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

September 8, 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
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
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

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

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. I think we're catching a little bit of echo here, but happy Tuesday. I hope everyone had a lovely Labor Day weekend. We'll get started with our ICAD Task Force roll call. We have Sheryl Turney, Alix Goss, Anil Jain, Gus Geraci, Jim Jirjis, Ram Sriram, Rich Landen, and Tom Mason. Are there any other members on the phone that I haven't announced? Hearing none, I'll turn it over to our co-chairs to get us started.

Summary and Action Plan (00:00:42)

Alix Goss
Well, good afternoon, everyone. This is Alix Goss. I'm going to kick us off today with a little bit of our summary and action plan. Michael Wittie and I will walk you through the last few recommendations, wrapping up our work from the last meeting. Then, we'll turn it over to Sheryl, who's going to launch us off with some discussion around the broader intersection of clinical and administrative data conversation that we've been eagerly wanting to get into. We'll then take some time for public comment before wrapping up with next steps today. Next slide, please – one more.

So, just as a little bit of background setup – a little recap from last week and also a setup for this week – let me clarify that we focused the last call on the Recommendations section of the draft report. This is a part of our ongoing effort over the last couple of meetings to ensure that we are appropriately capturing and editing revisions to the draft report writeup of the prior authorization work. This is a major section of the work that we've done since March, and we're bringing that to a solid state, enabling us to then pivot into the broader intersection conversation.

So, we did go back through a number of the comments we had received from members on the draft content for the data classes, guiding principles/ideal state, and recommendations, and we have a few final comments we need to work through today. So, without further ado, unless there are any questions, I'd like to go ahead and ask Michael Wittie to queue up the actual report itself. I'm getting a lot of background noise, so if you could put yourselves on mute, that would be fabulous. I know the Excel team will help us figure out where that background noise is coming from.

One of the things I wanted to highlight at this point was that the draft report that we're working on – I'm really putting "report" in air quotes because this report is only our work to date. It is not a complete master report yet. It will grow over the next couple of weeks and take shape into a formal-looking report. I'm happy to announce that our amazing team at ONC has been able to secure us a writer, so we're going to be working on getting that person up to speed next week. That will help us with one voicing, so right now, we're really focused on getting the right concepts and considerations into the narrative that's been captured so far. And, to that end, we've been having members go through and review and comment on

the content, and then we're working through those comments, so we will continue the current round of commenting.

We're picking up on Recommendation 11, I believe, and this one is "To establish standards for prior authorization workflows," and I'm going to try to make this screen better. Sheryl, I'm not going to be able to see the Q&A at the moment, or people raising their hands, so I would appreciate if you could keep us honest on making sure that as we work through this, we are able to get our members' questions addressed.

Sheryl Turney
Absolutely.

Review Draft Paper and Comments (00:04:35)

Alix Goss
Thank you. So, Recommendation 11: "Establish standards for prior authorization workflows." So, in this case, we're talking about the triggering in the workflows that needs to happen when we're dealing with electronic health records and want to be API-enabled. This is about driving efficiencies and reducing burden. We're really in that lifecycle of standards to workflows and enabling us to really have highly computable data that lets us move forward with reducing burden. So, we did have some comments here. There was a comment for Arien, so Michael, you might need to keep me honest here – is this a new comment we haven't processed yet? Because I know last time, we were still catching up on a few things that had been addressed, but maybe hadn't been resolved yet.

Michael Wittie
I believe it is because Arien added the subsequent text in green that – subsequent to that comment.

Sheryl Turney
Exactly. Alix, I was the one who brought this up in the prior meeting, and Arien went in and added the verbiage, the narrative, and I think this exactly speaks to what we were talking about.

Alix Goss
Perfect. So, what we want to do is acknowledge that that's been closed, like I was doing last time, since we had a slight disconnect with vacations and editing, et cetera, so now that we know that Arien has come in and addressed a prior comment, we can consider that one closed, unless there are any concerns from the audience – the members.

Sheryl Turney
You might just want to read out what changed, Alix, since some of them can't read it because it's kind of small.

Alix Goss
Okay. So, I believe what we're looking for – and, you have to understand, also, I'm not driving, Michael's driving, so he has the ability to move the cursor. I believe what we are addressing is there was some green text that was embedded for this one that indicates that the task force recommends that the chosen standard or standards be sufficient to 1). Determine which orderable procedures, referral, or other

activities are subject to prior auth, medical necessity, and other similar preapproval checks, 2). Determine the requirements and rules for approval of an orderable procedure, referral, et cetera sufficient to collect required documentation or justification, 3). Automate the preapproval workflow using the provider's chosen technology platform without relying on portals or payer-specific workflows, and the final point that was added was to determine the definitive status of a preapproval request programmatically in the provider's chosen workflow.

Sheryl Turney
Perfect. No one has their hand raised.

Alix Goss
Thank you. We can go ahead and check that one as resolved so we can hide it, knowing that we don't lose that one. So, Michael, where are you taking me to next? He's just doing a little bit of cleanup, from what I can tell.

Sheryl Turney
Yup, accepting the text.

Alix Goss
Okay. I appreciate everyone's patience while we do that because this will help us to not have carryover in future calls.

Sheryl Turney
There are still no hands up.

Alix Goss
Michael, where are you headed to next on the comment?

Michael Wittie
Well, there's actually a second comment here on Recommendation 11 about workflow in terms of real-time transactions, which may be covered by the automating in the provider's chosen technology, but there is discussion here, and we had discussed offline about the need for appropriate health IT to support reducing the need for prior authorization without – or, having sufficient health IT in place that prior authorization isn't unnecessarily called for when data exists and are easily – or, should be acceptable in –

Alix Goss
Michael, I'm having a really hard time hearing you. You're really far away, and I don't know if it's just me, but there seems to be a lot of background –

Michael Wittie
I'm afraid it's my –

Andrew Truscott
You don't seem to be getting us either.

Michael Wittie

Sorry?

Alix Goss

Yeah, I think all of us are having a really hard time hearing you, which is making this a little bit harder of an interaction.

Michael Wittie

Okay, sorry. Is that better at all?

Alix Goss

Not really. I think what I'm trying to do is get my arms around –

Michael Wittie

I'm going to call in on a different number, so I will return. I will just leave the comment here so that you all can see it while I transfer my phone.

Alix Goss

Okay. So, I apologize for that little bit of a snafu, folks. Sheryl, you were going to say something.

Sheryl Turney

I think the comment that Michael has here – while he's trying to call back in – really had to do with the real-time, where there was a question from a prior presentation from the folks that talked about CoverMyMeds about real-time benefit checks, and I think that's what this really is trying to get to, but at the end of the day, I think what we said was we don't want to necessarily make real-time the goal. The goal is that the data for this one should be there when a provider needs to make a decision about a prior authorization.

So, from that perspective, data about the rules and all of the other things that we've specified in here really need to be in a place within their system where they can access the information when they're trying to make a decision about the prior authorization, so a lot of it may not be specific for this particular patient until you say, "Yes, based on this clinical condition, we think this patient should have this procedure." Then, there is the ability to say, "All right, now, what are all the things that I need to do, and do I have all this data in front of me, or are there more tests I need to run, et cetera?" So, I think it was just trying to pull away from the fact that maybe with pharmacy, it's easier to do over real-time benefit check because of what might be required, where if it's some other procedure or something of that nature, it may not be as necessary. Jocelyn now does have her hand up.

Alix Goss

Okay. I now have actually opened the document up so I can actually look at it myself, and that'll be helpful as we move forward.

Michael Wittie

This is Michael. I'm back.

Alix Goss

Wow, can we hear you. That's really great.

Sheryl Turney

Jocelyn?

Alix Goss

I think that was Sheryl just calling on Jocelyn, so why don't we go ahead and hear from Jocelyn if she can get her audio going.

Jocelyn Keegan

Thanks. So, the only thing that I would interject – and, I love the sentiment of where it's going and that we can acknowledge that pharmacy is more mature at this point in time in moving toward real-time than some of the clinical workflows are for medical prior authorization, but I would never want us to back away from the expectation that the data in the exchange should be real-time or near real-time. From my experience, there are plenty of things that will hit the pause button on data being available or questions that need to be answered that will slow down anything happen in real time, but I think if we think about the service layer and we think about moving toward API, we want that ability for there to be increased response that is expected to perform from a technology perspective in real time.

There may be data or gaps that require things to be queued and to be held until better information can be collected, but the access on either side – the expectation at the service layer should be that things are real time. I don't know if you folks are reading that differently than I am, but I just don't want us to back off of the expectation that in 2020, we should expect these interactions to be real-time.

Alix Goss

I'm seeing Rich making a comment as well in the chat box, and it's reminding – I feel like we've already vetted and agreed to part of these notes from 8/18, and I feel like we're starting to have a repeat conversation here, and I think Rich is affirming that, and I think that's part of your commentary, so I think this may be one of the situations where we were going to have vehement agreement.

Jocelyn Keegan

I agree, Alix. Thanks.

Alix Goss

So, the next person's hand I see up, Sheryl, is Tom Mason.

Sheryl Turney

Yes.

Thomas Mason

Yes. I was also going to say I agree with the real-time discussion that we're having, but I just wanted to point out something small. I think the recommendation looks good, but I was just thinking that from a burden reduction perspective, we may want to add language related to "a clinician or a member of their care team" in terms of being able to address – within workflow, not focusing the language specifically on

the clinician, but maybe adding somewhere in there if they prefer to have a member of their care team be a part of that workflow or something along those lines.

Alix Goss

Yeah, I think what we should do is make a general comment to capture that for future integration that we want to absorb that – or, review to incorporate an aspect related to the care team would be really nice because the care team can be pretty diverse, so I think we want to make sure to figure out where we can leave that in appropriately.

Michael Wittie

This is Michael. This reminds me of a conversation we had a little bit last week, I think, in terms of thinking about having the underlying health IT necessary to reduce the need for prior authorization where the information exists, just – I'll state the need within the electronic record, which gets to an older concept of "Five Rights" for decision portals the right information to the right person at the right point in workflow, et cetera. So, I don't know if folks would want to incorporate some of that into this language.

Sheryl Turney

I think that's important – this is Sheryl – and the other thing I would say is the only hesitancy I would have about real-time or near real-time is the fact that I would hope our first goal would be not to have prior authorizations as certain situations are met. Especially if it's a value-based care program, then the easiest burden would be not to require a prior auth. So, I don't want anything we say to preclude payers' ability to go there and then feel like they have to have it because it's required in other cases where there is a prior auth and the provider might not be in a value-based program, so I just want to put those two comments out there as well. It should be the right information at the right time for the right action, but we shouldn't be requiring it if, in this case, because of certain situations like value-based care, they're going to waive the prior authorization for a certain set of procedures anyway.

Alix Goss

So, I think what we've had so far is this idea about making sure that we can involve the greater care team, and that we're respecting the right person at the right time for the right reasons, the right data, the right clinicians, and all that, so what I want to do is capture that and move on so that we can address the last two recommendations and move on to broader interaction conversation, but I do see that Anil has raised his hand. Maybe you have a comment on Recommendation 11, Anil.

Anil K. Jain

Yeah, I just want to go back to some of the comments I've heard and go back to Michael's point – and, we did discuss this at a prior meeting, where we want to make sure that prior auth doesn't become a default because we didn't set up our existing decision support, alerts and guideline mechanisms into EHRs correctly. But, once it does happen, I agree with all the comments about reducing the burden involving the broader care team, and I think if we go back to last week or the week before, we'll have language in prior areas that alludes to the fact that we want to make sure that the electronic health record was set up with the appropriate decision support so that ePA becomes an exception rather than a broad rule that everything has to go through – nothing anything different than what you guys are all saying, but we've discussed this a few times, and there should be some comments in prior sections that we can refer to.

Michael Wittie

There are checks in the guiding principles that I actually drafted a while ago and can send to people if they want to look at some language to that effect that doesn't have a home.

Anil K. Jain

Okay.

Alix Goss

Well, if that text doesn't have a home, one of the things that we need to do is have Arien and Rich get us approval to take out all the text that's been struck through at the very bottom of this document in purple that's a carryover from our earlier working documents, and I would like to have a section that would start to add in that other content that we like, but aren't sure where it goes because one of the things that I noticed this morning, when I was working in this document for several hours, was that we didn't have a table of contents and a structure, so I added that at the beginning – little helpful hints – and then I've gone through and added a bunch of comments, and so, I do think that this paper will morph notably as we start to add in the broader intersection conversation.

So, I don't want to try to find the right home now, I want to get the rest of the parts of the meal put out in the kitchen so we can plate ourselves the right dinner that we need to go into the dining room, so to speak. So, Anil, I think your hand went down and then came back up, if I observed correctly.

Anil K. Jain

No, I must have done something wrong. I don't remember touching it twice.

Alix Goss

I might have missed it. I didn't want to not call on you if you'd raised it again. So, I think there have been a couple comments here in the chat box. Jocelyn was talking about adding specifics to the right data/right time, and I noticed that Michael used the term "the five Rs," so I think we might need to make sure we're in agreement about what the five Rs are that you're thinking of, Michael. Also, I didn't want to lose the point that Rich Landen indicated that he really felt that Sheryl's comment was fundamental that if no prior authorization was necessary, that that's the most efficient workflow, so if there was some other comment we should be capturing there, Rich, to underscore Sheryl's remarks, please make sure we don't miss that. Jocelyn, I see your hand is up. You're on mute if you're speaking.

Jocelyn Keegan

Thank you. The only piece I would add to that is that point that being patient-specific information – because where things fall apart in current formulary and benefit is that it's not specific enough to be actionable, so when we think about the right data at the right time, everything needs to be at the patient level, and being very clear about that gives you the grounding to make sure that you get data that's actionable in the moment. Whether it's "Do I need to do a prior auth?", "What's formulary and what's covered?", or "Do I need to referral?" getting that patient-specific validation is really important. So, overall, patient-specific –

Alix Goss

I apologize, I didn't – we lost the complete screen, Michael, so I'm not sure what –

Michael Wittie
I'm sorry, I was trying to find the right document with that "Five Rights" language in it.

Alix Goss
Oh, okay. Maybe we can come back because normally – I've heard of four, but you added a fifth one, which makes it a little challenging. I couldn't make up what the fifth one was.

Michael Wittie
It's the whole CDS consortium. The text, essentially, is –

Alix Goss
Let's not.

Michael Wittie
Okay, then, I will stop. Tell me when –

Alix Goss
Okay, we'll come back and get those five Rs later, and Jocelyn, I think we'll go to the transcript and pull the content we need. I'd like to move on. I don't think there are any further comments on Recommendation 11. Could we please go to Recommendation 12 if there are none?

Michael Wittie
There's something about identifiable deficiencies, which we discussed – I think it was you, Alix, addressing missing info before the denial, so that's similar to what we just discussed.

Alix Goss
Okay. So, that's an old comment, so we can move on to Recommendation 12 fully. This recommendation is titled "Create extension and renewal mechanism for authorizations," and this is essentially getting at those complex situations where we know there's going to be ongoing treatment and we logically need to extend or renew the prior authorization, and right now, it's often seen as tremendously burdensome, and so, we were looking to have this recommendation to help move that along, and Anil had a prior comment on this that we may want to expand this to include extensions, and I think we already did that. We changed the title, so I'm thinking that is all set.

Anil K. Jain
It's already done, yeah.

Michael Wittie
Okay, I'll mark this complete.

Alix Goss
Thank you, Michael.

Michael Wittie

I can accept Arien's insertions to do it for 13.

Alix Goss

Okay, the final recommendation we'll review today is "Include the patient in prior authorization." This one was really about trying to make sure the patient was much more involved in the process, and Anil was suggesting that we be more direct and the prior auth process be patient-centered with engagement transparency empowered to contribute information, and I'm wondering – it looks like there were edits made that might meet your request from the… Arien did some editing after this.

Anil K. Jain

This is Anil. It does look like my comment was addressed in the revised text. There are different colors and strikeouts, so I'm not sure what the final would look like, but at first glance, it looks okay.

Alix Goss

So, what I'm going to say is we all get many more bites of the apple, let's call it good, and then, hopefully, what's below this is that purple text that I was referring to that we'd like Arien and Rich to verify that you're – anything that's not been struck out you can let us know about if we need to do any further incorporating of content, but all of those are working notes below. All right, we have now concluded our prior authorization recommendations review. Thank you for the feedback that's been provided so far. I'm going to turn it over to Sheryl to pivot the conversation.

Sheryl Turney

Thank you, Alix. I'm sharing my screen, so I won't be able to see if anyone raises their hand, so, Alix, hopefully you can let me know.

Alix Goss

I will certainly do so.

Sheryl Turney

Let me know when you can see the screen because I'm sharing it, and hopefully, it is displaying.

Alix Goss

It has just now fully displayed.

Broader Intersection of Clinical and Administrative Data (00:26:52)

Sheryl Turney

Okay. So, just to explain why we have yet another picture, as a way to try to create some discussion for the broader intersection, I tried to put together – based on our recommendations so far and our guiding principles and initial view – not a workflow or a process flow, but just an ecosystem map, if you will. I call these my placemats so I know what things we're dealing with, and what this is meant to depict is just that we have our basic – hold on, I have my popups to get rid of – we have our basic stakeholders, which are our providers and patients, and we've got many EMR systems that are all represented on the left. Through whatever it is that we do, we have to have some sort of identity and consent management

process, so we all know that regardless of what system we're using or what data we're using, we're all talking about the same people.

So, while that's not a core component of what we – of course, we've built into this privacy and security. We have not said we want to take on a special task of identity and consent management, but I did want everybody here to be aware that there are multiple groups that are looking at ways of ensuring that there is established greater security that the patient is the patient, and one of those might be through some third-party ability to manage identity management, so I didn't want to preclude that from putting a picture together. So, this doesn't assume it, nor does it prevent it, it was just meant to show that identity and consent management might be supported by a third-party identity manager if that is what occurs in the ecosystem.

And then, we've got systems that need to interact with one another, and there may be EMR systems that are tightly coupled with labs, providers, surgical centers, and others, but they might not be tightly coupled, so that's why I've shown some on the right-hand side of this picture, and those would be the ones that are not tightly integrated and maybe not sharing the same EMR system. So, when we're looking at the broader intersection of clinical and administrative data, we have already said, based on what we have put together in our papers, that we want to have a system that's integrated where the clinician, the patient, the payer, and any of the other stakeholders would be able to identify what information is needed in order to take an action.

And, again, trying to move outside of prior authorization, they could even be making an appointment. In our recommendations, we've already addressed the fact that if we want a patient to make an appointment, the first thing we need is to know what insurance the person has or if they don't have any insurance, so we've already addressed a recommendation around having a standardized ID-type card that would allow any system that's using it to be able to digitally address or accept that information by having the information in a standard format, and then, potentially, whatever underlying requirements are there in order for that not to have to be double-keyed or typed in again by the patient in an iPad because they can't translate the information, et cetera, and often, that generates a lot of problems because especially with older people or people who need glasses, often, those numbers are so small, they make mistakes when they're typing them, and that's where all of the patient identity really starts. But anyway, I don't want to go down that rabbit hole. I just want to talk about the fact that we've talked about some of these things already.

What I tried to highlight here – and again, maybe everybody already knows this, but there is information that needs to go back and forth between all these stakeholders about the patient. There's also information that needs to go back and forth about the admits, discharges, and transfers. Currently, in the interoperability rule, there is a provision that says the hospitals need to share this with providers, but that doesn't actually extend to payers, and it does cause some gaps with payers because I know Anthem and others try to utilize those ADTs, and we've been trying to receive those ADTs for years so that we could help get the gaps in care closed as well. If a patient didn't make a follow-up appointment within 30 days of being discharged, maybe they didn't make that rehab appointment. Maybe they didn't make that physical therapy appointment. Maybe they didn't fill that prescription.

So, there are a lot of things that we utilize that information for in order to close gaps in care that help support the provider, where we could send reminders, and they may have some of the information or they may not because again, if a patient uses a pharmacy – I didn't put that on here, but it should be here – and the pharmacy is not tied closely into the EMR system, then they're not going to know whether the patient picked up their prescription or not, so they won't be able to get a prescription reconciliation.

And, some of those things are the things that we want to have when we're looking at broadening the system, so again, I tried to put a picture together that could start some conversation, but some of the things that we're looking at here – what we need to challenge ourselves is what needs to be reviewed or discussed relative to that greater intersection and exchange of information that may not have been covered in our discussions of prior authorizations, and I know for a lot of the work that the payers do, we all are working on how to close gaps in care, and that's a significant amount of time and cost, actually, because from a payer's perspective – and, let's take a national payer, any national payer – in order for us to try to close those gaps in care, today, we belong to multiple HIEs, we receive data from some of our providers – not all of them – not all of our providers belong to the HIEs, and they all have hundreds of EMR systems, so to try to be able to connect to all of these systems to exchange the information that is really needed to try to close these gaps in care is a significant burden on everybody.

It's a cost to the provider because we're collecting in multiple different ways. I think that looking at the HIE system that we have today is something we need to do because they all collect data differently. We probably belong to 30 or 40 of them, and they all collect different data, they all do it with a different type of transaction, some are X12-based – only a few, actually; most of them are data extract – but a lot of times, that data that we share doesn't actually go back to the provider at the member level, so that speaks to some of the issues I brought up in the past regarding the need to have administrative data included in the USCDI, which we do have a recommendation for that came out of the prior authorization work.

But, I want to make sure we're really looking at the broader picture so that we can look at all of the types of impact, and in the broader picture, if we strip prior authorizations out of the thought-making process here, the patient really has a lot of burden too. They have to sign on to EMR systems for multiple EMRs. I know if I look at my daughter as an example, she has to go to four different systems for four different things, and two of them use Epic, but they're not the same Epic, so she can't get her data in one portal, so that's four different portals, and the information really needs to be shared among them all, but it really isn't, so her ability to have that data in one place is impacted, so she really can't. And then, her information on her health insurance is through her payer, which, again, doesn't provide a very broad view of data there either. What she can see is generally 30 days old or more. She can't see a claim in the middle of the process. She can only see the claim once the claim has been paid.

So, I know there are a lot of ways we can go with this, but I did want to at least give us something to start with to start this conversation. I don't know if this is helpful, and I apologize if it's not, but I thought it might be, and I'd like to open it up from there to see where people would like to go with this.

Alix Goss
So, you do have a hand raised from Anil.

Sheryl Turney

Hi, Anil.

Anil K. Jain
Hey, Sheryl. I think this is a great start. I just have a couple comments. First, I think one exercise might be to see how other groups are depicting the clinical and administrative data ecosystem so that we can refer to diagrams from different organizations and see whether our group can harmonize them. So, if we start with a couple of different groups – and, I'm not going to pretend to be the expert on how other groups like Da Vinci, for example, might be approaching this and how they're depicting it.

The second comment would be that your comment around the gaps in care insights got me thinking about what gaps in care can we not measure if we have patient information already flowing bidirectionally, and so, maybe the thought would be that if you have the EHR and you have the PHR or the patient portal off to the left, in the middle, we could start thinking about if there are process and outcomes metrics and definitions that need to be passed between the different data ecosystem players because one of the challenges we have – and, you kind of alluded to it – is that we have different "data models" for different collection systems, but we also have different rules. So, what one health system might call a gap in care might have a slightly different definition for another payer.

So, thinking about rules going back and forth in addition to patient information going back and forth would be an interesting way to think about that middle area that you're depicting with gaps in care insights. There are a lot of business rules that need to be used to figure out what you're calling a gap versus what I might not have gotten to yet as a doc or what someone else might be calling a gap. So, those are just some thoughts, but I think we do need to see how other folks are depicting this, and then show how our group is harmonizing some of those thoughts.

Sheryl Turney
Yeah, I think that's a really good – go ahead, Alix.

Alix Goss
I was going to say – go ahead. I have one person in the queue when you're ready.

Sheryl Turney
I just wanted to comment. Anil, I think you make a really good point, and I do think that's a really good approach for addressing it. I know one thing that – unless I'm seeing it wrong, and maybe, Jocelyn, you could weigh in on this because you are the expert in the Da Vinci process, but much of Da Vinci is really focused on the use case that it's representing. So, if you look at PDex or the document exchange lookup service, those all have great pictures to represent that process, but I think at the bigger level is really where there's a little bit of a gap. Maybe it's there, but I am not familiar with where to go to look for it.

Alix Goss
So, Jocelyn has her hand up. If you want to stay on that theme, we can go down that theme because I think what you're trying to get at, Sheryl, is this idea from Anil that there are going to be models existing in the marketplace that really tackle clinical and administrative data and how we understand from those models that we could then glean the problem areas that we could then try to harmonize or overcome, if I heard Anil correctly.

14

Anil K. Jain
Right.

Alix Goss
Jocelyn?

Jocelyn Keegan
Sure, and I'd like to make a grounding comment first about the fact that everyone organizationally in technology is in a very different place in the market today, and there are may vendors, providers, and payers that are working with each other to meet people where they are today using existing technologies, some of them API-based and some of them not. The work that we're doing in Da Vinci is really around identifying the business challenges themselves, and Sheryl, you did a good job of capturing this. So, at the highest level, if you think about the power of FHIR, it is this ability to come up with a fit-for-purpose set of resources for healthcare in moving to APIs, but what we're doing with the IGs themselves – the implementation guides – is saying for a particular business problem – and, to your point, many of the things that you're talking about on this slide are things that are representative implementation guides for Da Vinci – how do you do that specific work?

And, what we do with the implementation guide is really get to that layer down to say using things as they're currently defined in FHIR, how we would constrain them, where in workflow would those types of workflows would actually appear, what data is available at that point in time to be exchanged between those two partners so that we can actually automate as much of that work as possible from an API perspective, and then saying where FHIR isn't specific enough or there need to be adjustments for those resources, creating profiles to say, "For this specific business problem, this is how you would do it."

But, I think it was Anil that made the comment – I think one of the things that we look at is we're not defining this for every activity for every interaction, we're creating a set of exemplars, and part of the work that we're doing now that would be on the first version of each implementation guide, and we've gone through balloting, and we're basically on the precipice of publishing a whole boatload of stuff, is now turning to the community and saying, "Okay, we did some examples. There are exemplars out there of how to do this. Now, how does the community come together and start to do this across a larger set of exemplars?"

And, prior auth is a really great example of this. You have probably done one or two exemplars. There are hundreds of different prior authorization interactions, but that core purpose of having a tool that asks, "Do I even need to do a prior auth, and if I need to do one, what are the rules, and if I need to do it, how do I automate it?" – having that framework that we build into these implementation guides then say, "This is how you do one," so somebody can propose how to do another one that's slightly different is incredibly powerful when we think about trying to take all of this really intense human activity that we do today around these workflows that there's a lot of knowledge between the butt in seat and the keyboard that translates to this information and automate it so that that human being can actually do higher-purpose work. It's a little bit of a –

Alix Goss

So, Jocelyn, I feel like what you're also getting at, if I heard you correctly, was Da Vinci is definitely giving us a way to solve an issue, but it's also doing it in ways that are trying not to get so in the weeds that the pipes that get built can't be reusable, and it's that framework I think I heard you mention that really is that model of data flowing that can be automated machine learning that really lets the humans go and do other things to their highest capacity to aid our patients, but it's that methodology of the framework that I think you were getting at.

Jocelyn Keegan

Alix, I think that's a really powerful point to hone in on because I think that what we see is there's something between saying, "I'm just going to do everything with FHIR and write it out however I want it between me and my business partners or my products in the API it interacts with" versus saying, "Okay, for these common interactions, how do we develop the template? And then, we can expand." And so, when we think about the configuration or customization that needs to be done, it's done at this level really in the weeds between business partners that's going to be critically important as opposed to everybody starting back at Step No. 1, through sort of doing your configuration once you get to the T, U, V, and W steps – not the A, B, and C steps – of the interactions themselves.

Sheryl Turney

Yeah, I think that was helpful.

Jocelyn Keegan

I'm more than happy to have Anil, Arien, or anyone else disagree with me, but if I get where the conversation was headed, I think this idea of saying there are frameworks that need to created using FHIR, but I just want us to be conscious of the fact that not everybody in the industry is not going to do everything via FHIR and completely FHIR right now. So, the framework is what's important enough – moving towards it is what's important, not that everybody needs to be compliant in Year 1. There's a lot of improvement we can make by moving people in the right direction.

Alix Goss

But, from a policy perspective, I really do hear two themes coming out of what you said: Meeting people where they're at with a diverse set of complex technology investments, and as we move forward, finding ways that our data – the core of our data, the USCDI alignment we've been discussing – really enables us to build frameworks that people can implement along the way, so that needs to span administrative clinical ecosystems, and I think we've already got some of these tenets in the guiding principles and recommendations work that Sheryl referenced before, and we're trying to tease out where else we want to go. I just want to make sure I'm hearing or capturing the right principles.

Jocelyn Keegan

I think you are, but the way I like to think about it when I talk about it from a consultant perspective is the fact that everyone is on this journey, and if we think about it being a fair step up in the model of maturity that we're looking for people to have in the industry, there are so many people who are at Step 1 or not even close to Step 1, so how do we get them to Step 1, but acknowledge that there are players out there that are already at Step 4 and 5 – they've already done this base layer? We wouldn't want to govern them. So, when we think about a policy approach, Alix, it has to reward the folks who have invested and

are ahead of the game and not stymie them, but also make sure there's an onramp to the highway for the people that are just getting started and picking up their heads to deal with this challenge.

Alix Goss

Actually, I heard you call out something else, which is really – for me, you're channeling some of the small-group discussions that we had around recommendations, and that you've nicely captured this – we've got the leaders, but we've got a huge install base, and we have to figure out the bridges while also focusing on the right destination on land, and so, there are onramps for all regardless of where they're at, and that's something we need to think about – the technology status. One of the things that I've been –

Jocelyn Keegan

It's even the access to capital, right? I want to be mindful that not everybody has the ability to crack open their EHR and put a smart app in place. I want to think about behavioral health specialists that barely have technology, and I want to think about that small regional plan that we want to pass forward for them, just as we want to raise the bar for the guys that have access to capital and have the ability to throw bodies at actually building real-time API.

Alix Goss

Yeah, they're all really good points, and I think we need to make sure they get captured, and it sort of helps lead into why I raised my hand, so I'm going to lower it now because I'm going to go ahead and ask my question, Sheryl, which is building on some of the things we've already discussed with Anil and Jocelyn, but to take it from a slightly different realm around this rule and data model comment that Anil was making, and wondering how – or if – we should be thinking about downstream data usage that's not just clinical or administrative because I'm not sure how we might include some of the population health – the public health vital records.

As we've been looking at COVID, we've been seeing that there's this great opportunity to tap into health information exchanges because of their ADT feeds to augment our syndromic surveillance efforts, and we've talked a little bit in the past about where our boundaries are on our data models, and I didn't know from a broader intersection discussion how the task force felt about whether or not that public health- and vital statistics-type information should be inside or scope or if we should really – if we're looking at the broader intersection, how does public health either fit into a clinical bucket or an administrative bucket, and what does that mean to us as we move forward? There are a couple hands raised.

Sheryl Turney

Let's go with the people raising their hands. I think that was a great question to pose to the team. I can't see who they are, so go ahead and call the list.

Alix Goss

Sure. We'll start with Anil, then move to Jocelyn.

Anil K. Jain

I think it's a great question, it's a great point, and if we're going to go through the effort of harmonizing or aligning clinical and administrative data, given that there are public health needs, but also not forgetting the broader clinical research and the research operations that typically fit into this paradigm, which is

somewhat related to public health, but not typically, I think we should be thinking about all those additional use cases that benefit by the work we do around aligning clinical and administrative data and thinking through that the stakeholders and actors of the future are going to have a much bigger vested interest in public health than we've seen thus far. So, it's a great question, and I think we should use the opportunity to not forget that efficiencies created here will benefit other use cases that benefit people in general, but not to forget clinical research.

Alix Goss

That's a really good point. Talk about – I hadn't thought about reducing burden, but the data flowing for vital records is what I also heard when you were talking, but that whole research for evidence-based medicine and that churn because this is all connected, so those are good points. And, the next person in the queue is Jocelyn.

Jocelyn Keegan

Alix, the only point I was going to make – and, I agree with what Anil just said – is I think that thinking about the needs around population-level data is something that we are seeing the plans that are more advanced and the provider systems that are more advanced really ready for in the Da Vinci world, so this ability to be able to port statistics at a system level or creating norms is incredibly important, and I would just separate out what we're doing to support public health from population-level information as two very distinct camps. That's all.

Alix Goss

Oh my goodness, I'm so glad you said it. So, population health is different than what I was thinking, and you're underscoring my point that we shouldn't conflate those. They're very different, and I agree with you, Jocelyn, so, thank you for – I'm not –

Jocelyn Keegan

I have friends at Providence St. Joseph and the advanced gameplay they have going on around population-level data compared to some of the other provider orgs out there, so…

Alix Goss

Absolutely, yeah. I'm really thinking about that data flow need – the provider burden of feeding lab, cancer registries, the syndromic surveillance needs, all of those new data elements that we're going to become much more dependent upon now that we've garnered a deeper appreciation for public health emergencies. Sheryl, there are no other hands up.

Sheryl Turney

Okay. I know – to speak to that question too, the CDC asked multiple payers for data on COVID, and one of the things that they called out was that some payers were providing data with CPT codes and others with DRGs, so they had to reconcile all of that, and we often have a lot of those disparities come up with the reporting of APCD data where it's obvious that not all systems capture data the same way, and so, what I would caution us about is that what happens with APCD which I would not like to see happen here is we're often being told to change the data so it can be consistent from the space perspective, but my concern is every time data is morphed, it becomes further apart from the source, and so, it's left to some interpretation on how that data is morphed, and so, from a research perspective, Anthem would never

change the data from its source that we were reporting on, but often, data that is in these APCDs is changed drastically from its source.

So, I just want to get something like that out on the table, that whatever it is that we do recommend, consistency would be important in terms of the way the data is either captured or exchanged rather than having had some layer added after the fact to then change the data to what someone needs so that they can report on it more easily, and again, to me, that just definitely impacts the quality of the data.

Alix Goss
So, that actually starts to – very interesting thought process here, Sheryl, because it really starts to speak to maybe the provenance of the data, and being able to port that through when the data makes the hops, and also, ensuring that you're complying with the consent aspects of how that data is to be used.

Sheryl Turney
Just to make it clear for this group, in the APCD world, we have multiple things that the payers have to live with, and one is a prompt payment rule. So in multiple states where you have a prompt payment rule, payments must be made within so many days once the data is complete, and what they have in terms of what's complete is a very small list, so that's what must be there in the next 12 transactions in order for us to make a payment. But, when it gets to the APCD, they want what we call literally hundreds of aspirational fields that may not be present on the claim, but they're expecting us to produce data in there because that's what they want to have to review it.

So, with whatever it is we're doing, I just hope that we're going to focus on what's real in the way that it actually works rather than what's aspirational because defining what should be and defining what is not always the same. That's the only thing I want to throw out there. I love the idea of having vital records connected. I do know that in some states – and, I don't know why, but there are some limitations from state rules related to connecting the vital records because they have those with the APCDs today, and they're unable to connect birth records and death records for some reason, and usually, it's something in the law that prevents it. Multiple states are trying to work through those, but that is something specific for this group to be aware of.

Alix Goss
Oh, but that's actually a secondary usage of those as opposed to what – I wasn't thinking in that concept when I made the suggestion. I was thinking in the concept of providers need to submit data to various public health registries, including, but not limited to, birth and death registries or immunization registries, for instance, and that information flow – out of electronic health record – could be an area of burden, and we might be able to think about the information flow and the services that enable that because most public health registries do use HL7 2.x versions, and so, if we could think about that as part of our data model, we might be able to benefit not only the timeliness, but also reduce the burden.

And so, what I hear you also saying is another problem that I'm very well aware of, which is as we start to want to aggregate data sources to inform policymaking related to all-payer claims databases, or APCDs, sometimes they bring together sources of data, and when it comes to public health, you can't always tap into those for laws, and that's very common, but I think there's also this downstream data fidelity that I

was hearing you mention, and so, I think we might have tackled that if we actually accomplish the robust mapping recommendation that we already have. So, I think that that's sort of an important aspect.

But, I also think that you elevated another aspect for me, which is in the broader convergence conversation of clinical and administrative data, data does get used downstream for all kinds of other things that we've been talking about – population health, public health, claims processing, et cetera, but is there an implementation into our conversation that we either need to leave on the table or throw out is this aspect of how the data that we use does inform policymaking, and is there some – because we've called out evidence-based medicine and other ancillary services, but what about the policy downstream that gets informed from such things as how we've crunched APCD, and we think we know that there are way too many CABG surgeries being done, for instance. That's something we need to think about.

Sheryl Turney
I can tell you that most of the APCDs today do look at the waste calculator, and they quote the Milliman one that's often talked about, but that list of waste calculator procedures, and so, they measure against that to determine what type of waste is occurring most. Again, there are a lot of disputes in these conversations – because I participate in most of them across the country – on whether or not that really is waste. I think there are a lot of physicians who feel like they wouldn't necessarily agree to some of these things that have made it to the list. But, at a minimum, what it does is that there is some education that needs to occur, but most health systems are not using the list for that purpose. They're basically using it to inform the state, "Oh, this is what showed up for these lists of providers that appears to be wasteful," and so, it always has a negative bent to it, and again, I'm not trying to evaluate whether that's worthwhile or not, but it causes a lot of concern from providers and payers both.

Alix Goss
Thank you. Anil's hand is up.

Anil K. Jain
I just want to underscore a couple things that I heard. I think it's all really important that we have people start to think about those use cases, but I don't want us to also minimize the challenge when it comes to having additional use cases. So, the code sets, the documentation, diagnoses, procedures, and laboratory tests, and the way we describe them all might serve us really well from a clinical and administrative point of view except for the exceptions that Sheryl just spoke about in terms of the appropriateness of CABG or whatever. But, when you start to get into additional use cases, thinking through vital statistics, we want to make sure we emphasize that we'll need to have additional ways of harmonizing all the way until we describe things because thinking of something as simple as the example of a death certificate – you can't simply use data coming out of the electronic medical record or any billing system to figure out what a death certificate might need to look like, and that's a simple example. There are much more complicated things when we get to public health and clinical research.

So, I think having a comment that although this is our goal and we want people to be thinking about how this harmonization will help additional use cases, we understand there's a significant amount of complexity with bringing those universes into the same world that we're living in with the clinical and administrative data. I might have 25 different ways of describing a diabetic in the clinical setting, but if I was doing clinical research or public health, I might have significantly more ways of describing that, and I

just want to make sure we don't minimize the complexity involved when we're bringing different use cases in, although we should create the environment for those to be brought in with the right code sets and terminologies and an understanding that more investment will need to be made.

Alix Goss
I really like what I'm hearing you say Anil because I agree with you. The death record example was perfect because basically, that's happening – the death record generation happens way outside of the EHR, and so, I was trying to help us start to create some boundaries, and I think what you started to do is help us to say we can create some kind of content for our report around creating the environment and supporting those downstream needs, but we want to keep ourselves from going into the weeds of all the complexities of the use cases, and so, I think that there is maybe something that Rich might have said in his chat box, and I'm going to read it.

His feeling is that "We do need to incorporate public health research/vital records into the converged ecosystem. I don't know that we're at a point where we can propose solutions, but we do need to ensure that while working on the convergence, we leave both the architecture and the expectation for further work in those areas," and I think that's getting at what you're saying, which is create the framework, put a line in the sand and respect it, but let's not get ourselves wrapped around the axle on that one for right now.

Anil K. Jain
Yeah, I think it does say it. I just minimized my window – it was expanded so I could see the screen – and I see Rich's comment now. I think he said it much more succinctly, but that's what I'm getting at.

Sheryl Turney
I agree with that as well. Do we have other questions, Alix?

Alix Goss
No, there are no hands raised at this time.

Sheryl Turney
So, some of the themes we just talked about are to further expand the need for code sets, and maybe it is worthwhile to identify a sample, and maybe this is too detailed, but this is what I'm going to throw out here: A sample group of data from the administrative side that should be looked at from a USCDI perspective for standardization as a starting point. That might be one aspect that would be helpful.

The other would be how to translate these things like AVPs and gaps in care into business rules, which I believe Anil also mentioned, from the perspective that the intersection and the broadening of clinical/administrative needs to support the broader business rules for not only, again, provider to payer, but also the integration of the patient and all those ancillary other systems that may not be tightly coupled with the EMR system so that that data can flow more easily and more consistently across because that's another thing – one of the examples – and again, I don't know any other way to do this than to point to an example, but when we were working with the CDC, they mentioned that some labs were reporting data with LOINC and others were reporting data with a different standard, so before they could use anything, they had to normalize the data. I don't know – is there a piece of a process where we want to recommend

certain code sets or standards be used for certain purposes to make that research-based more consistent and more easily attained?

Alix Goss

This is Alix, and I'm struggling a little bit with that question. I see Anil put his hand up too, so I yield to you, Anil.

Anil K. Jain

I think we might be on the same thought. I think we want to stay away from telling the researchers how they want their information represented. My general feel – and, I've done clinical research, I've seen patients, and now I work for a company that does a little bit of this curation business – is that it depends on the use case, and we don't want to add burden to the system, so I think the thing to do – at least, for our task force at this point – is to acknowledge that there is some work that needs to be done and create an environment by which that work can be done, and then brought back into an environment where we're at least harmonizing clinical and administrative data.

We are not going to be able to ask doctors like me and like my colleagues to start collecting the significantly more granular data needed for some public health projects or for some clinical research, but what we can do is say for the clinical and administrative piece, how can we start to bring those different things together so we create a minimum data set that is not asking doctors to be clinical researchers or to really understand the way that clinical research is done, but we're simply saying, "Here's a minimum data set. Now, you guys in public health, you guys in clinical research, here's a more refined way of looking at an aligned clinical and administrative picture. See what you can do, but you might need to build upon this. You might need to extend this and expand this." But, I don't think we should be asking all the rank and file care teams to start collecting data for a purpose that they might see deviate from the patient care side because this is going to add burden, and without knowing all the use cases, it's going to add burden without any good reason.

Alix Goss

Yeah, I was sort of going there, but not quite, Anil. Where I was going to go with this was in our existing recommendations and guiding principles for prior auth, we have talked about harmonizing code and value sets, and then, I was thinking that there would likely be some higher-level policy statement about making sure that there were – the efforts we were touting for NLM to work on with ONC with others could take and make sure that those were the – the downstream environments were factored in, but I believe there is plenty of ability to pull content for public health registry messaging from an EHR pre-systematically when you look at the use of the HL7 data existing within many EHRs, so I was not trying to create something specific, I was thinking more about how we get the automation that enables that data to flow more effectively without having anybody's fingertips on it.

We could get those submissions to happen, and we want to make sure that we're not losing sight of that as we look at this broader intersection of clinical and administrative data, and when I think about the clinical code set values and the administrative code set values, I think it's all tied back to this comment that Sheryl made about USCDI, just making sure all this stuff is woven together. I propose that we focus at that concept level for what we want to move forward because I think we want to get a different set of people to possibly look at that and then augment whatever mappings might be pursued.

Anil K. Jain

Yeah, I think that makes sense, but I'll give you one quick example of where I don't think we should go. So, let's assume that there's a public health project looking at asthma, and we'll just pick the Cleveland area, where I live. If you were to start pulling out of the record whether the individual patient has carpeting in their home, whether they live in an apartment versus a house, or things that might haphazardly be collected in the EHR but are incredibly important for asthma and public health, we could create an environment where somehow, there's a USCDI data model that talks about the person's home, and while they might be important for some segmentations, we don't want to give anyone the impression that all of a sudden, we're going to start collecting that information on each and every patient.

But, I agree with your broader statement. If it's a data exhaust or a byproduct of clinical care, we want to make sure it's available at the highest fidelity to anyone who wants to use it downstream. If it's not a byproduct of clinical care, then we should go through a community-based process of understanding what it takes to collect that data because it's in the public good. That's a very different perspective.

Alix Goss

Yeah, I'm with you on that line. Sheryl, I'm going to just note that we're about three minutes away from needing to take public comment and we have no hands raised, so we can finish this up and then hand it over to Lauren. I'm not sure if you're able to see all the panels on your Adobe.

Sheryl Turney

I can't see anything. I'm sharing the picture.

Alix Goss

Cool beans. So, you've got two and a half minutes and counting. So, I do agree with promoting the auto-generated as a clinical byproduct, and then, you made a comment about otherwise, engage community and figure it out. I am totally in agreement with you, Anil, and I'm not seeing any other hands raised on that point, nor am I seeing a lot of comments come in, although Jocelyn did – Rich agreed with you, and Jocelyn went on to further note that there are other FHIR accelerator programs handing a lot of other service functions/data need functions for those downstream services like social determinants of health and cancer, et cetera. I think we may have the framing of an additional comment or concept, Sheryl. I'm not sure where it will go yet.

Sheryl Turney

So, let's talk a little bit, then, about where we go from here with this because for our next meeting, of course, we're going to come back and talk a little bit about what happened in the HITAC meeting because we have that tomorrow, but we really want to start this broader intersection and go to the next place. I heard some themes today that I think we can start with and instead of focusing on a picture, focus on the themes, which were basically looking at the data from an ecosystem perspective, and then focusing on code sets and harmonization, and we might be able to pull it up to the level of how to harmonize at the ecosystem level more than just specific use cases. That's really the dichotomy. We're doing a lot of work in a lot of places right now at a detailed level, and we're trying to look at this from a macro level, so what are the most important things that we need to focus on?

I think the harmonization of the code sets, ensuring that we have this level of administrative data captured somewhere with the most important administrative information to start as a minimum set per what Anil and I were talking about. I think the other thing is ensuring that the stakeholders that are not what I'm going to call tightly coupled to these EMR systems have the ability through either some standard or certification process to share the data they have to share on the patient at the member level with each of the EMR systems, so if that means we need to further expand certain use cases within Da Vinci or whatever to help some of those things get worked on, then identifying what some of those might be. And then, I think the last thing that we talked about was the interplay of downstream with public health and vital records, and how that all comes into play and where it comes into play – how we would want to see that space addressed.

Alix Goss
We are now at 4:20. No hands are raised.

Sheryl Turney
I'll break there so we can go to public comment.

Public Comment (01:17:50)

Lauren Richie
Great. Thanks, Sheryl. Operator, can we open the line at this time?

Operator
Yes. If you have a public comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 if you would like to remove your line from the queue, and for participants using speaker equipment, it may be necessary to pick up your handset before pressing *. One moment while we poll for comments. There are no comments at this time.

Lauren Richie
Thank you. Alix, we'll keep you notified if we do get comments.

Next Steps (01:18:32)

Alix Goss
Thanks very much. All right, Sheryl, I think you were on a roll with trying to do a recap of themes, with the idea that – I think I heard you have at least three, if not four, themes as two areas we might be able to build out as a starting point for next call, but I'm not sure if you finished your list.

Sheryl Turney
Thank you. I don't know if I finished my list either. I tried to take notes with my wounded wing while I was doing this because I couldn't use my computer, but I think the other thing we talked about was something Anil brought up, which I thought was important, and it was that to do a scan of what's currently available in terms of models. Just so you know, I did look at a number of the big Da Vinci use cases before we put together our picture, and I have looked at a number of other stakeholders, but I don't know that I looked at everything that is out there, and so, if there is a better picture we can use to depict this broader intersection, then I think that may be something I'll ask the entire team to take a look at, and if you are

aware of a diagram that you think would be helpful for us to put into our process, let Alix and me know, and we can make sure that we bring it back to this group. I also want to say –

Alix Goss
I commiserate with your challenges in finding that picture. I've been sketching out one myself, so I hope people will give us their examples.

Sheryl Turney
Yeah, and I also really resonated with the example that you brought up, Anil, about asthma. It reminded me of a project that I did with UConn a long time ago where they were really looking at environmental factors to see what impact they had on asthma, and essentially, we had to build a system to support looking at that for this physician that wanted to do this project, and it was kind of a lengthy process, so I do understand the nature of how that collection of information can be quite burdensome and is quite time-consuming, but also, the way and the form in which you collect that information makes a distance.

For instance, it may be something that typically, a physician would ask if someone has an issue about a trigger. "Tell me a little bit about where live." Who knows what they might capture as far as that goes, but it might be enough information for them to help guide you with a treatment or a medication, but it wouldn't be something the EMR could potentially capture in any standard or structured way for them to do anything about. So, it's really key. That was a great example, actually.

But, I think that, then, speaks to what we're talking about here. I keep thinking about how if we can't ignore the COVID thing that we're all dealing with, there's certainly going to be information needed by both administrative and clinical going forward, looking at contact information, where people have traveled to, and who they've been exposed to, and certainly, systems can't capture all of those things, but in this situation in today's pandemic, those are important aspects, so, maybe understanding what some of the key triggers are for a particular condition or situation needs to be considered as each one of those examples would be worked on in a more detailed way, but that's probably not something that we're going to tackle.

Alix Goss
I'm getting a little bit lost, Sheryl, on whether you're looking for wanting to go into use cases or you're looking for a general picture that put the components of payers, providers, care, and coverage with the HIPAA and the CURES rule. I'm trying to figure out whether you want to look at all the use cases or just want a picture. I'm not sure what the ask is.

Sheryl Turney
I don't think we want to look at use cases. I think there are too many with too many variables. I think that we need to focus on what the themes are that we would want included in the broader intersection, and we should focus on those.

Alix Goss
Okay, that's helpful, thank you. I believe we're at the Next Steps slide, which I think you're covering, but you may not be able to see that if you still have your screen up, so let me know if you'd like me to…

Sheryl Turney

No, I can see it. Thank you, everybody, for your input today, both on the broader intersection and the report. Tomorrow, Alix and I are going to be presenting to HITAC, and I'm sure we're going to get input and feedback from them. Right now, they're only going to see recommendations in a PowerPoint. We're not sharing the paper yet. We're hoping to be able to share the paper before the October meeting, and so, we need to do a bit of cleanup with that paper, so please go in and look at the Google doc. If you have questions or comments, now is the time to include them. I think what we'll do next week – and, Alix and I will talk about this some more in a few minutes – is continue our conversation on the broader intersection after we've provided the feedback from HITAC and reviewed any task force comments on the Google paper.

There are some additional comments that have been made on the Ideal State and Guiding Principles after we had our initial discussion on them, so if we have time, we can go back and look at those. I think, though, we should try to focus our time on the broader intersection conversation so we can capture more detail around those themes before we actually go back and review the comments in the paper because we're going to have to weave those in anyway, and we can cover those additional comments when we're weaving in those broader intersection comments. Alix, are you in agreement with that approach?

Alix Goss

Yeah, I think we'll definitely hone our thinking, as you and I will have a call scheduled right after this. I think I need to reconcile our notes because I might have taken a few different things that jumped out for me, so we'll certainly evolve the themes and give ourselves a launch-off point for next week after we debrief the team.

Sheryl Turney

I think that's great. So, remember, offline, please continue commenting on the Google document, and also, if you're able to join the HITAC meeting tomorrow, let us know your feedback from that as well. Any final comments, Alix?

Alix Goss

No, you wrapped it up nicely. Thank you.

Sheryl Turney

All right. Any public comments waiting?

Operator

There are no comments.

Sheryl Turney

All right, then. I'll turn it over to you, Lauren. You can close her up.

Lauren Richie

I think that's it for today. We'll just meet again next week with feedback on the committee. Thanks again. We'll adjourn for today.

Sheryl Turney
Thank you.

Anil K. Jain
Thank you.

Adjourn (01:26:47)