The Office of the National Coordinator for Health Information Technology

Transcript

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

July 28, 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. Here we are again for our Intersection of Clinical and Administrative Data Task Force. I'm happy that you could be with us today. We only have one chair, Sheryl Turney. Alix Goss is absent today. Of the members, we also have Aaron Miri, Alexis Snyder, Andy Truscott, Anil Jain, Denise Webb, Gus Geraci, Jacki Monson, Mary Greene, Ram Sriram, Rich Landen, and Sasha TerMaat. Are there any other members I may have missed on the roll? Great. Hearing none, I'll turn it over to Sheryl Turney to get us started.

Summary and Action Plan & Cures Act Priority Areas for HITAC (00:00:57)

Sheryl Turney
Thank you so much, Lauren. I wanted to take a look at today's agenda. We are going to review the summary of what happened last time, when I wasn't here. We're also going to start bridging the gap into the intersection of clinical and administrative data and try to broaden our view. We'll take a look at the priority areas for HITAC, as well as one priority area in particular, which is interoperability. Then, we have public comment and next steps. We can go on to the next slide.

So, first of all, I want to thank everyone, including Alix, for all the great work that you've done while I was not here. I was really blown away by all of the work that the small group, as well as this group, was able to go through, so that looks like it's really wonderful, and I'm sorry I had to miss it. I had a medical procedure, but all is good now. So, let's take a look back at what the last meeting included. My understanding is that there was a great discussion around the recommendations and the remainder of those that you guys were able to take a look at in total and look at the straw men, including the possibility of continuous improvement, which led to the discussion of the star rating and other mechanisms for sharing some mechanism for continuous improvement of either the recommendations or the process that we suggest be put in place in order to allow the ecosystem to mature once we have our recommendations and standard recommendations, et cetera all put in place.

So, the idea is that once we create a floor, it will have the ability to mature on its own, and I know you guys went into the deep dive of the paper. If we need to, later today in our discussions, I can bring that up again so that we can relook at any of those topics.

Also, Alix led the discussion on the suggestion for a common data model, and again, where this really came from was that when we step back, and look at the ideal state and guiding principles, and assume all the stakeholders – forget the fact that we all represent different organizations, et cetera. If you're going to go out and say, "What's my system that I would need to put in place in order to support this work?", normally, you would start with the data model, which is really the atmosphere of the world that you're trying to deal with, and the data and where it comes from, and all the actors who provide that data so that you can create an integrated picture.

Today, we're all operating in all of our spheres without this federated or overarching data model. There isn't one at the national level that's been reviewed and accepted, and there isn't one that drives the prioritization or the work that the USCDI and some of the standards work. So, I and others thought it would be good to put this on the table as either a recommendation on its own or one that is in combination with supporting our overall standards recommendations to visit this topic and see if this is something that we could further because I do believe that it will help with the prioritization of use cases that are looked at by the various standards committee as well as the work that's being done currently, and you may have heard the notice or seen the notice today that USCDI is looking for recommendations for their Version 2. Likely, anything we recommend probably would not go until Version 3 of that USCDI, but those are all of the things that could be aided by a data model at this time, and that's really where the recommendation came from.

So, hopefully, as we're reviewing the recommendations in detail once the recommendations have been written up in final form, we can all spend more time talking and debating about what we want to include and how we want it to be framed in the final paper. Any questions about the recommendation discussion in the last meeting? Okay, I don't see any hands raised, so I'm going to go on to the other discussion topic that you had the last meeting, which is really the plans for drafting the final paper. I know Alix and I worked on some of these offline as well as drafting a final paper outline, and I know that she went through a very detailed work plan and timeline, which I 100% think is going to help us all be able to focus on our efforts and accomplish some of those objectives, so I know that you guys walked through that and looked at what we would be able to present to the HITAC on the September 9th meeting, and then, also talked about the introduction of the three priority areas.

And, just so you know where this came from, as we were drafting the overall plan for the final paper, we were discussing whether it would make sense to highlight those recommendations and suggestions that aligned with the three priority areas, which are really HITAC's three priority areas and come from the CURES Act. So, we're going to take a look at those today, and then we're going to take a deep dive into the interoperability aspect of it and revisit some of the discussion we've already had to see if we need to add something, if we've missed something, or if there's an expansion of an area that we need to have related to these priority areas that HITAC is focused on.

And then, also, I know Alix talked about the parallel writing and synthesizing teams approach. So, a lot of people stepped up, they volunteered, and they are going to be authoring a section. We have support from Excel and ONC in order to put the final table together and get one final voice, and at this point, I think we're all very excited to see what that final paper is going to look like and actually start reviewing it in total in these meetings. Any questions about the report drafting plans that you discussed last week? All right, let's go to the next slide.

So, one of the things we wanted to do is just revisit, if you will, what the charge of the task force is. Of course, we want to make sure that our deliverable, which is our final paper and presentation, meets the charge that we were set out to do, and I know we have this on all of the initial slides, but we wanted to revisit it just to make sure that all of the components that we're charged to deal with are covered in our final paper and recommendation. So, again, looking at the convergence of clinical and administrative data, we've been very focused on prior authorization, and there is more to the problem than just prior authorization because there's much more to the convergence of clinical and administrative data that could be combined

and available in a more electronic way that would ease burden on the healthcare stakeholders and all of the participants in the ecosystem.

So, the idea is to record once and reuse, and then, with all of our recommendations and our guiding principles, we want to look back and make sure that it fits the vision that we had in our overarching charge. We've had a lot of presentations and information presented to us by third parties, and that goes along with the charge to leverage its existing HITAC and NCVHS prior authorization hearings and other materials in order to inform us. I believe we've done a very good job of that, and we've also looked at the current standards groups and what they're doing, and we're focused on trying to produce the information considerations related to the merging of clinical and administrative data and the support of electronic prior authorizations to support work under way or yet to be initiated by any of the standards groups that are currently out there. Any questions as we revisit just what our charge is? All right, we can go ahead and go to the next slide, and the next one.

So, I know this might be a little bit hard to read, but individually, you can enlarge your own screens. I can't do it here for you, but there are some buttons on the presentation area where you can enlarge that. But essentially, what the CURES Act says is that there are three priority areas for the HITAC advisory to take a look at, and really, that's also where the work that we're working on was really initiated from. The CURES Act required that ONC and HITAC study the way to reduce burden and to increase the interoperability and leveraging of clinical and administrative data, and so, the three priority areas are mentioned in this section, which we have up in this slide and the next one, which really talked about achieving a health information technology infrastructure, and maybe I'll just read the whole thing for those of you who can't see it very well.

"For the purposes of this section, the HITAC committee shall make recommendations under Subparagraph A with respect to each of the following target areas. The first one, I, is achieving a health information technology infrastructure nationally and locally that allows for the electronic access, exchange, and use of health information, including through technology that provides accurate patient information for the correct patient, including exchanging such information, and avoids the duplication of patient records."

Here is where we would take from that the ability to obviously have electronic data interchange, and also capture the data once and reuse it so it reduces the burden on all of the participants in the landscape. And then, II says "The promotion and protection of privacy and security of health information and health information technology, including technologies that allow for an accounting of disclosures and protections against disclosures of individually identifiable health information made by a covered entity for purposes of treatment, payment, and healthcare operations. As such, terms are defined for purposes of the regulators promulgated under Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, including for the segmentation and protection from disclosure of specific and sensitive individual identifiable health information, with the goal of minimizing the reluctance of patients to seek care." And so, this is where we get the focus area of privacy and security.

And then, we have item III, "Facilitation and secure access by an individual to such individual protected health information and access to such information by a family member, caregiver, or guardian acting on behalf of a patient, including due to age-related and other disabilities, cognitive impairment, or dementia," and this is where that discussion that we've all had many times now on the healthcare representative on behalf of the patient and what's needed in order to ensure that data can be exchanged seamlessly for those

individuals who are supporting a member or a patient. And then, in IV, it's subject to Subparagraph D, "Any other target area that HITAC identifies as an appropriate target area to be considered under the subparagraph." Any questions about what the target area discussion is in HITAC?

Jim Jirjis
Yeah, hey, it's Jim Jirjis. So, the work we're doing around clinical and administrative, then – though, of course, privacy and security, et cetera are important, the belief in Section I is that this committee would assist with any HIPAA-approved use, right? I'm just curious – are you going over the slide to give context for what we're doing in the prior auth space?

Sheryl Turney
So, the question is would this committee deal with any approved HIPAA use? I'm not sure I can answer that definitively. Certainly, with any work that we're doing, we want to ensure that HIPAA-approved requests and disclosures would occur in a way that's the least amount of burden, but I'm not sure that's what you're asking. I think you're broadening beyond.

Lauren Richie
Hi, this is Lauren. I was hoping to jump in here too. I would just add that I wouldn't necessarily say it's within the purview of this committee to address or implement HIPAA. We certainly don't want to overstep the boundaries of OCR, but where there are implications for HIPAA, we certainly want to make sure we highlight that in the recommendations and the discussion so that if we need to consider engaging OCR or making sure that the recommendations specifically address that, we can do so. Does that help to answer your question, Jim?

Jim Jirjis
I guess maybe the question behind my question is why are we going back to this slide? Is it to frame and validate the work we're doing in the ICAD task force? What's the main message?

Sheryl Turney
The main message was to frame the work and make sure that everyone on this committee is aware of what the priority areas are because as we move forward in this meeting and the next couple of meetings, we want a deep dive on the work we've already done to make sure that we've addressed recommendations for those priority areas, so we may want to identify with our recommendations which priority area those recommendations support. And then, we may want to review what we have and say, "Hey, did we think of everything? Do we need to add to it?" That's the discussion we're going to have today regarding the interoperability function. Does that make sense?

Jim Jirjis
Absolutely, thank you.

Broader Intersection Discussion: Interoperability (00:17:36)

Sheryl Turney
Again, many of us have already seen this, but some of the people are not on HITAC, so they have not seen it, and maybe they had read it when CURES Act came out, but this is just a refresher, that's all. I just want to make sure we're all in the same place. All right, I think we can go to the next slide, and this is the

remaining verbiage, again, for the priority areas that there are – what it says here is that there are additional target areas. "For the purposes of this section, the HITAC may make recommendations under Subparagraph A in addition to areas described in Subparagraph B with respect to any of the following areas, and there are additional priority areas that can be defined, and the use of health information technology to improve the quality of healthcare, such as promoting the coordination of healthcare, improving continuity of healthcare among healthcare providers, reducing medical errors, improving population health, reducing chronic disease, and advancing research and education."

Also, 3 under there is "The use of electronic systems to ensure the comprehensive collection of patient demographic data, including at a minimum, race, ethnicity, primary language, and gender information, the use of technologies that support various other reporting, and systems." So, this just gives us a scope of what we want to make sure that we considered as we're reviewing our recommendations to ensure that we have a complete scope defined. Any questions, again, about what we're seeing here for the CURES Act? All right, with that basis, let's go to the next slide, which is really what the majority of the meeting today is going to be on. We can go to the next slide.

I want to start the broader conversation about the intersection of clinical and administrative data. And so, for that purpose, interoperability – which you would think is not a definition that would be debated, but I can just tell you based on the work that we did last year with the interoperability rule, we had quite spirited discussions about the interoperability, so again, for the purposes of us all understanding how it's defined in the rule, interoperability with respect to health information technology means "Such health information technology that A). Enables the secure exchange of electronic health information with and use of electronic health information from other health information technology without special effort on the part of the user, B). Allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable state or federal law, and C). Does not constitute information blocking as defined in Section 300J-52A of this title."

Again, this is just to make sure we're all on the same page in terms of what interoperability really is talking about regarding health information. Any questions about that? All right, let's go to the next slide, and this is really where the discussion begins. So, over the last few weeks, you guys have already done a deep dive on the guiding principles, and the titles of the various guiding principles are here. Again, just for the purposes of this discussion, "continuous improvement" was payers having an established process for regularly reviewing and communicating the services and medications that require prior authorization and eliminate requirements for therapies that no longer warrant them. The payer would review these, and communication processes will have been established and have been predicable with some sort of cadence of annual update.

And, there's a lot more to it, but I'm just trying to digest it down to a summary for the discussion today. That's about what we talked about last time regarding the addition of the guiding principle for continuous improvement, and also, the guiding principle for a data model – again, which I just discussed in the last meeting update – was the need for an underlying data model to help us guide the prioritization of work or the development of use cases by the standard-making organizations like HL7, USCDI, X12, and others, and help that guide the work.

The design for the future while solving the need for today was really us talking about how our approach for recommendations should really be sensitive to all potential burden, which would mean clinical types, patients, caregivers, and any systems that would be used to support all of those to drive adoption and obtain desired results. So, if a floor was established, ensure that there are corresponding operating rules and regulatory rules that allow for rapid standards development and evolution so it's not precluded by innovation and doesn't have to wait through cycles of things in order for it to mature. Any questions on those so far in terms of what we're talking about and what they mean? I'll go over the others in a minute. Then, we had real-time data capture –

Anil K. Jain
Sheryl?

Sheryl Turney
Yes?

Anil K. Jain
My hand is up. I'm not sure if you can see it. I just have a quick question and some level-setting. From a selfish point of view, Alexis and I are going to be writing or synthesizing these particular guiding principles around the prior auth work that we've done, and I just want to make sure I understand – since we've already started writing and synthesizing – what the goal of this discussion is. Is it to add new ones or change them? I want to make sure that the work we've done shouldn't be paused while we wait for the entire group.

Sheryl Turney
I don't think so because I think that the plan that we had was to take a look at what we've done so far for guiding principles and really focus on what's missing. Is there something missing based on what we revisited today in terms of the target areas, or even the interoperability deep dive? That's what we really wanted to look at, and again, I have the latest version of the Google doc that I can flash up if we need to go and look at the wording in general, but that was the goal for today – to look back and ask if we're missing any general areas or if we need to further develop a particular area. It wasn't to necessarily change what we've already done, but it was to ask what's missing and whether we need to add that, and if we need to add to it, how do we need to go about developing it?

Anil K. Jain
Okay, and just to be clear, the guiding principles – these nine – were in the context of prior auth.

Sheryl Turney
Yes.

Anil K. Jain
And, I'm seeing here "ICAD guiding principles," so are we suggesting that these guiding principles should be the guiding principles for all the work of aligning or integrating clinical and administrative data? I just want to make sure I'm not missing something around the guiding principles and our pivot to thinking about the committee's work in general outside of or in addition to prior auth.

Sheryl Turney

I do think that the idea was to look at these same guiding principles and identify, again, how they might be expanded for the broadened scope. I also think that it was anticipated that there might be different guiding principles, which would be the additional ones that might be needed if we look at the expanded spectrum of the administrative data and intersection with clinical. I think that's – so, you're asking the exact right questions, Anil. I think it's harder because maybe there's not a common understanding of what we mean by the broadened scope and what that really would mean for us, and I think that's where maybe the innovation component of it really comes into play – you don't know what you don't know – but as I said from the beginning, if you were to imagine that there weren't disparate systems and all the data was able to be integrated, how would that change things? Separately from just a prior authorization, might it change the way we provide care? What are the things we need to do to help enable that so that we can discover what innovations might even come from it? And, that's really where that comes from.

Anil K. Jain
Okay. I understand the concept that you're laying out, which is that as we broaden the scope and go beyond prior auth, what are some commonalities of the work we've already done that can be brought forth? I just wanted to make sure – again, for selfish reasons – that as we're doing all this editing, writing, and synthesizing, we're at a point where the broader group – we're able to freeze that, write it, and then bring it back to the broader group for comments so that we can discuss as a group.

Sheryl Turney
Exactly, and I think the anticipation was that if we apply these same guiding principles to the broader scope, they will potentially have some different discussions underneath each topic, and so, what will that mean? So, what I tried to do in the verbal discussion I prepared for today was pull out what might apply to the broader subject versus what was there defined for prior authorization –

Anil K. Jain
All right, thanks.

Sheryl Turney
– to help us move, and I'm not saying I got it 100% right, but at the end of the day, we need to start somewhere. So, one of the topics was the real-time data capture – I think that's where I was – and this is where I just captured the theme of "capture once and reuse." So, if we had that theme through the broadened scope, what would that really mean in terms of expanding beyond and broadening beyond the prior authorization? Okay, I see we have another hand up. Alexis?

Alexis Snyder
Hi, I'm just piggybacking on what Anil was saying with the work that we've been tasked to do. Alix spoke about us pulling out one or two sentences that define each of these guiding principles for the draft report as it rolls into the ideal state list, and so, with that said, based on the conversation the two of you were just having, I want to make sure while we're doing that that – should we be defining each of these from the information we've already all pulled together in a way that defines it broadly for future ICAD guiding principles in each of these areas, or should we be sticking with defining them for prior authorization because we would need to tweak it one way or the other? They definitely go hand in hand, and there's definitely an overarching principle that guides all of the ICAD work, I think, but should we be tailoring those couple of sentences in each area to focus on prior authorization or try to keep it broad?

Sheryl Turney
So, this is where it might be partly a style thing. I don't know if Alix and I are 100% – we don't have a 100% answer, but I would think is if we are talking about the guiding principle, it would make sense to talk about the broader, and then, also focus on the specific for prior auth so that we're talking about each subject area once rather than having it repeated multiple times throughout the document, so I think it would make sense to have them both covered under each subject area. If you think that makes the best idea as well – because I think it will be easier to read the paper that way, and it also will be more clear within each principle what of what we're saying applies to the broader versus what applies specifically to prior authorization.

But, in terms of what has been assigned already for writing, we didn't have any discussions yet on the broader, so it's not like material we could have given you guys to start with, so that is a factor of how we broke up the task force work, and so, we need to deal with it now. Would that make it more confusing or easier to deal with?

Alexis Snyder
I think it's fine. Like I said, they go hand in hand, so I think that while defining that guiding principle, while thinking about prior authorization, it will follow through for a broader definition as well, that if it was used later down the road, could then also have more definition for something besides prior authorization when it's more specifically written again. My question was basically if we should leave prior auth language out of it and just do it more broadly, but we'll just leave it the way we started doing it.

Sheryl Turney
I would like to say it would be better to be broader because then it can be applied to both the broader as well as the prior auth, but where it makes sense to be specific because it maybe wouldn't apply to broader, then I think we should be specific. Certainly, you don't want to make it more confusing in terms of what we're trying to communicate. So, I think where it makes sense is better to state – we're asking them to collect data once and reuse it. We should state it once, and if we need to be more granular related to prior auth, we can include that in the same section, but have a more specific reference as part of that section.

Alexis Snyder
Right. I think leaving it broader makes sense, then, because if you think about it, if we're defining the guiding principle broadly and then it leads into what that ideal state is, that's specific for prior authorization at that point.

Sheryl Turney
All right. And then, Anil, you have your hand up again.

Anil K. Jain
I just wanted to make a plug to keep things the way they are with my and Alexis's writeup because the context matters, and the entire group has been focused on the prior auth, and the guiding principles that arose from that discussion are where we're at right now. Now, it doesn't mean that we have to – what we could do is simply have the guiding principles with all the language that Alexis and I are building in, and then, move them later on into a more generalized form where we have more discussions about the broader scope, and then leave specific examples where they were. I think from a context point of view, since those

guiding principles were developed in the context of prior auth, it's going to be hard to make them generic and still be able to support from an evidence point of view as to why that's an important guiding principle as opposed to the examples we have there right now. That's just my two cents. I think it would be easier for us to continue doing the work the way we are, and then, after looking at that as a group, when we have had a chance to discuss what some broader general principles are, then we can move on them.

Sheryl Turney
Okay. I think that in terms of planning this meeting, Alix was hoping we could discuss the broader principles without having the writeup, but I think what you're saying is you would feel more comfortable having the current writeups there to even discuss the broader principles because it might make it clearer what those broader principles are that might be missing, right?

Anil K. Jain
Yeah. I don't believe the entire group was privy to all the discussions that happened between the smaller groups around these nine principles, and that's what Alexis and I have been tasked to do, is to build some context around them, describe them a little more, and then play it back to you. So, at the end of the day, I'll go with whatever the group decides, but I think that the context really matters for principles.

Sheryl Turney
I like that suggestion, and I do think it's easier for the stakeholders to react to something versus what I'm trying to do, which is really give you a context, and you can't see it, so I do think what you're saying makes sense to me, so we might tweak what we were going to cover for next week regarding that, and then, also, I see Jocelyn has her hand up, so I will call on her and maybe get more input from the group. This is a stakeholder-led group, so we're going to go in the direction of what makes the most sense to this group. Go ahead, Jocelyn.

Jocelyn Keegan
I just wanted to share that I agree. I think context and scope are important in the way that we created these guiding principles, and I think maybe the question we should be asking ourselves isn't how we generalize them more without that broader discussion, but instead, we should look to ask if there are guiding principles that are specific PA that are going to constrain us somehow when we look at other interactions and at least acknowledge that, or if there are missing guiding principles as we move to the broader community, but for our current task, I feel like understanding that we're not constraining ourselves is probably more important than picking our heads up and looking at the broader piece. Generically, I think that we could say all of these things apply to all of the things; I'm just concerned that if we add additional principles now into the work that we have in place that we're going to muddy the crispness of what we're doing now.

Sheryl Turney
Okay. I think that's a fair statement, so I don't want to do anything that's going to delay or distract people from what they're currently writing, and the idea was that this discussion is supposed to happen in parallel, if you will, and if that's not easy, then that's understandable, so as quickly as we can have materials to share to bring it to that broader discussion, I think that would be good. All right, Jim also has a question. Jim, can you go next?

Jim Jirjis

Thank you. I just have a quick question as to scope and charge. When I look at these things, they seem pretty complete. The only question I have is whether this is the right section or if we need to also address the incentive for people – recommend that ONC, possibly with CMS, address what would compel people to use this. I think of *Field of Dreams* – "If you build it, they will come" – and I think in some areas of prior auth, there are standards, but there isn't a lot of use. So, is part of this committee also calling out that incentives will be important to foster adoption of our framework?

Sheryl Turney
I agree with that, Jim. We have not had a lot of discussion about incentives, or even pilot projects or use cases that might be necessary to help inform the learning related, and whether or not the current use cases that are out there with Da Vinci and others represent the complete ecosystem or the complete picture because they tend to be focused on a specific aspect of something like prior authorization or data exchange, but is that the complete picture that we want to include in terms of our recommendations and scope?

So, I know that in terms of discussing in the paper, there was some discussion about what the levers are and potential recommendations could include related to incentives, regulations, or things of that nature that might be necessary in order to influence the adoption of the prior authorization and/or broader intersection of clinical and administrative data recommendations, and we haven't had a specific conversation on that topic itself, but I think even like the interoperability rules that are out there, they focus on an aspect of the environment that is within the scope of CMS. Whether or not those same interoperability principles get extended to much of the commercial business that's outside of that has still yet to be learned, so, like that, we might want to take that type of lens and look at the work that they're doing and saying if it's not going to impact the bulk of the work that's moving through this ecosystem, then how much of the needle are we going to move in terms of what's actually going to be improved?

Jim Jirjis
It seems like we ought to address it somewhere in the document, and I'm thinking of three levers – well, four, really. One is that it's so usable that people are compelled to adopt it. The second is that at least for the covered entities – the technology companies that have certified – that elements of this become requirements for certification. The third is that CMS use its authority over the insurance company programs to compel use, like they're doing in the sister regs that came out in May. Those were three conditions of participation, at least. There are levers; I don't know that we need to pick them for ONC, but we need to encourage using some combination of those to at least think – for things that have been piloted to work, they ought to address incentives in their approach.

Sheryl Turney
Yes. I hear you 100%. What do other stakeholders think of Jim's suggestion? Anil?

Anil K. Jain
Sorry, I was trying to get off mute. So, I think where Jim is going is where I think some of the discussions we've had have gone, which is how much do we want the various levers that can be pulled or pushed in order to accelerate what we're trying to achieve? I think a lot of it depends on how much of what we're recommending will fit into the natural evolution of interoperability, and that's already something that, as the standards evolve to support the various mechanisms and transactions that we're trying to accelerate here, I think it will be a natural flow.

In terms of specific incentives and all that, I don't see any harm in having a discussion section that makes suggestions, but we actually have had a number of stakeholder briefings, and they've asked us to consider a multitude of things, and so, one thing that might be interesting would be to go back, review some of those things, and see how many of them can be brought forward in a section once they're aligned to what we're proposing – recommendations we would have for different parts of our stakeholders, whether it's CMS, ONC, private-sector innovators, or whatever it might be. So, I think it's a great idea to have that, but I think it needs to be in the context of what we're trying to achieve throughout interoperability and what direction the stakeholders who have given us briefings would want us to go in within our purview.

Sheryl Turney
Yeah, I also like that idea, Anil, of having a stakeholder impact or statement, if you will, that shows who would likely be impacted and where we would need levers to be applied. And then, the recommendation of the various levers and this group discussing which are those we want to see pursued and with what sense of urgency, and then, if there are – I know that a couple of groups have come to us. AHIP talked about a pilot demonstration project, AMA discussed the idea of a pilot project, and I know Premier has presented to us and discussed the idea of expanding pilot projects, so there might be some recommendations related to how the pilot projects could help to expand or accelerate the adoption of those standards and whatever would be required to support the certification requirements. What do you think about that? Anil, you still have your hand up.

Anil K. Jain
I didn't raise my hand again. Maybe it just didn't go back down, but I liked what you just said.

Sheryl Turney
Okay. Does anyone else want to make a comment about that?

Jocelyn Keegan
It's Jocelyn. To me, there are a couple pieces that I would look at. One of the things that doesn't come across in the guiding principles – while we talked about being aligned to national standards, I don't think we really cover the sentiment that we've discussed around and has been discussed in the industry for some time about really raising the ceiling from a standards perspective – so, allowing for more innovation – so I think your point around piloting and testing out new methods is really, incredibly important, as I know that at least a portion of the folks in the AHIP pilot are using some of the Da Vinci implementation guides. So, I think if there's a way to incorporate that in the guiding principles, that's the only piece of all of the conversation. I think anything we can do to demonstrate practice exercise emerging standards with relief from existing constraints is important.

Sheryl Turney
Okay. I don't know if that was discussed as part of the continuous improvement.

Anil K. Jain
It was.

Sheryl Turney

It was, Anil?

Anil K. Jain
Yeah, it was discussed in the alignment to national standards, where we talk about a floor end – exactly what Jocelyn mentioned – as well as in the continuous improvement, where we talk about payers as well as the fact that we need to be keeping an eye out for things that might need to be enhanced within the framework. So, yes, it's discussed.

Jocelyn Keegan
Thanks a lot, Anil.

Sheryl Turney
Okay, that's great. So, just to further describe for this group what some of the other guiding principles were as we're having this discussion, we talked about information security and privacy in the prior authorization focus, but to try to broaden it, it would be looking at maybe that recommendations and solutions should meet the current health information and patient rights laws and regulations, but also provide the resources necessary so that all of the stakeholders have an understanding of the authorizations that have been provided. I know that's been a challenge in terms of discussion in many of the stakeholder groups I've been part of, where often, payers don't get to actually see what the authorization form looks like, and so, there are always questions related to sharing data for substance abuse and things of that nature, and that has to have some delayed impact on the overall ecosystem if there are always questions about what has actually specifically been authorized, and having those authorizations available.

So, if we're trying to bring this up to a broader scope, maybe including some conversation around those authorizations and disclosure notices and having some standards around that may help to support the overall broadened scope of administrative and clinical. Any questions or comments on that one? Okay. I know that in what we've talked about specifically for prior authorization, maybe that topic didn't get talked about that way.

All right, we can look at patient at the center. Here, again, the idea is to reduce the burden so we capture data once and reuse it, but also to provide transparency throughout the process so that things today that people cannot see what's available – it's not easy for a patient to understand what data has been shared and with whom, and for sometimes even what purpose, and then, whether that data is complete or not and whether that data that's needed for any type of decision-making needs to be supplemented, and who's needing to do that supplement, and who's needing to take that action.

So, I know if we focused it on prior authorizations, which is obviously what we've done, there's really no transparency into the process, but if we try to broaden it beyond even prior authorizations, I think often, the patient may not know – if they're not adherent with their medication, and even the doctor doesn't know sometimes whether or not they're adherent, and one way to tell is if they are getting the medication refilled. So, making the medication reconciliation requirement, which goes beyond prior authorization, might be something we want to look at. We do have use cases in Da Vinci for that. That's one of the ones that I know Anthem has been trying to champion, but those are some of the things that come to my mind when we're thinking about this. For this topic, we do have a couple of questions and hands raised already. Anil?

Anil K. Jain
I'm not sure what's wrong, but I'm not raising my hand.

Alexis Snyder
It's Alexis. I raised my hand.

Sheryl Turney
Go ahead, Alexis.

Alexis Snyder
I think Anil is going to say the same thing I am because he, Jocelyn, and I are typing in the chat about relatively the same thoughts. I just wanted to clarify that "patient at the center" and "transparency" are two different guiding principles that we have in the list of nine, and they are highly interconnected, of course, because we can't have patients at the center without having transparency and all the pieces you just mentioned that go into transparency, but I just want to be careful how we define "patient at the center" where we're defining "transparency" as a separate guiding principle within that hierarchy of nine principles.

So, just listening, to explain it based on transparency didn't make sense to me and others, it seems, and we should make sure that "patient at the center" isn't pieces of adherence to medication and how we can provide better use and getting information to the provider. That's not patient centeredness. So, the way we have defined "patient at the center" in the past is, throughout the entire process, really keeping a focus on lessening burden on the patient, ease of access to care, and getting what they need, especially when we're talking about the prior authorization process, and then, transparency is also an extremely important but separate guiding principle – again, it's connected to patient-centeredness, but shouldn't be used in the definition of "patient at the center."

Sheryl Turney
Thank you for that. Any other questions or comments? All right, and then, the next one we had was a measurable and significant improvement – again, this is really looking at recommendations that we would want to make that would be of some measurable effect, so whether it's applying it to the broader – I think it's a little harder when you're looking at the broader topic on how we would measure the improvements, unless it's looking at the availability of electronic information that's administrative versus clinical within the ecosystem where it doesn't normally generally occur today. So, I know that again, that might be more difficult to envision, but it's really talking about how we measure the improvement as a guiding principle and ensure that it's achieving what we're looking to achieve.

Again, on transparency, it was improving visibility and channels of communication between health insurance providers, healthcare professionals, and patients to minimize delays and ensure clarity for all of the healthcare requirements and ensure intra- and interorganizational communication so that data that's generated by all of the various systems and transactions are made available to the actors needed to support the continuous improvement process. So, again, it's making the data available and visible in a way that supports the needs of all of the healthcare stakeholders. Any questions on those?

And then, "align to national standards" is just what triggers and levers we have to accelerate industry adoption of national electronic standards as we move forward. So, do we have any questions or a

discussion that we want to have on what's missing from the perspective of guiding principles? Again, we may not get to that until we actually see what we've done for prior auth and actually try to put some definitions for the broader pen to paper, but at least at this glance, is there any comment that the stakeholders on this meeting would have in terms of what you think is missing? I'm not seeing any hands raised. All right, well, we have a little bit of time in our timeframe. We can either take a deep look at the Google document if that would be preferable, or we can move forward and close the meeting early. What's your flavor? Anil?

Anil K. Jain
I was just going to say that since Alexis and I are still working on synthesizing and we are not using the Google doc, we're doing it offline and will bring it into the Google doc once we have a stable view, I don't know how much sense it would make – unless others want to – to go into the Google doc to go over this.

Andrew Truscott
I'd like a bit more time to review the Google document.

Next Steps (00:59:06)

Sheryl Turney
All right, I agree. Let's move forward. We can go to the next slide. Can we move the slide? All right. It's early for public comment, so why don't we go and do a little wrap-up, and then do the public comment? So, next week, we had intended a broader discussion of privacy and security. We might be rethinking that based on the discussion that we had today, so we might come back with a different topic for next week because I do think we're going to take into account the suggestions that were made related to starting to look at the report writing and seeing where we are there, which is going to give us some better content to have the expansion go to the broader intersection. And then, our goal is still to have some recommendation and draft by September 9th. We have a long way to go before we're ready for that, but that's where we're going to go. Can we go to the next slide?

So, this is the scheduled meeting that we have with the work that is intended for the current agenda, but I want to go to the next slide, where it really talks about the report writing, and this is more the deep dive in terms of what the expectation is for the folks that are doing all that work offline, which is a Herculean task, so I do thank everybody for volunteering to do that offline work because that's really going to be a significant amount of what we're doing.

But, I do think that the sooner we can get to looking at and reviewing the various aspects of that data, the better off we're going to be, so maybe for the discussion that we have for August 4th, where there had been some deliverables that we were going to look at, we'll take a look at the background and the initial draft of the interoperability material to see if we can go from there with the information that we've talked about so far, and really move into digesting that as a group. I do think that's going to bring more to the surface. This is kind of what the schedule was for all of the writing offline. Any questions about that report timeline? I know you saw it last week, but this is the updated version if you hadn't seen it before. All right, since I don't see any hands raised, why don't we go early to public comment?

Public Comment (01:02:03)

Lauren Richie
All right, if we can ask the operator to open the public line…

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

Lauren Richie
Thanks.

Sheryl Turney
All right, wonderful. So, since we don't have any public comment, I think our next meeting is August 4th, which is next week at the same time, so I want to thank everybody for participating, and we'll give you some time back on your calendar. I hope everybody has a wonderful week, and thank you to all of those, again, who have volunteered to work offline and create the final report. We really do appreciate it.

Adjourn (01:03:22)