Intersection of Clinical and Administrative Data Task Force Update

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The Office of the National Coordinator for Health Information Technology

Today's Agenda:

- Task Force Membership, Vision, and Charge
- Progress to Date
- Next Steps
- Discussion

Task Force Roster

Name	Organization
Sheryl Turney (co-chair)	**Anthem, Inc.**
Alix Goss (co-chair)	**Imprado/NCVHS**
Anil Jain	IBM Watson Health
Arien Malec	Change Healthcare
Andy Truscott	Accenture
Leslie Lenert	Medical University of South Carolina
Ram Sriram	NIST
Sasha TerMaat	Epic
Abby Sears	OCHIN
Jim Jirjis	HCA
Denise Webb	Individual
Rich Landen	Individual/NCVHS
Debra Strickland	Conduent/NCVHS
Jacki Monson	Sutter Health/NCVHS

Name	Organization
Gus Geraci	Individual
Jocelyn Keegan	Point-of-Care Partners
Tom Mason	ONC
Aaron Miri	HITAC/University of Texas Austin
Steve Brown	VA
Mary Greene/ Alex Mugge	CMS
Alexis Snyder	HITAC/Patient Rep
Lauren Richie	*ONC*
Michael Wittie	*ONC*
Andrew Hayden	*ONC*
Ali Massihi	*ONC*
Cassandra Hadley	*ONC*

Vision and Charge

- **Vision**: Support the convergence of clinical and administrative data to improve data interoperability to support clinical care, reduce burden and improve efficiency—furthering implementation of “record once and reuse.”

- **Overarching Charge**: Produce information and considerations related to the merging of clinical and administrative data, its transport structures, rules and protections, for electronic prior authorizations to support work underway, or yet to be initiated, to achieve the vision.

ICAD TF – Scope and Approach

- A compendium of industry artifacts and FACA work products and source documents was created and used by the Task Force to inform and enrich discussions.
- A small group created a basic clinical workflow demonstrating the prior authorization of durable medical equipment (wheelchair) as an example.
- ICAD work group transformed this workflow into a workbook that highlights the Data classes required to support the clinical workflow for durable medical equipment, medical admittance and procedures, pharmacy, and specialty.
- Both of these efforts allowed the group to begin outlining the following:
  - Data classes aligned to current standards group adoption efforts
  - Guiding principles and a description of a re-imagined “ideal” state
  - Other considerations (includes considerations recommended to HITAC from 3rd parties)
  - Recommendations (includes recommendations made to HITAC from 3rd parties)

Progress to Date

- Weekly meetings began March 3rd, 2020
  - Meetings take place Tuesdays at 3PM Eastern, and are open to the public
- Subgroup Work began the week of March 16th
  - Created and are developing a collaborative Workbook to document Prior Authorization information needs, guiding principles, and other considerations
- Demonstrations held:
  - March 28th: Surescripts and CoverMyMeds
  - May 5th: Regence and Humana
  - May 12th: American Medical Association

ICAD Task Force Next Steps

- Continue weekly meetings and Workbook elaboration
- Elaborate on guiding principles and considerations with focus on privacy and security
- Fully define Ideal State
- Review the recommendations submitted to HITAC by 3rd parties
- Extrapolate PA deliberations to larger intersection of clinical and administrative data
- Draft Recommendations Concepts for HITAC feedback by mid-summer 2020
- Target Final Recommendations to HITAC in September 2020

Initiation (Completed) → Development (In progress) → Recommendations (Not started)

Questions for HITAC

1. As we move from PA focus to broader intersection of clinical and administrative data, what specific goal areas should be covered, or questions should be answered?

2. What are key considerations for the task force to keep in mind?
   - Coordination of benefits
   - Cost transparency
   - Attachment requirements
   - Request response and pended response timeliness

3. What piloting activities are needed to explore the barriers and challenges of EMR systems related to PA and the intersection of clinical and administrative data?

4. Is there a way to standardize the data requirements across payers which clinical decisions are based upon even if the PA decisions differ by payer, plan and product? And how would the USCDI fit into this model?

Discussion