The Office of the National Coordinator for Health Information Technology

Meeting Notes

INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA TASK FORCE (ICAD TF)

April 21, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

EXECUTIVE SUMMARY

Co-chairs **Alix Goss** and **Sheryl Turney** welcomed members to the Intersection of Clinical and Administrative Data Task Force (ICAD TF) meeting. **Alix Goss** summarized their recent work on the tabs of a shared Google document that has been used to determine how to improve the PA workflow process. **Sheryl Turney** summarized new work she completed on the document to better reflect work on the topic of prior authorization (PA) by the Health Information Technology Advisory Committee (HITAC).

Alix Goss gave an overview of recent work completed by a smaller subgroup on the Guiding Principles and Ideal State table in the shared Google document. Presenters referenced the shared document when describing their work, and a discussion ensued. As a result, several guiding principles and ideal state descriptions were updated and added to the lists.

Josh Harvey lead a presentation and discussion on new and reworked items on the PA Info Table section of the Google document. Another subgroup of the ICAD TF added information to the content standards associated with various data classes, including a new legend and color-coding.

Alix Goss noted that demonstrations with key players in the industry have been scheduled to take place at future meetings to give the ICAD TF an overview of important current issues.

There were no public comments submitted by phone, but there were several comments from ICAD TF members and members of the public submitted via chat in Adobe Connect.

AGENDA

03:00 p.m.	Call to Order/Roll Call and Welcome
03:05 p.m.	Summary and Action Plan
03:10 p.m.	Review and Discuss Guiding Principles and Ideal State Table
03:40 p.m.	Review and Discuss Prior Authorization (PA) Info Table
04:15 p.m.	Discuss Demos and Next Steps
04:20 p.m.	Public Comment
04:30 p.m.	Adjourn

CALL TO ORDER/ ROLL CALL AND WELCOME

Lauren Richie, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the April 21, 2020, meeting of the ICAD to order at 3:00 p.m.

ROLL CALL

Alix Goss, Imprado/NCVHS, Co-Chair
Sheryl Turney, Anthem, Inc., Co-Chair
Steven Brown, United States Department of Veterans Affairs
Gaspere C. Geraci, Individual
Jim Jirjis, Clinical Services Group of Hospital Corporation of America (HCA)
Anil K. Jain, IBM Watson Health
Jocelyn Keegan, Point-of-Care Partners
Rich Landen, Individual/NCVHS
Thomas Mason, Office of the National Coordinator
Jacki Monson, Sutter Health/NCVHS
Alexis Snyder, Individual/Patient Rep
Ram Sriram, National Institute of Standards and Technology
Debra Strickland, Conduent/NCVHS
Sasha TerMaat, Epic

Andrew Truscott, Accenture
Denise Webb, Individual

MEMBERS NOT IN ATTENDANCE

Mary Greene, Centers for Medicare & Medicaid Services
Leslie Lenert, Medical University of South Carolina
Arien Malec, Change Healthcare
Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin
Abby Sears, OCHIN

SUMMARY AND ACTION PLAN

Alix Goss, co-chair of the ICAD TF, summarized their recent work on the tabs of a shared Google document that has been used to determine how to improve the PA workflow process. At their previous meeting, they reorganized the first tab to mirror the United States Core Data for Interoperability (USCDI). The two smaller subgroups presented their work on the Google document, and they discussed the work of the "Happy Path" group and expanded the Guiding Principles and Ideal State Tab. Also, they heard detailed public comments from the American Medical Association (AMA) and CoverMyMeds. AMA will send detailed comments for the ICAD TF to consider.

She reviewed the agenda for the current meeting and explained that the two subgroups would present their work from the past week. Then, the ICAD TF would evaluate their progress on the Google document as a way to discuss updates, needed revisions, and next steps.

Sheryl Turney summarized new work she completed on the document: she added historical content from meetings of the HITAC, including presentations given over the past year. The items she added included descriptions of burdens, recommendations, and considerations. She noted that these items are placeholders, so the ICAD TF must evaluate them. By incorporating these items, the ICAD TF's final whitepaper will reflect recommendations that have already been made by stakeholders of the HITAC.

Alix Goss noted that an updated version of the compendium would soon be made available, along with a link to the Da Vinci Project's Guiding Principles.

REVIEW AND DISCUSS GUIDING PRINCIPLES AND IDEAL STATE TABLE

Alix Goss gave an overview of recent work completed on the Guiding Principles and Ideal State table in the shared Google document, and she thanked the ICAD TF members who supported this work as part of a smaller subgroup, which focused on two areas:

- Cleaning up content entered directly from the recent Workgroup for Electronic Data Interchange (WEDI) whitepaper
- Determining how to incorporate the Guiding Principles from the Clinical Advisory Council (CAC) of the Da Vinci Project

Josh Harvey displayed the shared Google document, which subgroup members referenced when they presented their work.

Discussion:

- In the Guiding Principles section, **Alix Goss** suggested the following change:
  - "Minimum necessary restrictions accounted for" was reworded to read: "Minimum

necessary information that is agreeable to 1) The Health Insurance Portability and Accountability Act of 1996 (HIPAA), 2) Local and State Laws, 3) Data Usage Agreements (DUA) & Business Associate Agreements (BAA)"

- **Sheryl Turney** referenced conflicts between HIPAA and DUA/BAA, and she inquired if the minimum necessary information required would be directly linked to the data shared.
- **Alix Goss** responded that the most important concept is that systems or people should only share the minimum information necessary to perform the business function. The emphasis of the reworded guiding principle was the scale of consideration, relative to the minimum information necessary.
- **Anil Jain** explained that, in a real-life scenario, a large packet of data is sent out to satisfy an electronic PA. However, he noted that some of the information included might not be necessary to complete the PA, and he discussed the example of STD testing in adolescents. They should not create a model where it is too easy to send more information than necessary.
- **Sheryl Turney** inquired how they would reconcile the reworded guiding principle with requirements in the new Interoperability Final Rule related to sending the minimum of Version 1 of the USCDI.
- **Jim Jirjis** referenced discussions about the segmentation of data that were held during HITAC meetings.
- **Anil Jain** agreed with segmentation as a possible mechanism. Also, he explained that, if there is one business purpose for PA with a limited scope, the entire patient history as depicted by USCDI health data classes and data elements should not be exchanged, and the new Interoperability Final Rule does not supplant this idea.
- **Alix Goss** voiced her agreement with Anil Jain and noted that there is an overarching policy objective in the HIPAA and legal frameworks in contrast to the concept of data availability within the USCDI. These two will eventually sync up in terms of standards.
- **Jocelyn Keegan** agreed with the previous commenters and submitted the following comments:
  - She described the ways that the Da Vinci Project addressed comments on challenges around data sharing during work on their implementation guides. The USCDI is the baseline for the data that they want to allow to flow freely in the industry, but trading partners have contractual relationships that allow for only certain data to be exchanged, based on the specific scenario and end-users' controls.
  - She described how the Da Vinci Project uses their guiding principles and shared a web link to the published version, which is located at https://confluence.hl7.org/display/DVP/Da+Vinci+Clinical+Advisory+Council+Members?preview=/66940155/66942916/Guiding%20Principles%20for%20Da%20Vinci%20Implementation%20Guides.pdf
- **Sasha TerMaat** inquired how the sharing of "minimum necessary" data would work. Would the user filling out the PA request enter one specific code into the relevant data class, or would everything in the patient record, minus particular data elements marked as "sensitive," be sent in the exchange? Or is there another method?
  - **Alix Goss** noted that there are a variety of ways to process this, based on if the interaction is automated in a system or done by a human.
  - **Jocelyn Keegan** described discussions taking place at Da Vinci concerning this specific issue. Some options they have examined include entering a specific diagnoses code, using time boundaries around the record that is exchanged, or other parameters set at the user interface level. Also, they have discussed letting trading partners set data sharing parameters as part of their contractual agreements.

        - In response to a question from **Alix Goss** about Da Vinci's implementation guide, **Jocelyn Keegan** described feedback that Da Vinci's CAC received on the guide. Medical industry professionals shared their desire to control PA data sharing within the application programming interface (API)/coding level, but it is really determined by the contract and relationship permission documents between partners in the process.
    - **Thomas Mason** shared an example of how a specific diagnosis and evidence of the prescription or ruling out of specific initial medications would drive the PA workflow, as opposed to giving access to an entire list of diagnoses and medications.
- **Alix Goss** noted that the subgroup focused on keeping the lens of the ICAD TF's work at the correct level. However, she inquired if a revised guiding principle is needed to capture the discussion concepts related to diagnosis and medication lists.
    - Several members agreed that this is too detailed for their scope.
    - **Thomas Mason** noted that he used a more detailed example only as an illustration of the many existing types of PA.
    - **Anil Jain** noted that he supports including examples that clarify the guiding principles, but they should avoid being overly detailed in their list of guiding principles that it needs to be updated often in the future.
    - **Jocelyn Keegan** supported keeping their guiding principles at the level of how and where decisions should be made and not at the level of implementation.
- **Alix Goss** proposed the addition of a guiding principle that underscores the concept that the right data should be used at the right time and nothing more.
- **Alix Goss** asked the ICAD TF to consider the following new guiding principle submitted by the smaller subgroup:
    - "Standardized minimal data will align with USCDI and will be the basis of data exchanged for prior authorization. To that end, if key/priority data is not currently present in USCDI, then the ICAD TF will prioritize feedback to the USCDI TF for consideration in subsequent versions."
    - **Anil Jain** suggested removing the word "minimal" from the guiding principle. It could be misinterpreted, and the data exchanged should be aligned with the USCDI. The word was removed.
- **Jocelyn Keegan** noted that Da Vinci has found gaps in the HL7 Fast Healthcare Interoperable Resource (FHIR) -based resources for USCDI in the PA process between payers and providers, and she illustrated her point through the example of a patient seeking a prescription for human growth hormone. She offered resources related to gaps Da Vinci has discovered.
- **Alix Goss** asked the ICAD TF to consider the following new guiding principle submitted by the smaller subgroup:
    - "Prior authorization process reform and improvements will be driven by patient safety, evidence-based medicine, and reduced burden."
- **Alix Goss** summarized work the ICAD TF completed on the Ideal State section of the Google document. Then, she directed members to items added to this section that were extracted from the WEDI whitepaper, which have also been worked on by the smaller subgroup. They are:
    - "Increase end to end automation for extracting Prior Authorization data request and response."
        - **Sheryl Turney** questioned the use of the word "extracting," and a discussion ensued. They decided to replace it with "processing."
        - The ideal state description was edited to read: "Increase end to end

automation for processing Prior Authorization data request and response."

- "Standards adopted to support end to end automation."
- "Policy permits use of multiple standards for exchange vs. only one standard for data content/data sets and operating rules."
- "Policy adopts a 'floor' of standards; not a ceiling." The small group suggested rewording it to read: "If a floor is created, then innovation leaders will still need support foundational standards for consistency in practice."
    - **Alix Goss** described the reasoning behind the previous three ideal state descriptions and noted that they are interconnected. She illustrated this by describing the existing "floor" and "ceiling" standards. She invited ICAD TF members to contribute feedback. They agreed to keep these descriptions, but **Alix Goss** will work on rewording them.
- **Alix Goss** noted that the following items for consideration were consensus positions from Jan 2018, and they were also included in WEDI paper. Due to limited time, only the first and last points were discussed. The following items will be addressed at a future meeting:
    - Accelerate industry adoption of national electronic standards for prior authorization and improve transparency of formulary information and coverage restrictions at the point-of-care.
        - **Alexis Snyder** recommended adding a second sentence to this point that reads: "Transparency will be maintained throughout as a concept throughout the care continuum."
        - **Alix Goss** will work on rewording this item.
    - {Payer's} will regularly review the services and medications that require prior authorization and eliminate requirements for therapies that no longer warrant them. {explore how that might happen?} {is the TF scope to address data element(s) that reflect when the PA policy was last reviewed by payer for applicability/use and consider expiration date}
    - Improve channels of communications between health insurance providers, health care professionals, and patients to minimize care delays and ensure clarity on prior authorization requirements, rationale and changes. {ensure the data generated by all the tx's are made available by actors to support continuous process improvements}
    - Protect continuity-of-care for patients who are on an ongoing, active treatment or a stable treatment regimen when there are changes in coverage, health insurance providers or prior authorization requirements.
    - Reduce the number of health care professionals subject to prior authorization requirements based on their performance, adherence to evidence-based medical practices, or participation in a value-based agreement with the health insurance provider. ("goldcarding")
        - **Jocelyn Keegan** noted that they should be careful when calling out specific exception processes for particular health care professionals, as these can have negative connotations.

REVIEW AND DISCUSS PRIOR AUTHORIZATION (PA) INFO TABLE

Sheryl Turney directed **Josh Harvey** to lead the discussion on new and reworked items on the PA info table section of the Google document. He noted that a smaller subgroup met in between meetings to assess feedback received and to work on rearranging the data elements and data classes. The subgroup

completed an initial path assessment beginning at the data class level. He gave an overview of how the subgroup added information to the content standards associated with each data class, and he explained the legend and color-coding. These indicate PA capability and adoption level for each standard.

He gave a high-level overview of how the new indicators described in the legend form a heat-map of standards that initially appear to be useful for PA purposes, but, upon inspection, they are also where adoption is lagging. He noted that the ICAD TF should analyze why adoption might not be higher in those specific areas and whether the standards might be liable and useful in the long term as they plan for the ideal future state of PA. He elaborated on some of these standards. Then, he asked **Jocelyn Keegan** and **Ram Sriram** to provide commentary on specific content standards.

Jocelyn Keegan noted that the content standard of real-time benefit check (also known as real-time benefit tool - RTBT) was added to the table. She encouraged the ICAD TF to request a full briefing on RTBT as it emerges as a standard with significant usage in the industry.

Josh Harvey summarized the area of emerging FHIR standards that **Jocelyn Keegan** built out in the table, using knowledge captured from Da Vinci's recent work. The HL7 Consolidated Clinical Document Architecture (HL7 CCDA) is an implementation guide that specifies a library of templates for clinical documents and prescribes their use for a set of specific document types. He explained that they did not color code the HL7 CCDA and HL v2 content standards because they were not sure how heavily they were being used in PA right now; they were captured during the subgroup's initial assessment as a possible item to be examined in the future. **Ram Sriram** explained that HL7 CCDA is not currently being used in PA, but some of its elements could be used in the future. He encouraged the ICAD TF to consider how this could be done. **Jocelyn Keegan** further elaborated that the subgroup wanted to capture how widely these standards are used across the industry today, but she also stressed they are not currently in use as a part of the PA process. She asked for feedback on how to categorize standards like these.

Discussion:

- **Sheryl Turney** thanked the subgroup for including the emerging standards, especially HL7 CCDA. Finding a way to use the HL7 CCDA was a point of discussion raised by **Les Lenert** at a past HITAC meeting, so she spoke with staff at Anthem and Blue Cross Blue Shield to see if they had attempted to use the CCDA as part of the PA process. They told her that the CCDA was not properly structured or codified to allow for the extraction of the appropriate data, even though the data are there, which is why it has not been adopted as part of the PA workflow. However, she would like the ICAD TF to continue to look into this topic.
- **Jocelyn Keegan** shared some insights gained by the National Council for Prescription Drug Programs (NCPDP) as it worked to automate cases. They have debated whether to expand the number of attachments added to a PA request, and she noted that, rather than leading to more approvals, increasing the number of attachments and the amount of data shared was found to lead to an increase in the number of denials for PA. Data that cannot be properly codified often flags the PA request for a manual review. Additionally, she referenced the ICAD TF's guiding principle to use the minimum amount of data necessary.
- **Ram Sriram** highlighted two items:
  - In the short term, data can be sent in the structured format, but it might have a questionable value in the workflow.
  - In the long term, a solution for PA justification is to use natural language processing techniques to map out the large amounts of English text/language in a CCDA, which would need to be semantically processed and understood. He noted that this technology exists but has not been widely implemented.
  - **Sheryl Turney** voiced her agreement with Ram, and she shared her experiences with using a natural language processing vendor and outlined pitfalls related to the project. She noted that translating items in the PA process from their natural state has led to issues.

        - Though she supported focusing on codifying the minimum amount of data necessary, she noted the importance of the discussion. Members of the HITAC will likely call on the ICAD TF to explain their position on this option in the future.
- **Alix Goss** noted the need to develop a new guiding principle or ideal state description to capture the complexities of sharing and processing CCDAs and other uncodified data elements, especially those containing large amounts of language/text.
- **Anil Jain** highlighted the need to look at the full picture for a PA workflow and not just what is entered into the electronic health record (EHR) for a patient. He recommended adding a guiding principle that captures the idea that PA should not be considered an activity done in a vacuum but should be examined in the context of the way that a clinician and their patients are making decisions as a part of the broader clinical decision support system embedded in an EHR.
    - **Sheryl Turney** noted that she would add these points to the guiding principles, and they would be considered for discussion at the next meeting.
    - **Jocelyn Keegan** supported the addition of new guiding principles. She built on **Anil Jain's** point that the information entered into the EHR is often not coded to support PA approval; rather, it is coded for patient care and medical record keeping.

Sheryl Turney asked **Lauren Richie** to open the meeting for public comments.

PUBLIC COMMENT

There were no public comments via phone.

Questions and Comments Received via Adobe Connect

lorraine doo: Alex Mugge will be late, but i am on the line listening for her.

Jocelyn Keegan: thats awesome! thanks sheryl! we were just discussing yesterday.

Jocelyn Keegan: https://confluence.hl7.org/display/DVP/Da+Vinci+Clinical+Advisory+Council+Members?preview=/66940155/66942916/Guiding%20Principles%20for%20Da%20Vinci%20Implementation%20Guides.pdf

Alexis Snyder: much preferred from patient and caregiver perspecitve as well! However we need to be careful about automated process thatsends all dx and not just the one needed

Alexis Snyder: agree with Tom

Jocelyn Keegan: agreed alexis. all sides of the docs/nurses and pharm in our DV experience and at NCPDP workgroup all agree, less, no more even when automated.

Jocelyn Keegan: I can share a list :)

Jocelyn Keegan: i like this. its about reducing unknowns and uncertainity

Jocelyn Keegan: throughout the care journey

Jocelyn Keegan: episode of care. . .

Anil Jain: I'm back in a few

Anil Jain: I'm back

Jocelyn Keegan: my call just dropped. be back shortly ;)

Jocelyn Keegan: i think this maturity aspect is important to the discussion

Jocelyn Keegan: can we take a stab at workflow next?

Meryl Bloomrosen: Please contact me re: pilots underway. Meryl_Bloomrosen@premierinc.com. Thanks, Meryl Bloomrosen 202 879-8012

DISCUSS DEMOS AND NEXT STEPS

Alix Goss noted that demonstrations with key players in the industry have been scheduled to take place at future meetings to give the ICAD TF an overview of important current issues.

- April 28 Meeting: Pharmacy/Specialty Drug Ordering presentations by Surescripts and CoverMyMeds
- May 5 Meeting: Medical Prior Authorization with Da Vinci Project CMS Document Record Look Up Service (DRLS) implementing members

She gave an overview of the next steps. First, she called for ICAD TF members to continue their "homework" approach to work by continuing to add information to the shared Google document, either individually or in small groups, by Friday, April 24. They should consider the challenges presented and the possible solutions. In the longer term, the ICAD TF could consider examining additional PA use cases (pharmacy, medical service, hospital service, specialty), and they should be prepared to make decisions about this work at the May 12 meeting.

Sheryl Turney thanked members for their contributions, and she encouraged them to focus their offline work on the "Other Considerations" and "Recommendations" sections of the Google document.

Discussion:

- **Jocelyn Keegan** requested that the ICAD TF go back to using the pictorial workflow model to apply different potential PA solutions in the market as a way to parse out the actors involved.
- **Ram Sriram** noted that he sent an older report on this topic to **Jocelyn Keegan**. She asked the ICAD TF to pause work on workflows until she has read the report and has used it to determine how to best move forward.
- Members supported the use of workflows to validate how data elements are being used at each step in the process as a "reality check." **Sheryl Turney** asked them to wait a few weeks before they move back to this step.
- **Alix Goss** noted that she would ask the Surescripts and CoverMyMeds presenters to address how various actors use data in the PA process.

CLOSING REMARKS AND ADJOURN

The co-chairs thanked ICAD TF members for their participation.

Lauren Richie noted that they would pick up with the topic of the next steps for their work at the next meeting, which will be held on Tuesday, April 28, 2020.

The meeting was adjourned at 4:26 p.m. ET.