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

June 30, 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
Alex Mugge	Centers for Medicare & Medicaid Services	Member
Jim Jirjis	Clinical Services Group of Hospital Corporation of America	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
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
Robert Lario	University of Utah	Presenter

Call to Order/Roll Call and Welcome (00:00:00)

Operator
All lines are now bridged.

Lauren Richie
Hello, everyone, happy Tuesday and last day of June – Oh, my gosh. Welcome to the HITAC Task Force. The members that I have either on Adobe or on the phone, Sheryl Turney, Alix Goss, Alexis Snyder, Anil Jain, Deb Strickland, Denise Webb, Gus Geraci, Jim Jirjis, Mary Greene, Rich Landen, Sasha TerMaat, Steve Brown, and Tom Mason. Are there any other members that are on the phone?

Ram Sriram
Ram Sriram.

Lauren Richie
Hello, Ram. Anyone else? Great. With that, I am going to turn it over to Sheryl, I believe, for our summary and action plan review.

Summary and Action Plan (00:00:49)

Sheryl Turney
Thank you so much. I really appreciate it, Lauren. Today, we have a process mapping conversation that we are going to begin and then, also, we've got Alix stepping up today. She is going to be presenting the prior authorization recommendations brainstorming that there is a strong group that has been going on, so we are very excited to hear that. We will have public comment and then next steps. So, let's go to the next slide. Fabulous.

So, I just wanted to give a brief recap from our last meeting. If you can recall, in our last meeting, we had several representatives from CAQH CORE who made a presentation. Or, actually, that was April Todd that made the presentation from CAQH CORE. And she presented an overview of the new operating rules that apply to prior authorization transactions and included some highlights from the 2019 CAQH CORE index report on medical industry electronic transaction adoptions. As well as, they presented some barriers to industry adoption of the electronic prior authorization. And also, they went over processes to identify closing automation gaps through changes to operating rules. So, that was a very wonderful conversation, and we had a great discussion afterwards.

And then we had AHIMA come in with three different presenters who all gave us a perspective of their background for the last century, in terms of helping to improve health-record quality by taking a leadership role in the effective management of health data and information and delivering quality healthcare to the public. They had some very interesting slides that presented some information. And also, their slide that really focused on issues beyond automation, generated a lot of good discussion from our team here.

So, with that, let's move over to the next slide. So, we are going to begin the process model of conversation. And in order to do that for you today, we have a representative of one of the small groups that we have been dealing with, Robert Lario, who is going to be presenting this fabulous process model that they put together. He did a very great explanation for us in the small groups. So, if you have questions, please feel free – We allotted enough time today for them to present this model that they put together, as well as, some background, in terms of how to read it.

And then also, in terms of generating conversation, because at the end of the day, the most important factor about the process model is not that we get a process model perfect because there are lots of groups trying to do that. The intent is to use this process model so that we can take our recommendations and our ideal space and our guiding principles and be able to use those to look at this process model, sort of test the

model, if you will, and say – Is this valid? Is this right? Does it help us, in terms of validating the recommendations and the guidance that we are going to be providing, and is that valid?

Because, as you all know, this is very complicated. We cannot present a particular process that is inherent to a specific EMR system, nor an administrative system. So, we have to present a model that can work within the parameters of, really, what the landscape is. And if we group the landscape, as I have defined it – And maybe I will explain that to you for one second before I turn it over to Robert – Is that there are really three levels of providers that we see if we group them together. One level that has an EMR system with CDS hooks, which is actually the capability that allows them to utilize APIs. And then there are EMR systems that do not have that capability. And then there are providers and systems that actually do not really have EMR systems, to speak of. They have systems that support specific aspects, like billing or their X12 transactions, but it really would not be considered an EMR system.

And we cannot focus on that broad spectrum, of course, because at the end of the day, we are trying to focus on how can we enable interoperability and interoperability rules, in order to have the greatest benefit to that entire landscape. So, we want to acknowledge that that landscape exists. And then we want to utilize the tools that we are creating to say – Will the recommendations, that Alix will talk about a little bit later, live within the realm of what we know is currently out there? And who can take advantage of it?

So, any questions about that overview? All right. Now, I am going to turn it over to Robert.

Alix Goss
Sheryl, this is Alix – If I could just add a little additional commentary. I want to link today's presentation that is being queued up right now, as Robert is sharing his screen. We want to just link this to our prior discussion with the data classes and categories discussion and some of the thought process that Steve Brown brought us from the VA realm about how do we really get our arms around the larger business process model. And I am really excited for today's discussion, and we certainly do not want to cut it short if we do not have to.

We will be diving into some straw man recommendations that we have started in a small group, but it will just be a starting point for brainstorming. So, I think it is a really great point that you make, Sheryl, in that this business process model is the launch-off point for so many other pieces coming together that we have been working on for last few months. It also enables us to then have a solid foundation for us to pivot from prior authorization to the larger conversation, as we move through the month of July. So, I appreciate your discussion about the levels and all the efforts of the small working group.

Sheryl Turney
Thank you, Alix. Anyone else have any questions before we move on? Robert, I think you are going to have to enlarge your screen a little bit because even if I enlarge this, I cannot really read it. But you might want to talk about it in total first. But I am going to turn it over to you.

Process Mapping Discussion (BPM+ Work) (00:07:55)

Robert Lario
I think someone else had a question before I start.

Steve Brown
This is Steve Brown from VA – What I wanted to say is that this work grew out of a use scenario Josh pulled together for us. And Robert has spent some amount of time, both with me and with the small group, trying to pull together a representative model. I think my hopes for this is for you all to get the basic familiarity with the modeling methods, to see what they can offer. Again, I think it puts what we have been talking about in context and also allows you to know, at various stages, what information requirements there may be, what documents may be going back and forth. So, there are great ways of trying to pull together all these things we have been talking about, as a group, and then putting them into the context of an overall process, rather

than a spreadsheet that is agnostic as to where any of this gets put. And understand that we did this time box. We are limited in effort. So, we did not intend this to be a perfect thing, but I think it is meant to be a pressed and organized framework for some of the group activities. I will let Robert pick up from there.

Robert Lario
Thank you, Dr. Brown. My name is Robert Lario. I am with the University of Utah and the Veterans Administration. I work for Dr. Brown. As Dr. Brown said, we were given a scenario that was in a Word document and asked to show how we might use these methods that we call BPM+ to express the same information but using these open standards. BPM+ is Business Process Management. It is a term that was coined through the Object Management Group. These are open standards. The method on the screen is called business process modeling notation. It is an open standard. It is available to anybody. It is free. There are many tools that implement this. There is a lot of documentation, a lot of classes and all, if anybody was interested in pursuing these methods.

It is a visual notation. BPM+ has three different methods. The first one is the process modeling, which I am showing you now. In a moment, I am going to show you decision modeling notation. There is a third, which we will not go into, called case modeling notation. We are actively pursuing other specifications to extend the BPM+ family to allow us to better articulate clinical knowledge. This particular method focuses on process knowledge. This is a tool by Trisotech. As I said, there are other tools, like Camunda and Sanovia and No Magic and SPARX – They are all different vendors. I did not want to confuse the vendor's implementation with the actual notation.

The notation, here on the left, is a pallet you can choose from. The primary things we work with are called tasks. Tasks are where things happen and get done. There are different types of tasks. There are gateways where we express the branching, as a result of something that has happened upstream. And there are events that either occur or are caught to help a process move forward. There are other aspects of the language, but I am not going to go into them. I will zoom in. I just want to show you that based on the document that was provided, we put down what we call pulls. These are these long, rectangular boxes. They are meant to represent an entity, a thing, a system, a person that is performing some activity and interacting with other pulls. Just to give you a bird's-eye view – Up here, we have got a patient. Here is the provider pull. We introduce this intermediate pull that addresses the process that supports the requesting of the authorization for a particular procedure. And then down below, is the pull that we use to express, perhaps, what a payer might do.

We do not expect this model to be correct. It was a first cut at expressing what we found in the Word document. One thing that is nice about this, it is an iterative process. You create initial model. You work through with your subject matter experts. You step through it. You remediate, make changes, updates. We do not believe this is correct. Again, it is a first attempt to get the conversation going. And our goal was to introduce these methods as, possibly, a way of expressing the information that you all are working with.

So, I am going to zoom in and try to make it a little bigger for you all. Let me pull it up even more. I have a very high resolution screen so, hopefully, this is close enough. Maybe somebody can confirm that they can see this okay? You can see provider?

Female Speaker
We can.

Robert Lario
Okay, thank you. So, this whole process starts with this notion of what we call a start event. The assumption we made, based on the document provided, was the patient was registered, and the insurance information has been collected and validated. We show here that there is some interaction with the patient, perhaps collecting information about why they are there, what are their medical issues? And there is an exchange of information going back and forth. We do not know what that is, but we just wanted to abstractly show

there is this exchange, maybe some questions coming to the patient, some answers coming back. But after this pass is complete, there is a document that was created, which we call the encounter.

I am going to come back to this because we can also go in here and express the types of data that would be collected, as a result of this. This data is then fed into the next task, which is – Should this patient be admitted? I am going to come back to this task, as well, because we can actually go into this and express some of the logic that would be employed to make this decision. I will come back after I finish going through the flows.

A result of this task is this admissions result document. That document is used to decide – In this task here, the decision was made – Should they be admitted or not? This was a flow about admission. So, if in this case, it was decided that they are not to be admitted, then this task ends, which is what this dark circle means – that the process comes to an end. If the process continues, then there is human intervention where they are going to review and gather some more patient information. They are going to update the patient demographics and the EHR. The encounter information will also come into the EHR, and then the provider will enter an order for the patient to be admitted. The admission order will then go into – This here is a service task. We are showing here that the system is – This is the notion that some program, perhaps, some system is taking this – Maybe it is the EHR – And it is sending on a request down to the authorization system to request an authorization for the procedure that was identified in the earlier tasks.

This is where the message is captured. It goes on to the next task. This dark envelope here means that a message is sent. This task is sending a message into the payer and requesting, for this particular procedure and diagnosis and this person, this patient – What are the rules that the payer will be applying to receiving authentic authorization? So, we get those rules back, and we feed them into another task, which is here – a process of making a decision. It is using those rules. It is taking the admission information that was received from the provider. And it is, essentially, determining, based on the rules provided, based on the order entered, the patient – Is the data that we have collected as a result of the order – Is it sufficient to submit? Or is there a data-quality issue? If there is a data-quality issue, we are going to take those rules. We are going to analyze the order and produce a document that expresses what the deficiencies are, or issues are, in the order that was sent.

We are then going to send that back up to the provider. We left the provider here when we requested an authorization. That process, for a specific patient, moves on and waits here at this gate. So, the diamond is a gate. It is a point of making a branch or – Not a decision – It is a branch, as a result of some change in information or some event that has been received. Here, we waited for an event to occur, either some issue with remediation or a response for the payer. In this case here, the message that came back was an issue of data quality. So, we are showing that there is some intervention by somebody at the system level, in EHR. They are going to address the issues that were identified, and then they are going to resubmit the order. That whole process then repeats.

We come back down. We go through all this again, checking the orders, because this is happening for every – You can imagine that for every patient where an order is being created, this is being executed. And an instance of this process could be at any point in the sequence, per each patient. So, for Joe, Jane Doe, they have come in. We are going to get the record, the rules again. We are going to look at what we have got. We are going to check the order again. And then this time, we have determined that the information is sufficient. We are going to run a process that is going to send on that request for authorization down to the payer. The payer receives it. They are using their same ruleset that was requested by the system earlier, and they get the authorization. They are going to provide their own analysis. They, then, make a decision. We feel this is an area that requires further explication and work, but it is a starting point for discussion. So, we do not – Again, I want to caution, we do not feel this is completely accurate. It is really meant to be illustrative, and we welcome an opportunity to explore this and then correct it.

But, nevertheless, based on what we had, the process shows that it is approved. If the authorization is approved, we send that information back to the system that requested the approval. That, then, gets sent

on to another task that, then, sends it up to the provider, which then goes to their process, here. If it is approved, then this process is complete. If we find, here – I want to bring your attention back to here. When the internal intermediate process submitted the request, it sat here on this task, waiting for a response. The notation we are trying to highlight here is – We have a timer on here – This is something that would be based on policy. Maybe the process waits three hours. Maybe it waits three days. But if the intermediate process does not receive a response for Jane Doe, it is then going to kick the timer off. It is then going to send a new request back down into the payer, essentially saying – What is happening? Why have we not gotten a response? Please give us a response. That is running at the same time all this is running down here.

So, coming back down – If the request goes through, and it is denied, the denial message is sent up, same catching process. Task gets that message, sends that up, that message back to the provider. Provider receives the message. It looks and sees what the message received was about. In this case, it is a denial. The provider will review the denial. They will update the patient information in the EHR and then come back around and try to get authorization again. Now, there are certainly some issues there. Maybe they decide that they do not want to resubmit this. Or they may have to escalate it. But this is as much information we had when we built this process.

The last two paths are – If they are neither approved but denied, we are now waiting for a pending state where in one case, it is pending because their data – the payer has decided that the quality of the information was adequate, but they have decided or found that there is something that is incomplete and it requires additional information. That message gets sent up, same process, kicks around again. That gets sent back up to the provider. The provider sees that there was a pending status. They intervene and provide the appropriate remediation and then come back around and wait again. And then, finally, the last is is that it is pending, but per the use case, said it was pending because, perhaps, there was some internal process that needed to be validated or approved and hadn't quite finished yet. And so, they are waiting for that to complete before they can make a final approval or denial. And that whole process runs again.

The last thing that I want to come back to is if there was an approval – This is per the use case – There is this task where the payer is going to decide whether or not they should audit this particular approval, and they have their own logic on how that might happen. They choose to audit. If they choose not to audit, nothing happens. If they choose to audit, this is a symbol that represents the notion of a throwing process. There can be some other process that has been defined in the enterprise. The catching side of that would be called start audit process, and it would receive, essentially, a kick to start all of the data that was provided here would be delivered to that audit process. And then, that audit process could start its process of auditing the authorization.

The last thing I would like to come back to is, I wanted to show you how we looked at this notion of – Should a patient be admitted? We took liberty and said, – Well, here is an example of how we might show that with further specification, using what is called the DMN, Decision Modeling Notation. So, if you humor me, think about – I am going to jump into this task. The decision task is represented by this little Excel spreadsheet. So, I am jumping into that, and this is the expression of a decision task. And I will try to zoom in for you a little bit. The decision tasks – The two major elements is the notion of data, which is shown by these oblong figures with a little piece of paper turned down. Let me zoom in a little bit better for you. And it shows that there is a decision being made. I will move up here. And here, for example, blood pressure is a decision that is being made. The output of this decision feeds the admissions decision. And then, the output of all of this would be some notification of whether the patient should be admitted.

What I would like to show you is that here, we went in and put in the structure of the data. I am sorry. I cannot zoom in any more than this. It is a limitation of the tool. But, essentially, it is saying that the demographics structure would have a first name, last name, maybe a previous name, middle name, suffix, data of birth, gender at birth, age, race, ethnicity (which is constrained to an enumeration of these types). And what I wanted to show is that this is a way of also – As a part of the process modeling, you can set

expectations on the type of data that would be required in order for the process or the decision to execute successfully.

So, coming and looking at this other data object here, which we call the encounter information. If I open this up, in the encounter information, it says we have some – Sorry. There is some health information. Do they have hypertension? Do they have kidney disease? Do they have diabetes? It is a very simple structure, just meant to be illustrative. Vital signs – What is their blood pressure? What is their temperature? So, this is systolic, diastolic. So, this is the information structure that would be required or used by, in this case the blood pressure decision. So, let me step inside the blood pressure decision. If you can humor me, envision that an instance of this encounter information for Jane Doe would be submitted to this task of making a decision. And this is the decision that is being expressed. Let me see. I might be able to get this in a little bit closer. Sometimes it will zoom in for me. Unfortunately, not this time. Okay.

Well, what you have here is a table. Each of these rows represents a rule. The left-hand side is the antecedent, the "if" condition. So, for example, rule one says, "If the systolic pressure is greater than or equal to 180, return hypertension emergency." The second rule says that, "If the diastolic is greater than or equal to 120, return the same – a hypertension emergency." The next rule is showing a range, where you can say, "If it is 140 to 179," and so on. This is just mean to be illustrative. We can have very complex rules of if things are in a range, if they are part of a value set. You can articulate how the rules should be run, if only one is unique. You can run all the rules and get a collection of things back. But what is nice here is that it is a very clean and clear way of setting expectations on, in this case, what would be deemed as a rating for blood pressure.

So, if you would envision this executing, that value of hypertension would feed into the admission results. The admission results would then use the encounter information, as well as, the patient information to make the decision if they should be admitted. The result of that task would be an admission decision or do not admit decision. And this process would then continue on. Again, this is just meant to be illustrative and show, perhaps, the art of the possible, show how these methods might be used to help more clearly express the expectations, and in sharing and elucidating the information more clearly.

So, that is the end of my part of this. Are there any questions?

Sheryl Turney
Thank you so much, Robert. That was really, very helpful. I know when we discussed it in the small group, we had a lot of questions. So, I am going to open it now to the task force. I do not see any hands raised. But if you do have a question and you are in the Adobe meeting, please raise your hand. If you are not, and you are on the phone and you have a question, please let me know.

Alix Goss
Sheryl, this is Alix. I want to ask you a little about the small group discussion that you may have had. This is a great model. It is mapping out the various steps of the process by actor and helps us to understand the clear, happy path, as well as, some of the more complicated aspects because we all know that prior authorization can be quite multifaceted and take a lot of participant involvement. So, I am curious – knowing that some of the small group members were unable to make it here today due to family vacations – I would be curious if you could maybe, either Robert or yourself, give us some sort of flavor of the questions you had. But also, along the way, curious around the patient level at the very top and noting that that function, that whole row, is very empty. It is just the existence of a patient, and I am curious to also understand if there was any discussion about maybe wanting to build that out in some way or even to represent the larger family community around a patient.

Sheryl Turney
So, yes, the addition of the patient characteristics has not been added. We were going to have an ask in this meeting to engage, maybe, one of the patient representatives to help us build that out a little bit more. And then, we also had talked about potentially working on a denial and appeal so that there is a little more

detail in that. But at this point in time, we did not want to hold the model. We wanted to be able to share it and engage it with the folks from the task force. Some of the habits that we discussed – Hold on a second. So, I wanted to briefly talk about those.

Alix Goss
While you are collecting those notes or those thoughts, Sheryl, I think it is a good point in time to call out that this is the first major foray back to the full taskforce on the business process model. And as we link this idea of the current state complexities as the front matter we need to do in setting the stage in our report, we will be able to use this coupled with the other data classes and categories where guiding principles ideal state, bundled up with our recommendations, and get us the full story, soup to nuts, that we are trying to tackle related to prior authorization. So, the goal would be, then, to get from today's feedback, enough of what else do we need in this and modeling effort. And it looks like we are trying to not only have a master model, but we are also trying to do where the denials or the tended dynamics are more called out as discrete models, in addition to this?

Sheryl Turney
Yes, that is a lot of what we talked about in the meeting that we had in the small group. Also, we discussed, as I already mentioned, the patient – the interactions and the process. And then also, there are some questions that the folks had who put this together – and did a fabulous job – whether there are any gaps that need to be closed. As they walk through it today, and earlier when we looked at it, the biggest one that I called out was really the patient access. And what data are we anticipating, as we move to the bigger question of intersection of clinical administrative data? Does there need to be there for the patient, as part of this process? And also that we do not want this to be an exhaustive process. This was not meant to do everything, nor were we going to take it the next step and do multiple types of prior auths. We felt like a generic, as they exhibited here, is probably the best one for us to use, as long as it had the approval, as well as, the denial and appeal.

Alix Goss
That is really helpful, Sheryl, because I think one of the things I would love to see after today's call – and maybe if we could get an updated version because I know I had seen an earlier PDF of this, and there was not even a patient there at the top. So, I must have seen a really preliminary version. This is, I think, a huge tool that we can use. And then if we do want to get our members to take a look at it, that, hopefully, we can get an updated version after today's input is received and infused into the document.

And I noticed, while we have been chatting, there have been a few more hands popping up.

Sheryl Turney
Yes.

Robert Lario
May I add something to that? I, personally, do not feel this is ready for distribution. It requires further discussion with the experts. There are some issues, even as I was walking through, that we did not address. So, for example, if the message is pending, we really punted. If you notice, the message just flows up, and then comes back around again, but there is no real remediation going back into the EHR. And, as you mentioned, there is no interaction back to the patient. This was a first cut, and I would caution against saying this is the answer.

I think the ask was – How could you use these methods? And I think part of the decision here is for you all to decide if you do want to move forward, perhaps, discussing next steps to advance this model to a level that does fairly articulate what you are trying to achieve before it gets distributed more broadly.

Alix Goss
Perfect capstone. Thank you.

Steve Brown
This is Steve Brown. So, the reason that the person at the very top does not really have much in it is because in the narrative use scenarios…

Alix Goss
[Inaudible – crosstalk] [00:36:25] I am sorry, Steve. Is this Steve Brown? I am sorry. I am just trying to figure out who is speaking.

Steve Brown
Yes.

Alix Goss
Okay, go ahead. I think she was trying to run those who had their hand up, so I don't know if you are asking a question or adding commentary for further discussion. **[Inaudible – crosstalk] [00:36:41]**

Steve Brown
I guess what I would say is the reason that there is nothing in the person pool is that in the original scenario, there was not any engagement with the patient. And what would be required to model that out to the next level is someone who is willing to write the narrative from the patient's perspective – What would they do? And add to that so that it can then be modeled out. It was not modeled in this first pass because there is nothing in the use scenario. And Robert's a good modeler, but he is not a good prior-auth guy.

Alix Goss
You can only model as good as your white boarding or your details provide. Totally understand, Steve, so thank you for that.

Sheryl Turney
Okay, so why do not we go to the folks who have their hands raised? Alexis?

Alexis Snyder
Hi, thanks. Well, I am a bit confused in a of couple places. So, one, based on what Steve was just saying, we had in earlier groups, as well as in our workbook in the larger groups, I had added a lot of narrative in reference to where patient and caregiver are not only engaged, but burdened in the process. So, I am not quite sure what happened to that. And as far as small groups getting together, I have not seen or heard anything. Otherwise, I would have gladly given more information, but I had to be asked for it.

So, my other confusion is if we are talking about this looking like current state or if this is what we are calling ideal state. And, I guess, before my next comment, if someone just answers that. Is this flowchart supposed to look like the current burden state? Or where we want to be in an ideal state?

Robert Lario
This is Robert. This is a representation of the flow that was presented, as an example. Again, I think this was just meant to kick the tires, if you will, of these methods and see how something that is in a narrative form might turn into a BPM model. I do not know that it is meant to be the answer. It was meant to be – The red notes are what I put in here as I was looking through it.

Alexis Snyder
So, my question – Is this the current state? Or is this what we are hoping for an ideal state?

Jim Jirjis
Hey, it is Jim Jirjis. Can I comment on that?

Sheryl Turney
Yes, please.

Jim Jirjis
These are great questions. What we were intending to do is – The task force has done so much work around the data categories and standards for open interfaces, et cetera. And if you remember, we started with workflows. Then we said –Let's pivot to the data and the standards. And now we are kind of pressure-testing it, using Steve's and Robert's model.

And so, one of the things we want to do is validate, right? Does our model, our data model – How would it support current and future states? And so, one of the neat things about this is if you look at the big rectangles that represent, I guess, the entities or stakeholders – One of the things that this brings out is that at every step of interaction, we could actually say – Well, data has to be transferred from one entity to another, one big rectangle to another. And current states or multiple different future states could be supported by that model we have worked on on that spreadsheet.

And this brings it out because we keep saying – Go back into the EMR. Does the data go back into the EMR? Well, what we were saying is that we do not know that it will be just the EMR. There may be app developers that develop multi-payer apps that interact with the patient, as well as, providers or their staff, as well as, multiple payers. What this could do is actually represent a variety of future use cases to validate our goal. Our goal is like meaningful use, like information exchange for non-clinical administrative. Our goal is to create data standards and standards for communication and open APIs that could support a market of different, possible future states and people competing over apps, et cetera that solve problems.

I just go back to this model because you could actually define out multiple different states, and it could validate. If the focus work of the task force was around data models, open APIs, and transport standards, then this demonstrates it could support a variety of different workflows. So, validation, I think, is the keyword.

And Sheryl and Alix, is that how you view this, as well?

Sheryl Turney
This is Sheryl. My answer is yes. And also, to be more-specific for Alexis, I think that this data model, because it is really focusing on the data and the process, is really what we hope the future will look like. But it is not a redesigned process, if you will, because that is not the role of our workgroup. We are looking at what we can influence, which is, as Jim just said and Alix said earlier, we can influence data standards, data classes, maybe some recommendations for automation that currently is not there or integration for automation, which is why we had X12 and CAQH CORE and others come forward and talk about their efforts. But it is not to necessarily reinvent the process because there is no hook for us to engage with a group to do so.

So, there may be more innovation that will occur as a result of EMR vendors and app developers having those data standards and having the ability to reimagine the whole utilization management process. And, hopefully, we will get into some of those topics when we are talking about the intersection of clinical administrative data. I can imagine, quite honestly, a world where all of the administrative and clinical data is available through one system. And that will enable and allow lots of other things to occur, but that is not what we are dealing with right now. Nor, is it something that I think is realistic for us to make recommendations towards until we actually have things in place, like an integrated data model, and then a basis to talk about those other things.

So, yes, this is not complete, and there is more work that needs to be done. And that is one reason we are bringing it back to this group. And so now, this group, who has tried to utilize the efforts that we have all put together in the workbook, but they were not part of the workbook. So, there may be data out there, Alexis, on the patient that they did not pick up because it was not apparent where they needed to look for it. So, maybe we will, if you are willing, join us for a meeting, and then you can help continue to build out that patient part of the process. And certainly, we can try to go in the workbook and seek to find what you have already populated, but I think that is where we are with that.

We also have another question from Rich, and then we will open it up to others. Rich?

Alexis Snyder
I do not think I got my question answered, nor finished my comment, but that is fine. And I was never invited to the group, just so you know. I asked a very basic question, and I still do not have my answer or an understanding, but maybe I can ask Alix further offline

Sheryl Turney
Well, the group was open to every peer who wanted to participate, and basically, the people that were invited were the ones who put their hands up. So, maybe it was a meeting you could not attend. I do not know. But we **[audio cuts out] [00:45:24]** include you in the **[audio cuts out] [00:45:25]**

Speaker
Are you still there?

Speaker
Yes. **[audio cuts out] [00:45:35]**

Male Speaker
Hello? Are we still on?

Alix Goss
Yes, this is Alix. It went very quiet for me.

Sheryl Turney
Yes, I was waiting for Rich. He had his hand…

Alix Goss
I am sorry – I would like to back up. Rich, if you do not mind for a second because I feel like I am a little lost, along with Alexis, especially knowing that she previously raised her hand to be part of that group. She was taking hiatus from guiding principles groups, so there might have just been a little disconnect. And apologize if I contributed to that to any way, but I think I am still trying to figure out if this is supposed to be really the identification for current state that leads us to the ability to then apply our ideal state so we can further validate any gaps or what it might be. So, I think, Alexis, is that getting at the crux of your question?

Alexis Snyder
Well, yes. It goes to my basic question again. I am not saying that we need to change process or reinvent the wheel. That was not my question or my suggestion. We are here to find out where the current state is and where we can make best recommendations for improvements in the future. And so, I am confused again if this model is trying to map out what the current state is, so that we can more visually see where the issues are that we might make the best recommendations for improvement in the future. Or is this an ideal state model of what it could look like in an ideal state, should things lead to improvement? And the reason I asked that was because I had comments about what is missing and needed that answer before I provided what is missing.

But I will say that, regardless of providing right now rather than offline at another date, what is missing – If we are talking about data versus engagement, we are still talking about a process where the patient is continually involved and needs to be because this is not what happens and not how the information flows. And they are burdened throughout the process, across that entire line almost. And so, I would just say that if this is a current state, there is a lot missing of patients. And if we are talking about ideal state, there is also a lot missing.

Robert Lario

This is Robert. Maybe if I could try to…

Alexis Snyder
And taking patient out of it – not out of it – but aside from just patient comments about what is missing, there are some pieces where if we are talking, again, current and/or ideal pieces about an endpoint at denial because that is not what happens and not what should happen at the endpoint there. So, I think there are a lot of places where, yes, I understand it is a working model, and that is what I am getting at – That it needs to continue to be worked on, and the patient and caregiver piece in it is completely lost.

Steve Brown
This is Steve, and let me just comment that I think a great next step would be to take the narrative that was created, that this model represents – was just a narrative, right, that Josh made? And edit it – add the part to it so that it is explicit and then that can be put back in.

Robert Lario
Or we can take the model and – I mean, the way this would traditionally work is you have a first cut, and we create the model. And then we review this with the subject matter experts, and we say – Okay, does this express what you were intending in the document provided? And you incrementally go through. You review it. You get feedback. They say – No, this is missing. At this point, we should go back to the patient and engage them. Here, we need go back to the system to either update or gather more information. This logic is inconsistent. And it is an incremental, iterative process. Usually you start with just a few people that know that particular part pretty well. And then, as the model matures and the group feels more comfortable, you publish it out, and you solicit more feedback. The whole curation, there is even governance and policies about how you manage these models.

And they can use it a lot of ways. One of them is just to spur a conversation and say – This is what we think. Another case is it is actually derived to some kind of contracts, how the system should interact. What is the expectation of data coming from one system? What is the minimum amount of data that we need in order to move on to the next system when the data is pushed across to maybe an authorization? It is an iterative, living process.

Alexis Snyder
Right. So, I guess I still do not hear an answer. This is an iterative process of what we think is currently happening? Or what we think should be happening?

Robert Lario
I think that would be directed to the authors of the Word document that was provided. I do not know the source of that. **[Inaudible – crosstalk] [00:51:05]**

Alexis Snyder
I think whoever wants to answer it, we just still do not have the answer.

Jim Jirjis
Yes, we provided just a simple narrative. This is Jim Jirjis talking. So, the small subgroup came up with just a simple approval, just to demonstrate what the tool could do, current state. So, your question is current state. A lot of the other questions you had about where is the patient? We did have bridged discussion about that and decided, instead of trying to do another version between last Thursday and today, we would go ahead and let him just show how the tool works, with the expectation that next steps would be to do a more future-use case, right? So, it was not **[inaudible – crosstalk] [00:51:54]**

Alexis Snyder
My concern is still back to the basic question. So, you say this is what the current state could be. So, are we talking about ideal state? Or what we think this is the current state is?

Jim Jirjis
Well, this was an attempt to do the first current state, but it is not even accurate for the first current state. And **[inaudible – crosstalk] [00:52:14]**

Alexis Snyder
That is fine. I just needed to hear that this was intended to look like current state. I had not heard that yet.

Jim Jirjis
Yes, it was. But there was no iteration to perfect it, which is probably causing some of the dissonance.

Alexis Snyder
No. Regardless of whether the patient line was in there or not, it was not clear whether it was current or hoping to be ideal.

Jim Jirjis
Okay.

Lauren Richie
Sheryl, this is Lauren. I do see Rich has a hand up. But, Alexis, did you have another question or comment before we move on?

Alexis Snyder
No. It just took a really long time to get that.

Lauren Richie
Okay. And should we go to Rich next?

Rich Landen
Okay, this is Rich. I am intrigued by what I think might be the power of this model, but it is too much to digest at first look. And for some reason, my screen keeps jumping around. So, if I put it into one quadrant to chase down a flow, as soon as I let go of my mouse, it jumps into a different quadrant. So, I cannot follow the flow easily. But from what I have been able to find, I have been able to see and trace the flows. I would appreciate, in this model, a lot more navigation markers. I am not quite sure what entity we are talking about at what point in the pool. Like in the provider pool, I am assuming it is a PCP or something. But then I get confused when we get to the block that asks the question – Should the patient be admitted? If we are looking at this through a prior-auth lens, I am not sure why all that process follows because should patient be admitted is the decision that has been made.

But if I am looking at it as a clinical decision support, then I understand all the process that follows. So, I am not sure what I am looking at here. And for most prior auths, there are going to be two providers involved. For an admission question, the first is – Who is the admitting physician? But then there is a potential that may or may not be included in the model of the hospital, who will actually do the admitting. So, I am not sure if all the structure to the right of that should patient be admitted – Is that going on at the hospital? Or is that still in the, let's call him or her, the PCP?

And then, if you look down to the next lane, the authorization system, I am not clear whose authorization system that is. Is that the authorization system belonging to the provider and the pool above? Or is it the front-end or the payer in the pool below? So, I just am asking that in one of the next iterations, can we be a lot more clear about whom these entities are and what their roles are?
So, again, to recap just in the provider lane, is it the PCP? Is it the hospital? In the authorization system, whose authorization system is that? Is that internal for the provider before it goes to the payer? Or is that the intermediary, acting as the front-end to the payer? Or just what is it? That is it.

Jim Jirjis

Yes, it is Jim. I can comment about what the intent of the narrative was. We had a lot of discussion about all the different use cases. There is the durable medical equipment. There is the pharmacy PPEs, outpatient medical services. And just to demonstrate the model, which was the goal, we decided to just start with the simplest, which is simply a patient being admitted and then an interaction between the hospital and the insurance company, or possibly intermediary of the insurance company. Around authorization, probably concurrent authorization for inpatient versus obs, and just with getting a simple approval, not to try to tackle all the complex-use cases because you can see how complex this model looks, even with the intent of a simple-use case.

I think, then, things were added about the outpatient. Do they need to be admitted or not? But the intent of our narrative was to say – Hey, a patient finds themselves in the hospital. The hospital, then, needs to know if the patient is insured, what their benefits are, do they need – What data is needed, what rules, send that data, and then the reply is given. And that is what the intent was. I think it got a little – Things got added along the way. I hope that answers your question.

Rich Landen
Well, let me just ask, for sure – In the provider pool lane, then, that provider is the hospital, not the primary care physician?

Jim Jirjis
Yes, I will have to – Because Steve and Robert then took our narrative and then built this. But that was my interpretation was the provider was the hospital. Is that correct, Robert?

Rich Landen
[Inaudible – crosstalk] [00:58:15] I had read it as primary care physician, but if I go back and look at it as hospital, it may look a lot different to me. Okay. But, again back to my point, can we make the labels more specific for the use case? If it is a PCP, say provider, PCP. If it is the hospital itself, say hospital, inpatient, or whatever. Thanks.

Sheryl Turney
Thank you for that. I do not know, Robert, we are not seeing the model anymore on your screen. It seems to be a bunch of **[inaudible – crosstalk] [00:59:01]**

Alix Goss
Yeah, Sheryl, I am having the same visual. It is totally grayed out. But I also noticed that Robert said if he could be of further assistance, to reach out. I was not sure if he was also dropping off at some point or if we were still able to work with him because I think this is a very fruitful discussion. I feel like the point of bringing it here today was to give it some light of day and get some tire kicking, which is always how we have effective iteration. So, I am hoping that we can stay on this conversation, even if it means we hold off on the brainstorming discussion at this point.

Robert Lario
I was not dropping. I was just making my contact information available to others. I know we were coming to the end of the discussion and just did not want it to fall off.

Alix Goss
That is very thoughtful, thank you. You may have a lot of contacts now because I do think that this business process model is going to be a really important piece. And, I think, understanding from which perch we are viewing it will make a difference. And I think there are, definitely, notable differences in the primary care versus the hospital point of view. So, thank you.

Robert Lario
I think it is important to just level the intent and purpose of this discussion. It was not my understanding that we were trying to present the answer, more so, as a method to help drive to our documenting and sharing

of the artifacts that you all create. So, I do not think it was our intent, in any way, to say this is how it should happen. It really is meant to say here is the art of the possible, as a method to express this process knowledge, decision knowledge, data knowledge in a clear, concise, and repeatable way that is based on open standards and open tools.

Sheryl Turney
Right. I think the other thing is that we need to add, at this point Robert, for – Alexis has another question. But the way this group has pretty much worked is we created – and that was Jim and Josh and others – created a Word document that this team worked from. So, most of the work was done offline. We had a preview of it on last week, Thursday, and then we are presenting it to you. Again, it is not finished. It was incomplete. And it does need to have additional data added. And we knew that the patient aspect was incomplete, as well, and that we needed to have the denial process built out so that there was a denial and appeal. But we knew those things were not going to be ready for today.

So, what I would suggest to the group is please take a look at what you see is missing, put some words together that we can send to the group that is working on this. Again, they are not working in a group setting, unless we need to have another meeting about it. But if there are descriptions that can be put together, that is, I think, more helpful so that they can do some offline work, put some of the models together, and then bring it back for a reverification because it is easier to start with something that is already there. And then with that…

Alix Goss
Yes. To that point, would it also make sense to send out that initial narrative because I think that that is sort of the foundation because I think some of us either may have forgotten some of the context, or we are not in the iterative process. So, I was envisioning it would be the current state would have been mapped, and that would then give us a second chance to run the future state. But it looks like it was actually more ideal state. Oh, and it looks like Steve Brown is actually pasting that into the chat box.

Steve Brown
Is there a way for me to attach the document we work from? Because a great way to move this forward would be to see what we have worked from and then make additions or notations on that. Like I said, Robert is not a pre-auth guy. He is like Mr. VPN and stuff. And me, I work for the VA. We do not preauthorize anything, right? So, that would be really helpful is to get that input in a format where we can understand it in context. So, mark up the original narratives. Anyone that wants to can have it.

Sheryl Turney
Yes, and I think that is what we need to do. So, I think what we will do today is share with this entire group the narrative and then also, we could get the current version of the process model, just so they can actually see it. Some people may still have struggled with the size of the boxes, to be able to read it and follow it. And then ask for input from this group by the end of day, hopefully. I know that it is not a lot of time with the holiday. But if you could provide some feedback by next Monday, then we can have another point in time, not next week or maybe the week after, we need to see what kind of time Robert needs in order to actually translate that into something.

Now we have a few people with their hands raised. So, Alexis, you were first. I will go with you.

Alexis Snyder
Thank you. I was just going to add before to the commentary about whether this was hospital being provider or primary care being provider. I think we need to be even more specific than that in this scenario because it looks so different, depending upon what the scenario is. So, for example, if we are talking about primary care, the process is very different and needs to be different. If you are sitting in your primary care appointment, and something urgent has come up, and your provider does not want to send you home and wants to directly admit you, that process and flow is going to look different than you are sitting in your primary care or specialist office, perhaps, and planning for a future admission for whatever reason, for an

inpatient procedure, et cetera. And those two flows are going to look different. So, I think when we also talk about going back to the narrative, we need to be really clear about what the scenario is because even to provide further details in the narrative, we all need to be on the same page about what the exact scenario is.

Steve Brown
Right. So, this is Steve. What I would say is if there was to be a group that takes – I should know the narrative, and Robert surely should have known the narrative, but if there is a group of you all – you are subject matter experts on this – to come up with revised narratives, that everybody agrees on, then we can take a look at that. This is not going to be a forever modeling kind of thing, right? I time boxed it originally with some number of hours of effort. So, I think what would be important is to have the subject matter experts agree, as best they can, in advance. And let's see what we can do within a reasonable level of effort. And the discussions about – You should do X, or you should do Y – Should take part amongst the committee members and come to some agreement on that, for sure do not leave me and Robert trapped in the middle

Alexis Snyder
But to be able to help with that narrative, I am saying we need a clear scenario for the narrative.

Steve Brown
Yes.

Sheryl Turney
Right. So…

Alexis Snyder
For example, of hospital versus PCP – And if we are talking about PCP, what is the scenario?

Sheryl Turney
Yes, I agree. I think what we need to do is finalize the narrative first and agree on what the scenario is going to be. It is not clear. When I went back and just quickly now read the narrative that was sent, it did not really specify, as you said Alexis, whether it was a PCP or an emergency room visit. And that process might be different, depending on the setting that the patient presents itself in. So, I do think it does help.

Unfortunately, I think none of us are experienced, and maybe this is where we can draw on Jocelyn to get more of the characteristics of what we should include in our narrative use case so it will be more complete when it goes to Robert, so we can use his time judiciously. Because, as Steve said, he allocated like 20 hours of his time to be doing this, and I do not know where we are up against that. But if we want to get this done and have it be meaningful, we need to make sure that we are being considerate of how much time that is being spent and really focusing on the narrative. We need to do that first. And we did not present it to this group. And we probably should have had a group that looked at it before we had them actually starting on the pictures. So, let's take a pause and see if we can insert that into next week's work. And then we can make sure that we are all in agreement with what that narrative is and then revisit it – If that will work for you, Steve and Robert?

Steve Brown
Yes, I think that is fine. Like I say, in general, if we can get some agreed-upon narrative where there is a much better patient **[inaudible] [01:08:54]** that was not in there at all, and put it in. And then we can eyeball it and see if there is anything that looks like it is overtly missing from the narrative or the certain question. And then take another pass at it, assuming that it has not gotten entirely out of hand.

Sheryl Turney

Yes. Okay, I think that is what we will try to do. All right, there are a couple more questions, so can we move on to those, as well? We had Jim Jirjis.

Jim Jirjis
Jirjis, yes, hey there. Because when we have the 20 hours, as we do that narrative, do we all have agreement over what problem we are trying to solve by doing this exercise? Because the intent was, as I understood it, to take a simple workflow and validate, going back to workflow, that our data model and spreadsheet that we have been working on – How that supports current and future states. Because I do not think, unless we are willing to pay, I do not think Steve and company – 20 hours is probably enough to do one simple example. I do not think we are going to – Unless we are planning on hiring him to map out possible future states for each of the use cases, do we all agree on what the purpose of this finite exercise is and how it is contributing to our recommendation?

Sheryl Turney
So, to restate what we originally said was we were only going to use this exercise, again not to make the process perfect, but be able to take our recommendations in ideal state and measure it against there to see whether our recommendations and ideal state guidelines actually make sense for the final recommendations of the prior auth. So, that was the purpose of it. It was not to create an ideal PA process, as I have tried to state over and over. That is not what this is for. This is to utilize, as a test mechanism, against the recommendations that we are making. And it was because Steve offered these limited hours, we thought visualizing it might actually be more helpful for the group, and it does sound like it is helpful. It sounds like there are some gaps in what we have already done. And again, I think it does make sense to look at that narrative and really specify out the narrative because that is going to help us as we are evaluating our recommendations and our ideal state narratives, as well.

Male Speaker
Yes, **[inaudible – crosstalk] [01:11:36]** I just wanted to make sure that everybody…

Sheryl Turney
So, we have another **[inaudible] [01:11:38]** make a comment. Let's move over to Denise.

Denise Webb
Okay, so I was just listening to all of this. It just seems, to me, like there was some breakdown on communication about the whole purpose of the modeling. And I think the way I understood it when Steve made his offer for some of Robert's time, it really was to illustrate the power of having a visual model to inform us, as we are making recommendations for ideal state. So, I think probably – And I think others have probably acknowledged this, including you, Sheryl – That the breakdown was not nailing down the current state narratives and scenario that we wanted to have modeled. So, I concur that I think we need to nail that down first. And if we can get a little bit more of Robert's time to model the current state for a scenario, that we all agree on, and then take a look at our recommendations for ideal state and where the gaps are in the current model state. So, I think I understand what you are proposing, Sheryl.

Sheryl Turney
Thank you. I think that – I mean – yes, thank you. Rich, you had another comment?

Alix Goss
If you are talking, Rich, you are on mute.

Rich Landen
Can you hear me now?

Alix Goss
Yes.

Rich Landen
Okay. I am just thinking that whether it is the model or the narrative, we need to pick a level at which we are examining. So, again, back to the provider pool line, we start off generic with the provider, but then we get specific with this is an admission. So, if we are going to be at the level of using a narrative or an example that the hospital admissions, it needs to be at that same level as the providers. Or if we want to stay generic and just say provider and then model out something, we should call them a generic, like patient service, instead of the specific hospital admission. So, I guess that is a challenge for the group. Let's not mix levels within our narratives. Just pick one that is reasonably mid-level. If we go too specific, it is not going to be generalizable. If we go too generic, it is not going to be actionable. So, someplace in the middle. Thanks.

Sheryl Turney
All right, that is a good suggestion, Rich. Thank you so much for that. I know we have gone way over. Alix, thank you for giving us…

Alix Goss
Oh, Sheryl, it is all good. I think this is such a critical conversation, and I think we have people's attention, and I think it was well-worth the punting, especially knowing that the recommendations group that you and I have been working with has got a good starter point for another fruitful discussion at a future meeting. So, I think if we go to public comments, then we can maybe pull back, and maybe you and I can tag-team on what that next steps looks like since I am slated to do it, but I also want to make sure to get your thoughts on it. Do you want to…

Lauren Richie
Okay, let's maybe go to public comment real quick? Operator, can you open the line?

Public Comment (01:15:30)

Operator
Yes. If you would like to make a comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 to remove your comment from the queue. And for participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys. One moment while we pause for comments.

No comments at this time.

Lauren Richie
Okay, thank you.

Next Steps (01:16:07)

Alix Goss
So, while we are waiting for comments to come in, we will leave the slide up, but we are on the heels of public comment, planning to go into a next step. And I think this might be a good, logical point, Sheryl, for you and me to tag-team a little bit because I think there has been robust discussion today. We understand that this modeling effort is complex, and it is sort of straddling a couple spheres right now. I think we realize is that it is – The first thing is that it is working on a narrative model, or a narrative of a use case, that we probably need to bring back into the fold for the group.

And I think if we think about Rich's input, we want to make sure that we have got a narrative that, maybe, is two-fold at a minimum. The first fold would be that inpatient, admission dynamic in a hospital. The other one might be more the primary care. I think we know that primary care has a lot of its own complexities, so

that might be the two flavors that we might want to go down in the narrative to simplify the current state buildout.

In addition, we know that this has been a body of work that has been handed off virtually. And I am amazed at how far it has come and the visualization. And I think that we have got a substantial point from which to pivot to bring clarity to the current state. And then to have that flavor aspect of, maybe, the institutional setting and the primary-care setting. And I am not sure if we want or need, at this point, to think about either a third or a fourth flavor, but let's not get ahead of ourselves.

So, if we can get that current state – I am sorry – If we can get the narrative out, focus on current state, we can ask people to do a review on that. I think, Sheryl, you were searching for a goal of some feedback by Monday. And that we would, then, want to possibly have a checkpoint with the full taskforce on that next week. So far, so good?

Sheryl Turney
All right, so I do not want to interrupt, but the narrative, when you read it, is not based on the current state. It really is based on an ideal state, and that is what was in the narrative, as I just went back and reviewed it. So, it was not meant to be a reimagined ideal state. It was meant to be, I believe, based on what I see, more of an automated, ideal state. So, I do not want to confuse the situation now by going back and saying it is current state because we had a current state model, and it was a model of the medical equipment. And the idea behind this was always to have a depicted ideal state that we could use to test the recommendations. So, I think we need to remain with that, instead of now changing it because we have limited time that we are going after. But we need to hone the narrative so that it is clear that that is what we are going after.

Alix Goss
Okay. I think I will go with that for right now. I am having a little bit of a challenge getting my brain wrapped around that because in order to do an effective compare of – to an ideal state – against what I am thinking is supposed to be what the ideal state vision was that we already vetted. So, I think, maybe, I am having a disconnect because I think you may be using ideal state in the term of a fully automated mechanism, and that is different – that is only a portion of what we envisioned as the big, uber ideal state. And maybe that was my disconnect. So, am I on firmer ground now with what you are thinking, Sheryl?

Sheryl Turney
Well, I am only going back to what was originally provided to them, which…

Alix Goss
Okay. So, what we can do – We will get the narrative out. We will put some clarifications around it so people understand what it is and what it is not, especially considering the number of our members that were unable to attend today. So, we will do the narrative. We will also, then, work effectively with Steve to manage his gracious resource allocation because I think that the kind of artifact that they are developing is going to be really valuable in our in-state report. We can get a little bit of a debrief after this, Sheryl, and kind of wrap our arms around this to help with the document that will come out for members to take a look at.

And in addition to the narrative state, if we could get some sample visual or a PDF version of what we were looking at, obviously labeled, "work in progress," that would help people. They could look at the narrative with the actual graphic, the graphical representation of what we have walked through today because I think those two pieces will help folks. And then what we can do is we will get that out. We will ask for feedback. And we will accommodate, likely, some changes in our plans for next week. And to that point, let me do two things. 1.) Ask Lauren and the operator if we had any public comment? And 2.) If not, could we go to the next step slides?

Lauren Richie
I do not think there are any additional comments, Alix.

Alix Goss
Thanks so very much, Lauren. So, what we will do is we will adjust next week to accommodate a circle back around on this topic and so that we can get some agreement among the task force and give very clear guidance to the next round of modeling effort.

Anything else that we want to talk about at this point, Lauren or Sheryl?

Sheryl Turney
No, I think at the end of the day, we are going to have to send out, to the group, whatever our ask is for their input for the next meeting. So, that will have to come.

Lauren Richie
Yes.

Alix Goss
All right. Well, thank you to everybody. As we roll into 4th of July weekend, I hope everybody has a great opportunity to enjoy time with family and friends over the weekend in whatever way you are able to do that in social distancing times. And we thank you for your participation today.

Be well, stay safe, and we will talk to you next Tuesday.

Male Speaker
Thank you.

Lauren Richie
Thanks, everyone.

Male Speaker
Thank you.

Adjourn (01:23:09)