midlevel meeting, but if any other folks would like to participate in that explosion of the wheelchair example, please let us know so we can include you when we meet offline to come back to this overall meeting.

Alix Goss
Well said. Considering the time that we're at… Thank you, Lauren.

Sheryl Turney
Thanks, everybody.

Lauren Richie
Thanks, everyone. Have a great day.