The Office of the National Coordinator for
Health Information Technology

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA TASK FORCE MEETING

March 31, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

Speakers

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

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Welcome again to yet another edition of the ICAD task force. We will pick up from where we were last week, starting with a brief roll call. I'll just go through the names that I have so far, and if I've missed you, please let me know. I have Sheryl Turney, Alix Goss, Aaron Miri, Alexis Snyder, Andy Truscott, Anil Jain, Arien Malec, Gus Geraci, Ram Sriram, Rich Landen, Sasha TerMaat, Steve Brown, Tom Mason, Carolyn Petersen, and joining us again today is Josh Harvey from HCA. Did I miss anyone? Okay. Hopefully, other people will join.

Sheryl Turney
Jim Jirjis is on.

Lauren Richie
Jim Jirjis, great. With that, I will turn it over to our co-chairs to get started.

Sheryl Turney
Great.

Alix Goss
Thank you.

Sheryl Turney
This is – sorry, go ahead.

Alix Goss
Go ahead, Sheryl.

Sheryl Turney
Hi, this is Sheryl Turney, and Alix is on. We're not quite synchronizing our voices yet, though, so we need to work on that.

Alix Goss
Sounds good.

Sheryl Turney
Definitely. So, welcome to the call today. I was going to start taking us through a little bit of how we got here and what brought us to the place that we're in as we start today. The hope is that today's session is going to be very interactive, so hopefully, we can get to that point and get everybody to provide some input, and then, also for today's session, the hope is to provide you some homework, but we also wanted to have a conversation related to capacity because we know everybody is dealing with lots of competing priorities with the COVID crisis, so we want to make sure that we utilize our time as effectively and efficiently as possible, and if people are having challenges as we go through that, please don't be afraid to share them

with us so we can see if we need to make adjustments to our timeline and our overall response to this process. Alix, do you want to…?

Alix Goss

So, for today's agenda, we're going to continue with a little bit of this level-setting that Sheryl started us on. Then, we're going to pivot into a deep dive on a table that we've created in a response to all the feedback we got on last week's conference call as we've been building over the last couple of weeks in March with getting our arms around the prior authorization exemplar and trying to understand the various data touchpoints, workflows, and considerations across a variety of prior authorization types so that we can have a framework that enables us to start to identify the recommendations that we want to pursue related to improving prior authorization, but also to use as an opportunity to think about what it's going to mean to intersect clinical and administrative data and what kinds of lesson learned we gathered along the way with prior authorization that can be insightful and helpful for us to bring back to the full HITAC committee for consideration in advancing to ONC's policy framework.

I think that once we dive in a little bit deeper to that new table format, it's going to help us have a conversation piece that we'll be able to use as a group moving forward to really advance our thinking around prior authorization and the convergence topic, and that we'll try to do a lot of our work in these sessions on Tuesdays. As Sheryl noted, we are particularly sensitive to the current landscape dynamics and want to wrap up today's call with some discussion around next steps and logistics, while also taking into account any public comments that would like to be submitted. I think we want to go to the next slide.

Sheryl Turney

Yes.

Alix Goss

And the next slide…and the next slide. So, I believe what I'm going to do is set us up a little bit for where we've come from, and Sheryl is going to tag-team with Josh Harvey – thanks to HCA for providing additional support to us. They've been building out a new table that we'll take a deep dive into today, and then start to actually update and advance through discussion, but I think we really want to make sure that people understand that over the last two weeks, we've come from a very vanilla version of a prior authorization workflow. We've got some really good understanding around trust considerations, opportunity for better information and engagement from and by the patient, really trying to promote a better ongoing dialogue that's based upon transparency, modern technology standards, and that would help us to really achieve a much more patient focus and efficient prior authorization approach.

When we evolved last week's prototype from the wheelchair DME workflow, we got a lot of really good feedback around linkages with USCDI, payment information and cost information, really wanting to set up some principles, goals, and assumptions from a framework as we move forward, and really not forgetting that there was a process model that we might need to be thinking about. And, as we started to really grasp the concept of the data, what it means to the overall framework for U.S. healthcare standards, and what that means for opportunities for improvement, we quickly recognized that there was a need to reframe the view that we were taking with PowerPoint flowcharts, so we wanted to create a tool that would give us a way to start to map out the data and opportunities and to have a structure that would help us reveal the opportunities and recommendations that we'd want to advance.

So, leveraging some prior experience of HITAC, Sheryl helped sketch out this idea of the table, so the table will give us the ability to get much more detailed in our information, and we want to make sure that we're not just reinventing a bad set of processes in a new set of recommendations, so hopefully, by having this tool that we're going to see shortly, we'll be able to really take a deeper dive and work collaboratively during these conference calls to propagate that table. Sheryl, would you like to round out that setup?

Sheryl Turney

Absolutely. Thank you, Alix. So, also, I think that we don't want to lose sight of the goal that we have in mind. Now, we created the table to try to generate conversation and capture information as we move forward, but again, it's supposed to be a tool to utilize and stimulate conversation. So, the goal of what we submit – it's not going to be the table, just so everybody understands that. The table is just meant to help aid in our conversations so we're all talking from the same point of view, if you will, or different points of view, but at least with common information in mind.

Also, I think it's important to remember the goal, and I think the goal goes back to what I said a couple meetings ago. This is ideally that – the goal is for a patient to be able either, through telehealth or arriving at a doctor's office, be able to know what is recommended, how much it will cost, and whether it is approved, hopefully before they leave the office. That's the goal. If we were going to say what our ideal goal is, that is it. So, what would we need to do in today's world in order to move us forward? That requires some knowledge of what we do today, but we really want to focus on what the goal is, and that is satisfying the patient and the provider so that they can provide the services at the point of service, whatever that point of service is, and what needs to happen in order to support that.

So, remembering that that's our goal – maybe before the next meeting, I'll even write that up as one of our summary points – why don't we take a look at the tool that we created with this grid that Josh is going to kindly share from his screen? And, I want to personally thank HCA for providing not only people, but time for folks on that team – Jim and his team – in order to help us at least come out with a straw model that we could then share with you guys, and at least have something that we could start with. So, I really appreciate that.

Alix Goss

I think we're ready to move past slide 6 because I think we've covered all the key points so far, Sheryl. At this point, what we want to do is pivot over so Josh can display his screen, and we can start having Sheryl and Josh walk us through that, and once they get the lay of the land mapped out for everybody, then we'll start to take questions. We're going to remind folks to say their name. I've already violated that a bazillion times. My name is Alix, so hopefully you're all used to my voice at this point. We're also going to then use the hand-raising feature so that we can manage comments and questions as they're coming in, and I'll support Sheryl through that effort.

Sheryl Turney

So, I'm going to start with explaining how we originally set up this table so you can all see what we've done so far. I am going to try to get it so that we can read it –

Alix Goss

We might – one of the things we just got coached about is that Josh can't see our chat box now because he's sharing, so if we want him to make that zoom in, which I think would be a fabulous idea because it's really small, even on my very large monitor, I think what we probably want to do is have you frame it up and walk across – there you go.

Sheryl Turney

Well, for those people who have the zoom on your desktop, if you go to full screen, it is a lot easier to read, I'll tell you that, but to Alix's point, when I go to full screen, I can't see who's raising their hand, anything that's written in the chat box, or anything like that. So, I'm going to go with the version that we currently have right now if that's okay, but I won't be able to see all those things. Essentially, what we decided to start with in this grid was the data categories that we're talking about. We wanted to capture that information because again, this is a lot about information and making that information available at the right time so decisions can be made.

Now, this is not an all-encompassing list. This is a starting list of some of the data categories, and I will say we do want to align them to what's in the USCDI, and we have not done that double-check yet, but we will, so after today's meeting, hopefully, someone will volunteer to take these data categories and try to align them with USCDI version 1 and say what's there today and what isn't there because that will help us inform things that may need to be added for version 2 in order to support the prior authorization ideal state, and after today's meeting, I will go into one of the tabs on this spreadsheet and define that ideal state that I verbally described, and you guys can comment on that and expand upon it as well to ensure that this is the goal, and this is what we've done to try to support that goal.

So, the data categories that we identified were some sort of patient identifier, a patient demographic, which could be name, address, county, state, ZIP code, all of that stuff, and again, we may have to break this down in order to align with what we have in the USCDI, but we wanted to capture it so that you would know what we were talking about. Who the payer is – we need that information in order to understand – when you're doing a benefits check, you need to not only know the payer, but also the plan that people have, and you actually might even have to know the employer group or what product, so we may expand that list to include the employer group and the product because an employer group may have one class of employees that have one plan and a different class that has a different plan, but sometimes, especially with formulary lists, it actually goes down to the product level, so it is more than just even deeper than the plan that we might need.

Benefits information – so, there will be a need to know what the benefits are, what the deductible is, whether it's an 80/20 plan, a 70% plan, or maybe an HMO plan. We need to know what those benefits are so that we can properly share cost and things like that. Whether the data is patient-generated or not – that's going to be really important because understanding where the data comes from is just as important as knowing – and, we have this in the grid to the right – the actor providing the data may be the physician, the physician's assistant, or nurse, but because it came from the patient, the translation might not be 100%. And then, the actors requiring that data, which we also have to the right, again might be different than who's providing the data in the first place, or they might have been the one that generated the data. So, those are some things that we know we need to capture.

Then, we also talked about the site of service. Where are the services being performed? Is it a televisit or something like that that needs to happen, or is it a wheelchair that has to be delivered to a patient's address, but the site of this particular visit that needs to get done might be a rehab center or something? Or, maybe it's a hospital, and that's where this patient has to have the wheelchair delivered in the wheelchair example, or maybe it's a surgical center. So, those are all things that need to be known for some of the actors relative to what they need to deliver.

Requirements to satisfy the request – there may be certain data that they need in order to satisfy the request, and we mentioned that last time – this person's an adult, but they're only 4 feet tall, and they need a smaller-sized wheelchair, or this person is 6 feet tall and 350 pounds, and they need a bigger wheelchair. So, all those things that you need in order to make the decision and for associating the proper equipment all need to be identified. Again, we're not trying to capture every single thing within that category that needs to be known, but we know that we need data about those things, and that's what we're trying to capture.

Status or state of the request – so, for something that, for whatever reason, can't be decided on the spot in our ideal arrangement, then how do we know what the status is, and how is the status followed through to a conclusion? Like that, the justification for the request – is there a certain requirement of data required by the payer or the source in order to substantiate the request of what those things are? Maybe it might be a test or a lab, or it might be some other information that needs to be provided defining what that is. The clinical diagnosis is usually required in order to make decisions on prior authorizations. Functional status – I think I'm going to need someone else to explain exactly what that is. I know we discussed it in the meeting, and quite honestly, I don't remember. Jim or Josh, do you remember what we referred to as "functional status"? I think this is one that came from Jocelyn.

Jim Jirjis

I thought functional status was some assessment of the patient's functional status that would be needed to justify some equipment. Can they walk? How far? That kind of thing.

Sheryl Turney

Exactly. So, that one is probably one that we need to make sure that we explain a little bit more. Maybe others understand it more than I do. Occupational status – maybe this is one that came from that workgroup meeting or Arien, also related to whether it's needed for assistance on the job or something like that. Maybe it's occupational therapy that they're talking about.

Jim Jirjis

I think it was both. I think part of the goal of occupational therapy is to include what's needed for activities of daily living and how to accomplish them, but also, should they be employed, how needing a limb, for example, is necessary for that patient's occupational status.

Sheryl Turney

Right. And then, we had history of past treatments. A lot of prior authorizations require that you have some sort of step that you have to go through in order to then say, "We tried all of these things, and none of them worked, so now, this is why we need surgery, or this is why we need X, Y, Z," so that would be important. Approval in the decision – whether it's approved or not needs to be known in addition to – which we didn't

list here, but we should add – what happens with the process for…if you disagree with the denial decision, how you go through that process to get your case reevaluated.

Requests for additional information because that often happens – hopefully, what we're doing with our process in defining what the data classes and categories are up front, the hope would be that payers know what they need and ask for it all up front, but sometimes they don't, so maybe there is some way that we can try to encourage that for each type of process, that's better defined up front. And then, again, cost to the plan and cost to the patient – understanding the cost shares that are related to the particular service would be important. Again, this isn't an exhaustive list.

As I said as we were going through it, a couple more things came to mind that we need to take into consideration, but that's the data category column, if you will, and we just wanted to have that as a point of reference because that's what we pulled out of the picture that we had. To support that picture, this is all data that we saw that we needed. We also got some information from Arien from the last meeting regarding the wireframes, and we tried to accommodate that data in here as well, but then, when you look at the columns, again, this was just for our ability to say where we would want to put levers, where we need recommendations around understanding how that data is exchanged today. Is it structured most times or not?

For a lot of these, the answers can be multiple, but if there is a structure that's available that's a standard, then maybe looking at that standard and making it more widely adopted might be a recommendation that we could have, or understanding what the limitations are for some providers that can't utilize electronic capabilities for submitting prior auths. I know today, we still get a lot of paper, whether it's faxes or images. How do we fix that problem so that it's not coming in that way and make services available that are not burdensome to the provider so they can utilize these electronic connections?

Then, we looked at content standards, which is the coding and the USCDI, so we wanted to be aware of the data that was already required under the USCDI and what data isn't in that list that we might say has to be there for prior auth, and we may say that as part of this recommendation, we need to move forward more quickly with these items to USCDI version 2 or something.

And then, we talked about different transport standards. These are the ones we're currently aware of, which is X12 for pharmacy and BPVT and the HL7 with all the different processes it's forming for APIs. There's also HL7 for the clinical data exchange, the CCDA, and then there are other emerging standards that we may need to think about and try to move forward. I'm trying to see – can you move –

Alix Goss

Sheryl, we do have – if we could scroll to the right so you can finish up the overview of the structure, that'd be great because I've seen some people's hands go up and down. People are holding off until you get through not only explaining this one, but also our "Other considerations" tab. I don't know if you're going to go through that or hold this.

Sheryl Turney

No, let's hold that for after the questions, but I do want to at least get through the grid first. And then, we have again the actors providing data that we took the first stab and actors requiring data that we took a stab

at because again, those are things we need to ensure that there are APIs or something available to exchange data between those parties so that they can support the prior authorization. And then, we have room here for comments and recommendations. So, that's the structure of the grid, and again, it's not set in stone. There may be columns that are missing; there certainly are data considerations that are missing, but let's now open it up to questions.

Alix Goss

So, we're going to take questions from the members. Steve Brown, I saw you had your hand up, and then you put it down, so I'm assuming that you did that intentionally, but let me know if I'm wrong. Otherwise, we're going to start with Anil Jain.

Anil Jain

Great. First of all, I think it's great to have a table form. It's much easier to understand. I just have a couple thoughts. If you scroll to the categories, I wasn't sure whether you wanted feedback on specific or broad categories of data that might be missing, or if this is – I missed a part of the beginning of this – the start of some homework. But, when I see some prior auth in my practice, oftentimes, one of the questions is what kind of a provider am I that's making the request? For example, if I'm a rehab doc and I request a wheelchair, it's going to be less stringent than if I am a primary care doc, which I really am, making a request for a wheelchair. So, I think having provider-specific data about the requestor – who's making the request, what specialty they are – is an important part of the data that needs to go to any kind of prior authorization.

The other thing that's missing that I often see in these – and, perhaps I'm imagining things, but as a clinician, I think having some level of urgency – how quickly do you need this? It goes back to a comment that was made earlier about the functional status of a patient and what occupation they might have. We have to have some sense of whether this is something that can wait a month or whether this is something that needs to happen tomorrow, and obviously, in a nonelectronic world, you get on the phone and you let people know that it needs to happen stat or tomorrow, but we need to have some way in the data to sort of transmit that level of urgency.

The final one is most of the prior auth approvals that I've seen – again, I'm very limited in scope; I'm very part-time nowadays – have some sort of duration or explanation of how long that approval is good for. So, let's make sure that we have some kind of time duration as part of the data that goes and comes back so that we're able to use that information appropriately in the context of what already happens today, but in a clunky way.

Sheryl Turney

That is such great input. Thank you, Anil. I think all the things you mentioned – the way we're looking at this – and, Josh is now adding to the grid – is we want to add the information, and then we can always review it later and say, "No, we don't need this now," but more is better, and it can cause better conversation, so thank you for those. I think they're all valid, and I think we should add them all.

Alix Goss

It looks like Josh has done that. Next in your queue is Arien.

Arien Malec

Hey, thank you. I just have one geeky correction, and then a couple of comments. Almost nothing in the columns that are labeled “transport standards” are actually transport standards. By and large, they’re content standards. We usually distinguish terminology standards from content standards, so terminology standards are the coding and code sets that are used, and then, content standards are how they’re formatted and assembled. It’s not urgent, but just worthwhile for correction.

And then, I think one of the areas that is missing here is some – and, this is the thrust of the comments that I supplied on Friday – they’re hierarchies of needs here or hierarchies of data specificity, and we should be thoughtful about content – so, informational content of the sort that’s provided potentially through the coverage discovery work in Da Vinci, which is primarily around using more of a decision support framework and supplying content on “Hey, this procedure requires X, Y, and Z” where providing patient- and plan/product-specific content on prior authorization requirements is helpful.

And then, the second is status information – so, what is the status of a prior authorization request – and then, the third is documentation. In some cases, we’ve got a lot of very structured information, and in some cases, we have narrative information – so, I think of the data categories. We should have placeholders for narrative, clinical notes, and potentially things like scan documents. As we roll out electronic prior auth, it’s likely that we’re going to be doing a stepwise approach to getting to the Holy Grail of fully electronic in prior auth, and we should be thoughtful about ways of automating the process with things like attachment standards and patient/plan/product-specific documentation, and overall general status on a prior authorization request and response, even when not all of the specific documents are fully formatted and fully available in complete electronic format. Thank you.

Alix Goss
I think we need to make sure as we’re going through each of this – and, once the speakers are done, make sure that the specific they’re looking for us to add are actually captured today because that was an action-packed set of comments. I don’t want to miss any of this.

Arien Malec
Hopefully, it’s the same information I provided textually in the email I sent over on Friday, but I can provide you more information via email if that’s helpful.

Sheryl Turney
And, just an infomercial inserted before the next question – you all are going to get write access to this grid, so once we are done today, we’ll give you instructions on how you can go out there, they’ll be emailed, and then, within the grid, we’re asking people who make an update – we’ll tell you how to do it, but you all will have the ability to go in, modify, and update this grid to keep us honest. So, thank you.

Arien Malec
Thank you.

Alix Goss
The next in the queue is Alexis.

Alexis Snyder

Hi. Just in terms of how it's flowing from the patient side in terms of things that might be missing, I think we need to make sure we're taking into consideration duly insured folks. So, in the benefits area, we need to have a place to take in information from both sides, what part of the deductible might be picked up by the secondary insurance, whether the coinsurance is included on the dual inside as well, what that secondary covers and does not cover, and what that second payer needs from the provider regarding what the first payer has paid for, whether that's a denial, or what portions they have paid, and what's left over. That's a huge piece.

I think another area – when thinking about more complex needs in something like durable medical equipment or a wheelchair versus a prior authorization for a procedure or a prescription, we need to consider that more information is needed from the DME provider, maybe somewhere around lines 19-20. Quite often – or, I think, most of the time – if we're talking in terms of wheelchairs and not just a basic necessity for someone, perhaps, after surgery for the short term, but something that's going to be somebody's long-term method of getting around day to day, it's very hard to determine what that cost is up front until they've met with the DME person who is really assessing all of the proper equipment they need and what add-ons are going to go into that product.

So, we might be able to come up with a list of ballpark figures from the payers – "We start with this, and maximally, we pay this" – but those numbers are going to change drastically depending on what needs to be ordered, and that isn't always something that the primary care, the rehab specialist, the PT, or whoever it is is able to know exactly what's going to be needed. Sometimes, they know that their patient has a specific need, but they really need the DME person to weigh in on how they're going to help that person with the equipment and what those pieces might be. And then, lastly – sorry, I lost my place on my list. I think I got them both in there. Yeah, I think so. I think that's it.

Sheryl Turney
Thank you. Those are some great adds.

Alix Goss
Next is Rich Landen.

Rich Landen
Data categories that I don't see in there would be – let's call it a routing category, and two aspects: The sender has to know where he or she is sending that. For example, is it sufficient to route it to Anthem.com, or is there a specific end address for a hospital versus DME versus pharmacy product? So, how to get it – where point A and point B are is first. Then, the second part of the data category would be whether there are specific routing requirements. Does it have to be through a vendor? Is it certain formats only? Must it be a payer portal? So, I'd add that data category for routing in both those senses. Thanks.

Alix Goss
Rich, I'm going to build on that a second. Jocelyn, I think you had a comment in the chat box that ties back to something that Rich just said about portal faction, and so, maybe we can make sure to capture that if it was overlapping with what Rich just said.

Jocelyn Keegan

I think so. I think at the end of the day, you have to represent current state, and I got the sense sometimes with the team on the creation of the Excel – on Monday, I caught part of the end of the call – from my experience, I just think it's really helpful to know what current state is, so as we start to look at the potential solutions to fully automate the workflow, we're making sure that whatever we're doing gives the complete solution that the current, say, less than perfect manual work that we require folks to do today – at least get somebody to a full answer, versus sometimes when we create electronic solutions, we sort of cliffhang people; we don't fully solve the problem.

So, I think knowing what "current" is, soup to nuts, gives us the ability – I'm a product manager by training – to make sure that whatever we're proposing is as good as – if not better – we want it to be better, but it has to work just as well as the current paper/fax/phone call processes do. I don't know who made the comment earlier – maybe Arien – about the urgency. When I'm on the phone, I can tell somebody, "I need this auth in place now because I have an urgent need," versus I've got somebody coming in a month from now for a surgery, and this is just part of paperwork getting put ahead. That happens in the margins of a fax and in the urgency of my voice as a caregiver on the phone with a payer.

Alix Goss
So, we've got the time sensitivity part. I just wanted to make sure – I thought I saw something about the paper/portals dynamic, and I heard Rich bring up the aspect around the…

Jocelyn Keegan
I guess my feedback is that when we look at transport in general, we need a column that represents "current," what happens today, and whether that means it's a… I don't know the exact format, but I think for each one of the steps, you need to identify how we're doing this in the hook-or-crook world today.

Alix Goss
I think we have to take that as a placeholder and figure out how we might represent it here, but Rich, I'm hoping we captured your comment as well. Sheryl, are you ready to go to the next one, or do you have a comment on this?

Sheryl Turney
No, but I was going to say that we did – and, I didn't describe the other considerations, but one of the things that was captured in our prior discussions was the fact that we do need to describe at the beginning of this the current state, and I agree with what you're saying, Jocelyn, but suffice to say that every provider might be in a different place, so I think those types of things, we might say, "Well, the current state supports this, and yet, what we wanted to do in the future is going to provide this same level of service or turnaround that even the lowest technical partners have experienced today, whether they use a phone, a fax, or an image of some sort. Maybe they scan it in, but whatever it is, we need to at least support that level of urgency for those cases that require it.

Alix Goss
Next in the queue is Denise, and I don't have anybody else queued up after that at this time.

Denise Webb

Thanks. Hi, this is Denise Webb. I just had a question about the distinction between the data category of “patient identity” and the data category of “patient demographics.” It seems like those two are intertwined. And then, I was just going to suggest that on the time sensitivity of requests, we might refer to that as the PA priority, and probably the actor providing the data would be the provider, and the actor requiring it would be the payer.

Jim Jirjis

It’s Jim Jirjis. We had talked about that exact topic about identity versus demographics, and there is a lot of overlap there, but we’re also thinking in the event that fulfillment requires information about their ZIP code or other parts of the patient’s demographic that could better tailor fulfillment of the service, that that might be different than the subset of data used to confirm identity of the patient. That’s what that was meant to get at.

Jocelyn Keegan

I can add a little color there, Jim, if it’s helpful.

Jim Jirjis

Please.

Jocelyn Keegan

This is Jocelyn again. So, a good example of this is things that are dispensed for specialty medications that actually have to get shipped to the patient, so often, you need information like where they’re going to deliver this shipment, whether somebody is going to be at home, at what time, and if it’s going to be something that requires refrigeration, and then, anything beyond that about needs or financial information about the patient that is very separate to the identity of the patient.

Sheryl Turney

Exactly. I think those are all really valid points that everybody’s picking up, and this is exactly the conversation we were hoping to have. Are there any other additional comments?

Alix Goss

There are a couple others in the queue. We have Steve Brown, and then Anil. Steve? You’re on mute if you’re talking.

Steven Brown

I tried to come off it. It’s this “working from home” thing. This is really interesting, and I think it’s a good starter kit. What I see is an admixture of characteristics and data about several different sets of actors, actions, and the like. So, there’s stuff about patients, there’s stuff about providers, there’s stuff about insurance companies, and those kinds of things. We probably need to have other patient-related data that’s not just clinical diagnoses or ICD-10 per se. Goodness knows – I know that when we’re looking at authorization for expensive medications, there are other medications and reactions to them and reasons why you can’t do it, or these sorts of things. There might be lab tests. So, patient information beyond simple diagnoses, functional state, and occupational status is likely to be necessary, and much of that may well be structured. Allergies to medications are a justification for going with the expensive one instead of the

cheap one, for example. For this general category of "other patient information TBD" that would conceivably be specific for the thing being requested –

Jim Jirjis

Do you mind if I comment on that quick point? I think there may be an opportunity to improve this spreadsheet. We had "diagnosis" separate from "justification for request," and I think one of the things we meant by "justification" was what are the more granular, detailed specifics about a patient status. Cerebral palsy might not be in ICD-10, but the specifics about what the need is to justify the service is what we meant by "justification." Is that the same thing you're talking about, and should we word it better if it is?

Steven Brown

Maybe so. There may be other patient data, or maybe you want subtypes or something like that. I don't know. But, that could be part of it, and some of it may get complicated, but in general, the patient-generated thing – what you're talking about there is metadata, like the provenance of a piece of data. That's sort of like the goose of this "duck, duck, goose" relationship because there's data about data that could apply to just about any of this. Let's see. Then, there's a bunch of process data too, and observations about processes, and status of process, and timing of process that might help to organize things that are roughly similar in overall model.

And, what I don't see – I'll come back to it – is where in a process all this stuff needs to be applied, and I know that's a next step, but there are also – as we said last time – modeling approaches to bring to bear information at various steps in a process, and what's interesting is if you do your process models right, you can actually run simulations to look at the impact on health outcomes, for example, of delivering the DME at the point of care. The other thing I'd say is in terms of the standards, people are still using HL7 v.2, so you might want to include that for the "as is," as horrid as that sounds.

Sheryl Turney

That's all –

Steven Brown

So, it's like the antithesis of emerging standards.

Sheryl Turney

Okay, I didn't mean to interrupt. Did you have more, Steve?

Steven Brown

I guess that's okay for now.

Sheryl Turney

Are you sure? Okay, always feel free to jump in again, but thanks for all those great points. Maybe one of the things we can do after the meeting as a follow-up is – we did talk about defining the data categories so it's more understandable to everybody, but also, we can reorganize them so they are set up by process versus inputs, et cetera, within the categories, realigning them so they're more in that type of order. I don't know if that makes it helpful for other people so they're not all mixed together, but we can look at that afterwards if you guys think that would be helpful.

Jim Jirjis
I think it'll help people who haven't participated in creating it to understand it when you show it to them.

Sheryl Turney
Yeah, absolutely, and I know this is new for everybody here, so I'm really actually very pleased that people are already chiming in and providing input because sometimes it does take time to just assimilate what has been done and what this really means, and again, this is fluid, so if we need to adjust it and you guys have recommendations relative to that to make it easier to utilize – because the goal is how does this help us drive the recommendations? That's the goal of this exercise we're going through. So, Alix, why don't we go to the next person?

Alix Goss
Okay. That would be Anil.

Anil Jain
Thanks. So, just a general comment about the various data categories. One of the things that I do worry a little bit about is today in the paper world, as a clinician, I get to choose what I write, and most of the time, I'm hopefully pretty comprehensive, but I do get to choose, and I would think that in the electronic world of making this a little easier, it's going to be too easy to overshare and too easy for that data to end up in places that it shouldn't be.

So, for every data category, I would recommend that we somehow tag it as essential for the transaction and that it should be kept over time or whatever the rule might be, but that other data is simply used in that moment to do the authorization, but is not maintained because it could change the way that information is shared, and also, I think there's information that's going to be transmitted that's very relevant for the approval, but doesn't necessarily need to be with the employer or the plan. That is probably a controversial thing to say, but we do need to limit to what is minimally necessary for the approval and not make this into a massive packet of data that's moving around that people are grabbing different parts of.

Alix Goss
That's a really interesting comment. I really appreciate that because it's a nice segue into the fact that at some point, we're going to need to think about this not only from a data flow perspective, but also a privacy protection perspective and why we've tried to make sure we've had some of those different views on the task force. I think at this point, Jocelyn – if you're done, Anil; let me check that before I pivot to the next speaker.

Anil Jain
Yeah, I'm done with my comment, and I hope we have a chance to revisit this later, as you said, as we think more through the model.

Alix Goss
I very much think we need to. Jocelyn, I'm seeing you type, but I'm also seeing your hand raised.

Jocelyn Keegan

Just a couple quick points – and, I think this is a really important point that Anil is raising. As we look at all the steps leading up to getting a prior auth done and that ability – by increasing transparency – to reduce the need for actual PAs and for data even needing to be moved because we're giving the provider better, high-quality, high-resolution information about the patient-specific benefit, we should reduce the overall amount of data that needs to flow, but I think the second piece of that – and, we spent a lot of time on this around Da Vinci and the community in FHIR – is the ability to get to that "just enough data, just the right data" at a given point of time with the flexibility you get from a more modern standard like FHIR.

And, we've spent a lot of time across all of our use cases talking about data provenance, minimal use, and actually have developed some guiding principles, but I can share or forward those along to the group before our next meeting, but I think this concept of what falls under existing TPO and what is the intent as we move forward as an industry to move just the right amount of data and no more, and to ensure that that data has very direct actors and owners of the content as it moves through the healthcare system. I think that's incredibly important for us to keep in mind, and I'm more than happy to share the work because getting to the point where we've gotten has been a little bit like peace talks, so we should leverage it.

Sheryl Turney

Jocelyn, I think that's a really important point. We can't forget HIPAA and the minimum necessary, and some stakeholders do feel like it's easier to just give them everything and let them figure out what they need from that, and that does definitely act in the opposite of what has been intended. Also, I don't think it's the easiest way to do the work, and then, with the new interoperability rules, the holders of that data are then all responsible, and I think it will get confusing as that data has to be shared down the road. So, I think that's a really great point. Did you have others?

Alix Goss

There are no other hands raised at this point in time, and we're just shy of 4:00.

Sheryl Turney

Okay, then why don't we describe the other conditions and considerations? Can we go to that – because we didn't describe that – and then we can come back and talk about what might be the homework assignment, et cetera? Unless there were more questions you wanted to pose to the group, Alix, before we moved on to that.

Alix Goss

No, I think at this point, people are clearly getting their arms around the table with the data categories, and we'll come back to the homework assignment in access dynamics and subsequent messages. So, I think the parking lot idea in "other considerations" was something that emerged from some of our calls in the last week. Do you want to walk us through it, Sheryl?

Sheryl Turney

Sure. So, as I said, we did talk about how we need to describe our ultimate goal, as well as what the current state is that we are moving from. So, there is an understanding, and we're not – this is probably going to be the preamble to our recommendations, but you do need to set the stage that basically says, "This is where we're starting, and this is what the ultimate goal would be, and these are the levels of steps that we're recommending in order to get there." So, those are things that we're hoping that different folks from

this group will – I have to change my little slide here because it keeps popping around on my screen – that stakeholders from this group will help to weigh in on.

So, the idea will be in terms of guiding principles, if there are things that you believe need to be there in order to guide us – for instance, what Jocelyn has said: The principle that we must provide a minimum first step to be as good as what providers, patients, and payers have that exist today. That would be one of our guiding principles. So, as we move forward, we're going to need to break up the components of our resulting whitepaper that will include the current state, the goal, the guiding principles, and then, some of the recommendations, and we might want to organize those once we start getting into it based on different themes or topics, and then we can work on those. But, as we discover these, our idea was to create a tab on the worksheet for these topics that we would allow you guys to go in and start populating. Maybe you want to populate some things on the grid, or maybe you want to populate some things relative to some of these other aspects that I mentioned. Those would all be there as tabs within the spreadsheet, and you would have the ability to add your info.

The one thing we're going to ask as we ask you to add info is to utilize a little approach that we used in some of our HITAC groups before, where if you add a comment, if you would not mind adding your initials and the date of when you added your comment, so that way, as we get those comments, the goal would be – hopefully, those will come in between meetings, and then, in the next meeting, we'll review everybody's comments and see where we're going.

Not very soon, but within a month, we'll hopefully have the frameworks of our eventual recommendation paper put together, and we'll all be working on different aspects of formulating that, so we'll not only be working on this grid that helps to inform us, but also what the eventual recommendations are going to be. That way, we'll know what's current and what isn't, and then, the goal will be as we review those with the group, if the group accepts those, then we'll just accept them into our document, and then the next week, we'll know who added what and when they added it so we'll know that we need to bring that up in the workforce meeting so we can keep going forward. That's just a little organizational thing that we noted after we were working in a couple of groups that helped us know what the next topics were that we needed to discuss, and because you can't really edit and highlight with versions like you can in Word on the grid, it makes it easier to do it that way.

The other thing that you could utilize as an option is selecting the cell, and then adding a comment. With a right mouse click, you can add a comment. If you want to add a comment but don't want to change the underlying data, but you have something to say about it, that's another way you can add information, but again, if you wouldn't mind just putting your initials and the date you add it, that would allow us to work it through during the session. Are there any questions either about the considerations, the parking lot items, or how to update the grid going forward? Again, it's all premature because we haven't yet gotten the structure of the whitepaper for the recommendations, but that's something that is going to probably be homework for Alix and me to put together in the next several weeks, and once we get that, we can move some of those narrative topics over to that document, and we would have both a Word document as well as Excel grid out there. That's the goal, and I'd like to do it sooner rather than later just because it helps everybody visualize the end goal that we have in mind. Any questions about any of that? Again, I can't see the hands raised.

Alix Goss
There are none raised at this point in time, so I think the key thing there is that folks on the task force will be receiving a subsequent email that will give you the link to the Google doc. We are looking for you to also receive in that email some helpful hints that were just outlined by Sheryl related to adding your initials and date, or using the comment box which will capture that automatically for you that will review those updates that we will ask you to do between meetings at each of our meetings, enabling the group to advance this together, and that in parallel, we'll be looking to build a report outline which the "other considerations" tab will support. So, I just wanted to recap that to make sure the instructions are clear, and I'm not seeing any further comments on either the table or the instructions that will be coming out shortly after this meeting with a link to this grid, or table, as we're calling it.

Sheryl Turney
All right. Any other –

Alix Goss
I think we can go –

Sheryl Turney
Go ahead.

Alix Goss
If there aren't any other comments, we should go back to the slide deck.

Sheryl Turney
Yeah, I agree.

Alix Goss
So, we got ahead of ourselves. You'll be receiving a link. Can you go back to make sure I didn't miss anything on that slide? Okay, there we go. We can include those instructions as we move forward, so thank you for that. Can we go back to slide 12, then? One of the things that we wanted to talk about was that ultimately, we would prefer to do our work as a collective team on these calls, and to make sure that we're staying in agreement as we progress through the table and other work efforts that will result from the table's completion and the recommendation opportunities it reveals.

But, we also realized that we were meeting a little bit offline, and we realized that that was helping us get structured and get going, and then, along the way, the COVID-19 outbreak happened, so we wanted to step back and consider whether we should be adjusting the frequency of these meetings. We do have a goal of having recommendations drafted and ready in the summertime for the vetting and fine-tuning process, ultimately to support a full, complete report submitted and accepted by, I believe, the end of September 2020.

So, I'd like to open it up for some thoughts and discussion around how we can complete our work. Can we do that if we move to a biweekly meeting structure, giving us a little bit more room between meetings to do editing, or do we want to try to continue on our current schedule, or are there other things that we should be thinking about? We recognize that we are in the healthcare field, and that a lot of us are being pulled in

a variety of ways, so we want to open it up for dialogue to stay as is, go biweekly, or think about something else that might help us get to the point of our deliverables. Sheryl, I'm going to open it up for questions if you don't have any other setup.

Sheryl Turney

The only other thing that I did want to say is at this point, we don't have any change in our guidance relative to the end deliverables, so I think that may come as well, depending on what happens with the COVID crisis. So, at the end of the day, if we can encourage people to speak up on this point – because again, we know you have competing priorities, but right now, we want this to be interactive and fluid, but also recognize that you have multiple demands. I might just caution that sometimes, with two weeks in between meetings, it might be difficult – people will put it off a little bit longer and forget, and then we won't have the input. So, that's a little bit of my caution or concern.

Alix Goss

That's a very good point.

Jim Jirjis

Jim Jirjis here. I was going to vote to continue weekly simply because the COVID thing – the more work we get done collaboratively together, the better position we'll be in if the COVID thing really gets hot in a month and we have to back off. So, I'd be in favor of doing as much as we can frontloaded to hedge risk, and then later, when things are better defined, it may lend itself to more individual work as we get to define work streams where people can bring their specific expertise to that part of it.

Alix Goss

Thank you, Jim. I'm seeing comments coming in, but the person who's raised his hand is Anil Jain. Please give us your thoughts.

Anil Jain

I think we should stick with weekly, and I think that if we look at what's happening with prior auth in the COVID-19 era – there are several things that are happening, but first, everyone is trying to reduce the administrative burden, so for things we would have typically needed prior auth for, we don't need it, but for things that are critical, like certain drugs and equipment, there is a higher burden for higher auth. So, if anything, I think we should continue to meet weekly **[audio cuts out] [01:05:45]** what we're doing to help reduce administrative burden when we should have our clinicians focusing on care instead of process. And so, I would say let's meet weekly. If not everyone can show up on a weekly call, so be it, but I think this is, in some way, tied to what we're going through. If we can help reduce the administrative burden, there's more time for frontline people – if not for this particular crisis, then for the next one.

Alix Goss

Thank you for those remarks. Are there other comments? I'm seeing a lot of agreement with what Anil just said in the chat box. Folks are agreeing we should stay on a weekly basis.

Sheryl Turney

Yeah. One point I do want to make is if we do decide to stay on a weekly basis, we could decide to keep the meetings to an hour if the group would prefer that, or continue with what we have, but if we finish early,

we finish early because we may not have enough discussion going on to continue, at least in the beginning, and that's completely okay as well. We've had that happen in the other groups. We then made the public comment earlier and adjusted it if that was the need because these are interactive meetings, and not like just presenting the topic for people to weigh in on. This is meant to be a work group. So, I don't know if Lauren or anyone from ONC wants to comment on what I just said. That is what we did last year.

Alix Goss

I think there's a theme in the chat box related to momentum, and it's resonating for me that if we can nibble at this, keep the cadence up, and have the weekly meetings, and we get a fair amount of attendance, we should be able to continue to chip away at this rock of Gibraltar, as we know prior authorization to be, and can loop people back in through our offline tools if they're not able to be on the calls, and I imagine there will also be extensive review processes as we get further down the road in any kind of narrative being developed.

So far, I have not heard anybody in favor of changing anything up. I'm hearing that the cadence is right, the topic is important, let's not let off the gas, let's actually keep going and get to the point where we're really advancing this new tool and iterating it on a weekly basis so that we can continue to make progress, so in the face of no commentary from ONC or others on the call, I'm thinking that's where we're landing at this point in time in the dialogue.

Thomas Mason

Alix, this is Tom. I just wanted to add the only thing that will be changing is that we're also in the midst of standing up a new task force related to COVID, so I just wanted to mention that, and I know Lauren will be back in touch with more information related to that, but just in case some of the HITAC members that are on the task force also want to be a part of the COVID task force, I just wanted to mention that we understand that there may be competing responsibilities in terms of the task force as well as our day jobs, so I just wanted to add that as well – there's more information to come on that.

Sheryl Turney

We'll definitely have more information there, particularly for the HITAC members, but we don't have a timeline just yet for any HITAC COVID-specific activities, but we'll certainly let this group know once those plans are solidified and see if that impacts this group and its activities in any way.

Alix Goss

Thank you for that information. It's clear that you've got an eager group of folks who want to continue the work, but we understand there's some other priorities happening, and there's a lot of support that ONC provides through the platform and the coordination between meetings. Lauren, at this point, are we ready to go to…? Go ahead.

Sheryl Turney

I was going to say I think what we're hearing is what you reiterated, Alix. People want to keep going, so until we hear more from ONC, I think that's a good way to go, and I do think we can go early to public comment, right?

Alix Goss

Lauren?

Lauren Richie
Yes, we can go to public comment.

Alix Goss
Yeah, we're about six minutes early, but…

Lauren Richie
Operator, can you open the line?

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

Lauren Richie
Are there any comments in the queue?

Operator
There are no comments in the queue.

Lauren Richie
Okay, we can keep this slide up for a second just in case and check back to see if anybody chimes in. Alix?

Alix Goss
Okay. So, we're at the point where we've done a bit of a wrap-up for today already, and then, as task force members, you will be receiving an email with a link to the Google doc that Josh was displaying for us earlier and that we were editing. We will ask you to be mindful of indicating any edits and changes so that we can process those between meetings. We are eager for you to get this link in your hands so that you can dive in and start adding comments and edits to extend this work, as the goal is that when we meet next week – gosh, it's hard to believe we're already starting to talk about dates in April – we will be meeting on April 7th at 3:00, that we want to start to have a structure for the next couple of calls where we are really coming to agreement and finalizing that table, and then starting out in parallel to think about the report guidelines that Sheryl was taking and really starting to put some structure to that early on so we keep that end goal in mind, which I think is really important, and at this point, I'm not sure that I have any more wrap-up. Sheryl, do you?

Sheryl Turney
Well, I think our tag-teaming is getting better. I want to thank everybody for their participation today. This is exactly what we were hoping for, so I think we are making some good progress, and for homework, what I would ask is please go out and check to make sure you have access to the document. Some companies – like my own, actually – have firewalls, and it is possible to provide access via a personal email account, but we need to know that if that needs to be opened up, so you can communicate that back to ONC when you

get the email, and they can open that up for you. The other thing is that we are going to try to build out some of the informational items that we're looking for, and hopefully I will work on at least taking the structure to put together the end deliverable so that we can start talking about it, and then people can start actually building out some of those components as well, and hopefully we can do that even before the next meeting, if I can carve out some time for it. But, I want to thank everybody for their input. This was a really good meeting in my eyes, and I really appreciate your effort on this important work effort.

Alix Goss
Well said. I do think that we can use some of the prep time we have scheduled each week to build those out now that we're going to be able to really have this grid/table be the tool that we're – everybody's working offline, and that'll give us the chance to pivot our thought process to the framework, and then start to build out the "other considerations" tab.

Sheryl Turney
All right. Lauren, no more comments, and I'm seeing no more hands raised. I think we can call the question.

Lauren Richie
Okay, fantastic. Any more comments? I don't see any. Operator?

Operator
There are no questions in the queue.

Lauren Richie
Okay. With that, we will speak again next week, and we're adjourned for today.

Sheryl Turney
Thank you.

Alix Goss
Thank you, everyone.

Jim Jirjis
Thanks, guys.