The Office of the National Coordinator for Health Information Technology

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

September 29, 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 for Health Information Technology	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 for Health Information Technology	Designated Federal Officer
Michael Wittie	Office of the National Coordinator for Health Information Technology	Staff Lead

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

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Welcome, again, to our ICAD task force meeting. We're getting down to the wire here. Of our task force members today, we have Sheryl Turney, Alix Goss, our co-chairs, Alexis Snyder, Anil Jain, Gus Geraci, Ram Sriram, Rich Landen, and Sasha TerMaat. Are there any other members on the phone?

Thomas Mason
Hey, this is Tom Mason.

Lauren Richie
Hi, Tom. Okay. And with that, I'll turn it over to our co-chairs to get us started.

Summary and Action Plan (00:00:40)

Sheryl Turney
Thank you so much, Lauren. And today, what we have planned is a little bit of the summary and action plan of what we did last time. Alix is going to lead us again in a broader intersection discussion wrap up, which we're really looking forward to. I'm going to lead the review on the report outline and framework. And then, we have public comment and next steps. So, we can go to the next slide. So, just a little bit about what we talked about last week. We had a very great discussion about synthetic testing. We also had a very animated discussion about price transparency. And we had a lot of people speak up on that point, which I think was really, really good. We also, in that meeting, talked about some policy and regulatory barriers, which we're going to expand on today. And then, also we touched on third party credentialing as it relates to supporting the patient. So, I want to appreciate everybody in their ability to weigh in the discussions last week and look forward to finishing up those topics because we're really getting down to the wire now.

So, I'm going to turn it over to Alix Goss who is going to lead the conversation today with the broader intersection. Alix.

Broader Intersection Discussion Wrap-Up (00:02:01)

Alix Goss
Thank you, Sheryl. We're going to go ahead and start to work through our attempt at synthesizing our discussions from 9/8, 9/15, and 9/22. I'm hoping that my screen will be shared with all of you. So, I just need an indication that maybe it's – yeah, here it comes. So, I'm going to first start out with sharing my screen related to the broader intersection themes and report content development that we've been doing building on the last three conference calls that we've had. I really want to do a shout out to Michael Wittie in preparing a synthesis of your feedback and to help us identify guiding principles, ideal state, and recommendations content that we need to weave into our final report. So, today will be a nice opportunity to do a touch point on whether we've heard you correctly and get some reactions so we can work with our

editor to weave in some of the new principles and recommendations. Additionally, we thought we should finish up the third party credentialing in support of patient at the center.

There was a discussion that we did not get to complete last week related to how do we handle the credential access. Not like credentialing as in a provider credentialing but as in an individual supporting a third party app having access to its data. And then, we want to do a final call for consideration areas that we need to explore in the broader intersection discussion. As you've heard several times, we are in what we believe to be the home stretch. So, this will be a really good conversation for us to finish up today. And that will then also enable us to move into our subsequent agenda items where Sheryl will be talking through the outline we've created for the draft report. And so, I'll be displaying that and taking notes as well. So, without further ado, now that I've set up our focus area for today, I'm going to move us into our synthesis of the broader intersection discussions. So, what I want to do is sort of walk through this document to get reactions. And I will take notes as we go to capture any additional thoughts that we may have.

And Sheryl is going to assist me with monitoring the hand raising so that we can make sure to get all of your questions. The goal will be to give us yeah, you got it, no, you didn't and here's why. Very perfunctory sort of feedback so we can try to get through this and then, continue with the rest of the discussion areas that we already identified. So, the first guiding principle that we thought we heard from you I've given a short title name to of a level playing field, not attached to it but, hopefully, you can give me some feedback on whether or not we should be adding a new guiding principle that addresses and on ramp such that players at all levels of technology and standards use maturity can integrate data at the individual and patient population levels. So, we're thinking that that should be a guiding principle that we would add. I'm going to go to the second guiding principle just so I can get feedback on the two of these at the same time, especially since I know that there are a number of members who are still joining.

The second guiding principle that we thought we heard from you could be maybe a short title of in workflow, which is really the concept that we've discussed numerous time. We really don't want portals. We want everything to be within the natural workflow of a given stakeholder. So, information should be available in the system that the relevant actor normally uses in regular workflow and that we weren't sure, and I put a note in here to get feedback, that we could consider this maybe its own guiding principle. But we might want to carefully consider the alignment with or the difference from the prior authorization generated guiding principle of real time data capture and workflow. So, for right now, we can, certainly, add an additional in workflow, no portal sort of guiding principle and then, use our upcoming review period to further hone our thinking about how these fit together in the report. I'm going to pause there and see if there are any questions, Sheryl.

Sheryl Turney
Right now, we have no one with their hand raised. I will comment since no one else has. But I do think that based on the discussions that we've had, we, essentially, did state these things multiple times, not only within the broader intersection conversation but also within the prior authorization conversation that we had. So, I do think both of these guiding principles, if they were implied, may need to be beefed up. Or if they weren't specifically called out then, we need to add them because I do think that it is an issue. And since we had the meeting last week, there were a couple of meetings I attended. One was a Karen meeting. And a patient spoke up talking about their care journey as an advocate for an individual. And it just really focuses so much on the need for an easy to use workflow to get information from one provider to another and having

the ability for all of that data to be shared in a natural environment and some of the things that can happen when it isn't.

And while I was speaking, now Rich has raised his hand. So, I think we can go to Rich. And then, if there are others that have things they'd like to offer, go ahead.

Rich Landen
Yeah, it's Rich. I'd just briefly like to agree that these should be guiding principles, particularly the second one to strong signal to strategically do away with portals and favor a more in workflow reduced burden design of the system.

Alix Goss
Thank you for that feedback, rich.

Sheryl Turney
Yeah. I do think that anyone that has clinical experience that weighs in here, it's going to be very important because they're going to be able to speak to this specifically, obviously, because it is something that impacts them. But it is, certainly, going to be a burden on the smaller providers who maybe are not hooked up to the large EMR systems that have the ability to hook all of these bells and whistles into it. Anil has raised his hand as well.

Anil Jain
Yeah. I just wanted to speak to make sure I'm understanding what you mean by portals because I think I would agree that we want to make it seamless in their workflow. But we're not saying that we would not favor portals where there is single sign on. I don't think we want to limit the kind of technologies that would help the various stakeholders with the task at hand as long as it's embedded in line with the workflow. Whether it's a portal that's got single sign on on the back end shouldn't end shouldn't matter, right, or am I missing something?

Sheryl Turney
I think what you're saying is accurate. So, maybe how this is worded, Alix, we need to tweak a little bit because I think the key is that whatever we recommend, it needs to be within the workflow without added burden to go outside of it.

Alix Goss
Okay. I think I've tried to capture that consideration. So, what I'm hearing is – I'm also seeing Andy Truscott. Welcome, Andy. I think you just joined and your hand is up.

Andrew Truscott
Yes. I was listening before. Hi, it's Andy here. I don't think we should say no portals. I think we should say that no portal is mandated or required. A portal could well be part of infection workflow, etc. But it shouldn't mandate it.

Alix Goss

Right. So, Andy, we're going to open up a can of worms here but I need to go there. Under the direct data entry capabilities permitted under HIPAA, portals are, by de facto, already permitted.

Andrew Truscott
Yeah. So, we shouldn't say they're not. That's not a can of worms. That's correct.

Alix Goss
No. I just realized I was going back to open up a can of worms of prior discussion around direct data entry. That's what I'm referring to. And so, how would you modify what you're seeing us present here on no portals that don't have single sign on integration?

Andrew Truscott
I don't quite understand the language, especially no portals that don't have single sign on integration. Do you mean especially portals that don't have or do you especially mean not portals that – I don't understand the language you're typing in the first part of the sentence.

Alix Goss
Yeah. Because I'm trying to do them in shorthand to try to take care of it. That's why we're on the call. So, I really am referring – these are my shorthand notes right here. And I'm referring to more of this feedback summary that we've reviewed at the top of the call, which I apologize, you may not have heard in that we were really talking about this idea of –

Andrew Truscott
I was biding my time. I would, actually, prefer we stay mute on whether portals or not. It's implicit from the fact that we're talking about APIs that may or may not be utilized by a portal with other constraints and controls around them. But that's my personal view.

Sheryl Turney
So, maybe wording that says – and we have a lot of hands raised now. Maybe wording that says, Alix, instead of no portals but if portals are used, they need to be within the natural workflow with single sign on. That's what I'm hearing, right?

Anil Jain
This is Anil. That's what I was trying to say just to be clear.

Alix Goss
Yeah. I got that part.

Sheryl Turney
All right. We have Rich with his hand up and then, we have a few others. Go ahead.

Rich Landen
I'm thinking we've probably got two issues going on here. And I'm getting a little confused. I agree with the single sign on since we're talking about if we're going to use the portal that should be accessed within the workflow single sign on. It makes all of the sense in the world then, yes. But I think the way I'm looking at

portals fundamentally, it's an alternative use, particularly by health plans, where there are adopted federal standards for transactions. In our case and point, prior auth transaction. And the portal represents more of a specific to that particular payer work process. Whether that means **[inaudible] [00:14:18]** or manual data entry. So, I would resist not including a statement saying for that use of the portals, those need to go away. And if portals can be reconfigured in such a way as to utilize standard transactions without any additional work by the provider or any customization or any one off solutions that would be, certainly, acceptable.

But as Alix, I think, started to say, what we've seen with the evolution of the HIPAA exception for direct data entry is all sorts of on off solutions by payers. So, if the provider has 30 health plans, they've got 30 different ways of submitting the same transaction on 30 different portals. And that's the piece that I think it's time we put a stake in the sand and say those need to go away.

Alix Goss
So, I'm going to call directly on Andy Truscott because, Rich, what I think that you just summarized is what was discussed on the prior calls very clearly. So, there is now a difference of opinion. And folks, we need to reconcile that so that we do it here or we do it in the draft report. And I'm seeing lots of hands go up. So, Arien, please. You're first in the cue.

Arien Malec
Thank you. Yes. I don't think we are – I would submit that we are not split or of significant disagreement. I hear consensus around the outcome objective of accessing capability in workflow without special effort. And just hear the careful nuance that doesn't mean that there should be no such things as portals but that portals with separate log ins that aren't integrated into workflow shouldn't be the only or required way to complete a given task. And I don't think that conflicts or objects with allowing the use of portals. So, I want to submit that as a possible point of consensus that we have consensus around the notion that capabilities should be available and should be designed to be available in workflow without special effort on behalf of the provider or staff extender. And that portals, while they may well be used, should not be particularly required with separate log in or out of workflow.

Alix Goss
And I'm going to say I guess I'm having a little bit of I want to be a good co-chair and I want to be a really good teammate in notes capturing here. So, my conflict in my own head is, folks, we've got some really substantive stuff to get into at this point in the rest of the document and in the other agenda items. So, I think Arien just nicely sort of garnered the consensus. I'm hoping I captured Jocelyn's comment from the chat box about today's DDE provision of portal is really tomorrow's smart app and that's what we're trying to get at. So, I'm looking for wrapping this item up so we can move into some of the other discussion areas. So, with that said, I'll ask for final remarks. Arien, your hand is still up so I think that's just a hanging chat. If not, okay. So, Andy and then, Jocelyn.

Andrew Truscott
Okay. Quickly, I agree with pretty much all of the comments that have been made. I don't think we want to drag this out too much longer. I would suggest that we don't say single sign on integration because there are other approaches, seamless log on, etc. And we're being a bit prescriptive. Arien, I think you hit the nail on the head as I would expect when you said without any special effort. I think that would be the center to

put in. And to capture Jocelyn's smart comment as well, I would just say if user interfaces are used, they must have integration that requires no special effort on behalf of the user. That's it.

Alix Goss
Okay. I think that might have been – oh, Jocelyn.

Jocelyn Keegan
No, I'm off that. I'm just going to say ditto.

Alix Goss
Okay. Thank you, everybody. I'm going to move on to the next area. One of the things that we heard was related to a potential ideal state. And I wanted to affirm if this topic is a part of a broader vision statement that needs to precede prior auth. And if so, how might we tie that in with some of our other guiding principles knowing that we're trying to have guiding principles and recommendations, have some correlation. With that context, one of the things that we discussed was the stakeholder continuum. And so, a converged ecosystem that includes stakeholders across the continuum, including public health, vital records, research and policy makers would be able, without creating additional data capture or other burdens on patients and providers have the information that they need. It could also support specialty and long term care settings. And capturing and exchanging data across all of these functions seamlessly will require consistency and has a real potential to reduce burden furthering our overall objective of record once and reuse.

If we've heard that sort of ideal state thought process correctly about stakeholders across the continuum, we think that we also heard a few recommendation areas. To establish a minimum data set that allows a refined way of looking at an aligned clinical administrative picture for these downstream stakeholders to see what they can do as a baseline that may need to be expanded later. But, again, not based on additional data collection by the clinical providers. So, what can we give them to start that will work and how can we then expand that over time is that first related recommendation area that we heard? The second one was related to information models and that we should establish information models in stages to align the clinical and administrative data for secondary uses based upon the highest societal priorities. This would need to take into account minimum necessary requirements and considerations. It may also affect the data concepts and elements that USCDI needs to reflect as we move forward.

Thirdly, we thought that there was a need to review the current administrative transactions and associated value and code sets to ensure USCDI supports those downstream functions as well. So, I would ask if you feel that we did hear – and I'm going to make this a smidgen smaller so we can see all of this on one page. Did we hear you correctly that we want to speak to a broader vision statement about a converged ecosystem? And if so, are the three high level recommendation areas in line with what we heard before? I see Andy's hand is up.

Andrew Truscott
I agree wholeheartedly. I'd probably insert the word "illustrative" in front of information model. I don't think we should be defining constraining information models but illustrative ones, which would meet the needs.

Alix Goss

Thank you. And we will give you lots of time to infuse important wordsmithing concepts because we're going to be releasing a report to you, a draft report for your review, later this week. Anil.

Anil Jain
Just a couple of thoughts. I think where we talk about public health vital records, research and policy makers in that converged ecosystem, we should change it from research to research and innovation. We want to make sure we allow for that innovation that needs to happen in the broader. The other comment has to do with really thinking through the different governance models and regulatory aspects that all of these different disparate stakeholders have to deal with. And what are we going to say about that because, in some ways, it's one of the biggest barriers to allowing for a seamless flow between these different stakeholders. I can't simply collect a piece of data in my clinical setting and then, turn it over to somebody for research unless there's IRB and all sorts of other things that are going on. The final thing, I think it's underlined even, the word "without", "without creating additional data capture." That's a pretty strong word.

Maybe our goal should really be to make it more efficient but I'm not sure that we're going to **[audio interference]** stakeholders without some additional minor work on behalf of the ones that are in the field because you might have to check off a box saying yes, you understand that this information might be used for research. And without any additional data capture, that's minimal. But I just want to make sure we're not trying to say something very, very extreme here.

Alix Goss
I see Jocelyn's hand is up.

Jocelyn Keegan
So, I think adding onto that point, when I was listening, one of the things that kind of struck me was I would include community and caregivers to the list of stakeholders. And I don't know if those are the right phrases to use. But I think we need to get the full list of stakeholders called out. And I think that adds onto the point that was just being made, which is I think it's about the right data and the right amount of data at the right time. And reuse and standards enables that. Because sometimes, it might just be about creating the hook in for the minimal set of data that I need as a community caregiver or as the Lyft service that needs to pick somebody up versus getting the entire patient record, this agreed upon patient record because you're, actually, providing direct care for the patient. So, I think it's more about the connectedness and the reusability than it is about saying once I actually decided I'm going to set somebody up with a Lyft service, I now need to get the address of where they're staying, their cell phone number so that I can get them set up on the app.

I think that, to me, it's more about the connectedness than it is about not coming back and asking for more different information.

Sheryl Turney
I don't see any more hands raised, Alix.

Alix Goss
I see Anil's hand is raised. I'm not sure if it's a hanging chat though. Okay. It's back up. Anil.

Anil Jain
Yeah, sorry. I'd add that I think we also are just not crystal clear in this. Within this ecosystem of the various stakeholders, it's really the payer or the member or the **[audio interference]** when it comes to making sure we allow the information to flow to those places where we can't lose sight of the fact that the patient is aware of this.

Alix Goss
Yes. Anil is breaking up for me. I'm having a really hard time hearing.

Anil Jain
Okay. Can you hear me now?

Alix Goss
Yes.

Anil Jain
It's about being patient centric, making sure we don't lose sight of that. Patients should decide where and how information flows within the current constraints of all of those different stakeholders.

Alix Goss
Okay. I'm sorry. I was just responding to Andy's note in the chat box. So, please guide me as to what I missed that I needed to capture in your statement.

Andrew Truscott
It was in the second bullet point there, I was –

Alix Goss
No, I got yours. I'm sorry. I was really – okay. I'll add it here. I was really trying to get Anil to tell me what I missed from him, his comments.

Andrew Truscott
His name is Anil, not –

Alix Goss
I know. I screwed up. I apologize, Andy.

Anil Jain
All right. So, this is Anil. Can you guys hear me okay?

Andrew Truscott
Yes, we can, Anil.

Anil Jain

Okay. So, I think in the transcript, it looks right. But I think the main point, and I'm looking at the text here, it's really around – now, I'm not seeing it. I'm not sure what happened there. It could be my connection. Let me just wait.

Alix Goss
I scrolled back up. I'm not sure which portion you're speaking to, Anil, and what portion of the document –

Anil Jain
Well, you were asking whether you captured my comments correctly and I'm trying to look for them.

Alix Goss
I captured them down here. I started to break them apart because it was running too solid. I was losing points because people were building on other people's comments.

Anil Jain
Okay. So, I think the two things to capture are that it should be patient centric. Each of the different stakeholders that are listed have a different relationship with the patient or consumer and we can't lose that. So, it has to be patient centric. The second thing is that we have to make sure that we don't oversimplify this idea that just by having this information being collected that we can just start pushing it around to all the different stakeholders without going back to the patient. That consent process is going to be important.

Alix Goss
Okay. I think I got it. Thank you. Are there other comments on the continuum considerations? I am not seeing the hands raised. So, I'm going to move on to the next area. One of the things that we talked extensively about in the last call in particular was the idea that price transparency is thorny and complex issue, which would warrant a separate task force to really evaluate it. And that our recommendation would be as such and that we, potentially, could look at a new guiding principle or possibly modify the transparency one to really reflect the dynamics related to differences across state lines, which we've talked about in a variety of ways, whether it was in privacy, complications, or the ability for machine learning and automated processing capacities by, actually, codifying those state rules. I'm looking at the chat box and I'm seeing Andy making a comment about focus on outcomes, not implementation approaches. And what I think I'm seeing is –

Andrew Truscott
[Inaudible] [00:30:39].

Alix Goss
No, no, no. What I'm thinking is maybe we need to make sure we called out that principle more clearly because I don't know that we have it in one of the eight or nine that exists.

Andrew Truscott
I'm not disagreeing with it either.

Alix Goss
Say that again.

Andrew Truscott
I know I agree with it. I'm not sure the entire task force agrees with it.

Alix Goss
That's why we need to discuss it.

Andrew Truscott
Yeah.

Jocelyn Keegan
I agree with you, Andy. It's Jocelyn.

Alix Goss
Okay. So, I'm going to come back to that in a moment. So, I want to – let me put a place holder and I want to give it its due time. So, before moving onto that point, I think price transparency, we're clear. We want to make a recommendation about it. We may need to just, as we're reviewing our guiding principles, decide whether or not we're clear enough on the state lines aspect and transparency or not. And we can come back to that one. I do want to talk next about the ideal state related to test data that there was discussion about a national approach for an ecosystem with synthetic test data that would include the great complexities of data and transactions so that app developers and partners can test against this and that this would really help us with more broad based testing and validation of the standards. And so, we came up with a recommendation that a test bed should be supported as a public service at the national level and account for the variances in state laws.

I'm looking for anybody having concerns with that. Jocelyn.

Jocelyn Keegan
So, as we phase down our first reg around some of our implementation guides on the Davinci front, I think that the issue around tech data are incredibly important. I'm not so sure there needs to be one all breathing, all doing, all serving actual platform. I think the question is about having data that's functional and meets the needs across the community and an ongoing source as the data set and the use cases expand versus it being one thing to do all things for everyone. That makes me nervous about flexibility in the moment.

Alix Goss
I'm glad you brought that up because I thought that there might be some reaction to this. That there are a couple of schools of thought. We started out with having somebody to create a synthetic test bed that could then be leveraged. But what got written up might be interpreted as the test bed and related services would be a public service and would be overarching. And so, I'm curious to see how others feel about this, Jocelyn. And I'm surprised we don't have more hands up yet. Is this something that we want the government to convene and infuse a direction? Or do we want the government to, actually, provide the service? Hi, Andy. Your hand is up?

Andrew Truscott

Well, gingerly. I can't speak for anybody else. There are products and platforms already out there, which many of us run and operate around test data. I think there is probably a need and a recommendation we can make around a collection of test data sets, potentially, which could be utilized. That I can see. I'd be interested in what Anil thinks and Arien. Actually, anybody but I'm picking on you two because you both start with an A.

Anil Jain
This is Anil. I think there's always a nice way for the government to set up the guard rails and the ask and let industry and public/private take a stab at it. I always favor that. But I think we have to decide do we want synthetic test data or do we want to pool actual data that's been anonymized and deidentified. They're two very different things. And I would argue that if we've already got a mechanism in place where industry working with regulators, working with standards bodies provide test beds where there are connectors and APIs and data that we shouldn't try to reinvent something. We should look at those different capabilities that we already have and try to put some guard rails around that and make some recommendations there. But I do like the idea of what is the role of pushing for a synthetic set of data that allows testing to happen. Because no matter how hard you try to anonymize and deidentify real data, it always becomes a thorny issue. So, that's my take on it.

Alix Goss
Jocelyn.

Jocelyn Keegan
So, I really appreciate all of those comments. Having worked in a different industry before coming to healthcare, I'm always surprised at the scarcity of real test data that's available and the amount of risk we incur as an industry by the kind of on the grid testing that participants do on a regular basis because of the challenges around VHI. So, to me, I completely think that there's a role here for industry to supply services to do this. And I think it was Anil that was speaking. I think that this point about what data to use when, when you use synthetic versus real, deidentified data, there's variability in deidentified data that you'll never get with synthetic data because humans are involved in the creation of the real data. And I think that, to me, it's almost about the cyclicality of when and where you need the data. It's one thing to say we need to come up with sources of all payer claims data in an X12 format because that's something that's been available and alive in the industry and in use for decades.

It's another thing to say as we unleash this clinical data and these workflows via API for clinical data or reusing claim data in new and novel ways, what is the role of synthetic initially and then, eventually, the role for deidentified when the data, actually, begins to flow or flows more consistently or products become better defined or standards become better defined. So, I think that it's a little bit of a soliloquy so I apologize. But I think that the where you are in the life cycle of where the data is needed is a question that needs to be answered about what type of data you need but that there should be some sort of convening that's happening about how and where we enable the innovation by making the data available. Because the data and the lack of test data is a blocker, especially if we talk about patient centric applications and new entrants to the market.

Alix Goss
Okay. Arien. Thank you, Jocelyn.

Arien Malec
Thank you. So, first of all, I had trouble raising my hand previously with respect to transparency. I think my perspective on that one is not that we should mandate a price transparency service because those things are really complicated. But to the extent that there is pricing or reimbursement data that is regularly available to business partners who were involved in the care of a patient and that is patient specific that that data should also be available and accessible to the patient. With regard to this issue, it seems like we're getting hung up on the difference between running a testing service and curating the availability of an implementation guide with good associated test data. And I wonder whether, just a probe for consensus, the latter is an area that we can all get behind. That any specifications in this space developed in this space with the convening power and coordinating power of the National Coordinator should be accompanied by tight conformance document and associated test data. Sorry, for two issues.

Alix Goss
Did I hear you correctly if I say tight conformance in test data requirements for adopted standards?

Arien Malec
Yes. Standards and implementation guidance, standards of specifications. There's a little geekery there in terms of the difference between those two.

Alix Goss
Oh, yes, because it really is adopted implementation specifications, if I can type right. And this is what you're proposing maybe is more of what we want to – as a new pivot on recommendations to be established? ONC to require tight conformance and test data requirements for advancement of an implementation guide as an adopted standard. I think that's really what you're recommending as a recommendation.

Arien Malec
Correct.

Alix Goss
That's the pivot there. And I'm hearing Jocelyn sort of look at something different from maybe looking at the life cycle. But, generally, what's the right sweet spot for ONC and the government to live in versus what is the responsibility of market, subsequently, also nuanced to at what point do you need what kind of data? So, I'm not sure how we're going to transform this, at this point, but those are the points I'm hearing so far. I'm not seeing any other hands up. And so, what I would like to do is move into the last area that we had coming into this meeting, which is our second to last guiding principle discussion. At the last meeting, Sheryl discussed an aspect related to patients having a third party credential to support the authorization and access functions to their data. And so, we didn't really get a chance to finish off that discussion at the last meeting. And so, I wanted to open it back up. Sheryl, did you want to make any brief opening remarks to extend what I already said to start the conversation?

Sheryl Turney
Thank you, Alix. Hopefully, you can hear me okay. I do appreciate that. I know that I was trying to explain what we were talking about by this. But the vision, again, is if you're holding your app in your hand, wouldn't

it be nicer to be able to go out to a third party or whoever it is, get a credential, and use that for access to all of the connecting points that you want to make in your app versus having 30 connection points that have to be maintained in addition to your app as you being the patient having to go forward. In the current framework, it's burdensome for the patient to have to connect all of these and remember all of these different passwords and sign ons that don't speak to one another and can't be shared. But also, those in the current environment have to be maintained along with the app that they're utilizing. So, I do think that this is something that you're going to hear more about in the future. I was on another couple of meetings this week with other industry folks that were talking about the patient burden.

And this kept coming up as an issue because it is limiting or inhibiting patients from even the idea of using apps because if it's something that requires a lot of things for them to remember, they tend to abandon it in the middle and don't complete it. And then, the only ones that do are the ones that are severely sick who, in many cases, need caregivers or others to help support them through the process. So, I do think whatever we can recommend that really focuses on improving the patient journey is really important. And so, again, the recommendation is to provide the pathway for patients to elect, not require but elect to utilize the third party credential service if that's what they want to do and to, again, encourage through some incentive, all of the systems that have to interact with those credentialing services to be able to adopt that credentialing. Because all it is is they create the token and that token who has been validated. And then, that token gets exchanged in the background.

So, rather than each service creating a token, it would be a single token that's used across the landscape. And we have many hands that are raised.

Alix Goss
I'm sorry. I thought you were going to call on Alexis. Alexis, your hand is up first.

Alexis Snyder
I guess going back to this being a separate guiding principle or thought of as being one, I hear what Sheryl's saying. I think there are some good ideas there. I would offer that perhaps the guiding principle we've missed, we've talked a lot about access and lots of different areas under transparency. And perhaps we should pull some of those out and make a guiding principle for access because they are two separate things. They can go hand in hand in certain pieces. But maybe we've missed the boat on a complete access guiding principle. And then, this statement here, the patient should have a third party credential, etc., seems more like an ideal state and then, maybe a recommendation for a third party credential comes out under this new guiding principle or access. And that was my overall thought. And just a comment to some of the things that Sheryl had mentioned. I would just say I think it's a large overgeneralization to state that all patients as a whole have a hard time remembering different things and using different portals.

And they start to fill out applications and then, don't bother unless they're severely sick and really need to. So, I just want to be careful about the overgeneralizations we use because I think that's a large assumption about a great population of people. And I do agree that we absolutely need to be patient centric, of course, patient and caregiver centric and make things as easy as possible with clear transparency and access. But I just wanted to be careful about making those overgeneralizations about folks.

Alix Goss

Thank you. I'm trying to make sure I captured your access portion of the transparency guiding principle and create a new GP focused on the access. And then, we can have a corresponding recommendation. But I think that is not eliminating your comment related to the need to maybe weave in some of the text that we had about this third party credentialing aspect and more of an ideal state than a guiding principle. I think I've captured that. I don't know if there are any more hands up or if anybody wants to help me refine the no testing –

Arien Malec
I've got my hand up. I've got some connection issues with the new Adobe Connect so I apologize for that.

Alix Goss
I just saw it popped up. Hey, but voice works.

Arien Malec
So, I'm a believer in stay in our lane. I think having a robust ecosystem for patient controlled high assurance identities that can be used across multiple settings is something I've been a big advocate for in the past, present, and in the future. I don't know that it belongs as a hard requirement in this document. I agree on the future state orientation that we should be designing towards an ecosystem where high assurance patient identities can be reused across multiple settings of care. And I think it would be an appropriate guiding principle that any standards and implementation guidance that we create that are associated with patient access and interaction requirements be designed to accommodate and prefer the use of patient high assurance identity and authentication tokens. I know that was a whole lot to throw at you but, hopefully, that makes sense.

Alix Goss
Yeah. Because I almost feel like you conflicted yourself. In one vein, I felt like you're like high assurance identity is an important topic, not our swim lane. Let's leave this alone. And then, it was like maybe we could come back and have a guiding principle. And then, I got lost. I wasn't sure if you were kind of compromised.

Arien Malec
No, no, no. Let me be clear. So, 1.) we shouldn't, as a side effect of this report, be creating requirements for high assurance patient identity and authorization services. That's the stay in our lane comment. 2.) We should also have, as a guiding principle, that any patient access standards and associated implementation guidance be designed to allow for the use of such patient identity and authorization. So, it would be a bad idea if the very design didn't separate identity assurance and authorization from the actual access to the service. And then, I think it would be appropriate to talk about, but I'm less passionate about this last point, a future state or ideal state where patients get access to high assurance identity credentials and authentication services and use those to access across multiple settings of care. But, again, I'm more than happy to go back to my stay in the lane for that one if that's too ambitious.

So, the one that I do feel strongly about is we should make sure, and I think it's appropriate, in our guiding principles that any such standard certification criteria be designed to be accommodative of patient proffered high assurance identity and authorization. Hopefully, that made more sense.

Alix Goss

I hope I captured it right. I'm curious as to how others feel about the guiding principles aspect as well as how far we should go on any recommendations.

Sheryl Turney
I think the one thing, Alix, is that the guiding principle you have is patients should have a third party credential. It's not that they should have. It's patients should have the – that should be enabled so that if they desire to use it, they can use it. That's what I was saying.

Alix Goss
Is that the tweak you were looking for? Patients should be enabled to have a third party credential is what you're recommending.

Sheryl Turney
Or the ability for a patient to have a third party credential should be – yes. I don't know what other people think but that's what I was recommending.

Alix Goss
Hi, Anil.

Anil Jain
Yeah. Just double checking, can you guys hear me? I've got not a great connection.

Alix Goss
I can. No, actually, the team increased your volume, which has helped a little bit.

Anil Jain
Okay. Wonderful. I guess I'm not following something about why would we not allow the industry working with consumers who would want this to do it themselves to set it up? Why do we need to put this forth? Is there something that prohibits us from allowing third party credentialing? I'm not following that.

Sheryl Turney
Without putting something in here, Anil, that allows for this then, the current mechanism today would have to be customized to support it. So, all we're saying is that as we're recommending the convergence of data to focus on the patient then, allow the systems that are going to be updated to have this capability so this service can be enabled if the patient so desires. Because it's going to make it a lot easier for them to integrate their data with a third party app.

Anil Jain
Right. But I guess I'm not educated enough about what the restrictions are in play today to allow that to happen by having a consumer work with a third party.

Sheryl Turney
There needs to be a standard developed to allow it to happen. Otherwise, it's not going to happen. That's the problem.

Anil Jain
So, you're trying to avoid –

[Crosstalk – inaudible] [00:55:14]

Alix Goss
Is it standardizing the technical standard or a policy standard?

Sheryl Turney
I think there needs to be a technical standard.

Alix Goss
Sorry, Anil. I think I overlapped you.

Anil Jain
No. I was just going to say I guess I'm being a little utopian in the sense that if there is a consumer demand for this that industry could work with the very stakeholders, consumers and come up with that standard, if you will, that could allow for that efficiency to take place. I just need to get myself more educated as to what the barriers are. If you think about the financial industry, there's plenty of folks who are allowing for the ability to aggregate credentialed access to multiple places. And yeah, it was a bit rocky in the beginning but it's, generally, working pretty well. And I'm just trying to understand what the role of us putting a specific set of recommendations are versus letting industry working with consumer groups figure it out.

Sheryl Turney
I think the complexity here is that, and I'm not saying there isn't the same B to B and B to B to C stuff that happens on the financial side, but the fundamental differences in payer systems versus provider systems that allow access for the patient. And, again, maybe I'm wrong but my understanding is most of the patient access systems from a provider side of facility side are individual based. Most of the payer systems, based on my own knowledge working for multiple payers, the access systems are, actually, subscriber based. So, there's a fundamental difference with the way they work. And just, quite honestly, to make it a level playing field, there needs to be, and maybe it does need to be a policy as well as a technical standard but there needs to be something in the background that allows it to be a common playing field. Because today, the two largest groups of systems are based on different types of entry and access. That's the problem.

Anil Jain
Okay. Thanks.

Sheryl Turney
It gets really complicated when you think about even the current interoperability rule, which provides for a patient to have individual access and you're a payer and you have a confidential communication under HIPAA that impacts that subscriber family, having to make that – when one is based on one family and one is based on an individual, even just making that happen is difficult for all the payers. So, just based on all the conversations we're having on how to make the two common when it's two different sets – one is individual and one is subscriber is difficult. So, as we've been talking about it, I think that these things have come up. And I'm just saying since we're touching on these subjects, I do think we should address it and

make a standard so that we all then have a future to drive to. Otherwise, it's going to end up being every payer implements it differently just like every provider implements it differently. And it makes it harder to adopt to these standard types of credentialing that we're trying to go to.

Alix Goss
So, I guess as I'm listening to this and having worked in deploying the direct protocol and thinking about X509 digital certificates and the ability for those certificates to be issued by trusted entities and exchanged with a certain set of rules that has been advanced from a technical architecture perspective. And I'm trying to link my old world with this conversation, Sheryl. Part of the dynamic I'm hearing is that part of the issue is knowing who is who in the zoo and who can actually get which data and which communications. And because we have patients moving in different places with different kinds of plan set ups, it's that there's a best practices that may be missing, not just a policy framework. But how are we all going to solve this and how are we going to treat Susie Q, the parent, different from Susie Q, Jr. versus Susie Q. III. And so, you've got a family that may all be covered under Susie Q, the employed. But there are three flavors of Susie Q and how do you know which Susie Q do you give which data at which time to respect privacy.

Sheryl Turney
Right. Well, that's, of course, the problem that we're all facing right now because of the fact that most payers are subscriber based versus individual. And, of course, we've all made modifications to the systems over the years to address the state laws and other things regarding individual access. But I think people would, actually, be even surprised at the low number of adoption of individuals on their electronic access that currently exists. So, at the end of the day, all I'm saying is since it is a different grouping of how the data is typically accessed, it's not really – credentialing is one part of it. But I also look at it and say we have an issue with consent because I want to know that Susie Q, the adult child, allowed Susie Q, the mom, to access her records if that's the case and for whatever certain situations. And often, I can't get access to any of those consents. I have to go with the trust factor that the consent was signed and that it does allow for that.

But at the end of the day, this is going to get more complicated. And it's going to get more widespread. And to me, the credentialing and access and consent should be kind of tied together. And we would want to be able to make that as simple as possible for patients so that they can get the data. There was an example that was provided the other day on one of the Karen calls where these individuals, it took them 37 days to get the documents to the doctor so the doctor could review them. And then, once the doctor said he couldn't make an appointment, they needed to refer them to someone else, they needed another consent. Well, if we had electronic consent that could have been done on the fly on the phone so that those records could go. And that cost the patient another two weeks. To me, that's what we're trying to address with having standards that provide for if the patient desires some sort of background service that can provide more ready access to their records through these services. That's all.

And Arien raised his hand.

Alix Goss
Awesome. Arien.

Arien Malec

Yeah. Thank you. So, as a technical matter and the reason I was focusing on the standards and certification here is that, as a technical matter, all of these standards or all of the modern standards are based **[inaudible 01:03:19]**, which allows for separation of each of these areas. There's a business model and policy coordination piece that's clearly important. I went through some of the White House work on NSTIC back in the day. And that just got ugly and political really quickly, which is where my caution about staying in our lane and making sure that we're focused on the right things comes from. So, I just want to reassure people as a technical matter that, first of all, all of these comments are right on. We should be separating identity, identity assurance, and authentication from authorization and access to these services. There's a burden that's placed on folks from a HIPAA perspective to be able to meet the HIPAA obligation that, in turn, drives a ton of burden on patients and also on providers.

And the good news is there are technical means to solve all of this. The bad news is there's business model issues and policy issues. And so, that's where my recommendation comes from to focus on the ideal state and focus on making sure that any of the standards and certifications that are built get designed from the perspective separating identity and authorization or identity and authentication from access and use of the underlying services so that you can separate these identities. But also, where a little of my caution of let's not boil the ocean here because a lot of the stuff we're talking about gets really complicated and also highly political quickly. Anyway, that's the meta comment. Thank you.

Sheryl Turney
I don't see any other hands raised, Alix. But I do think we got a lot of good suggestions out of this. And I think we're at a place where we could synthesize it now down to ideal state and guiding principles and maybe a recommendation to consider what needs to be looked at from a certification perspective.

Alix Goss
Yes. I have not looked at the agenda because I'm sharing my screen. So, I'm not sure where I'm at in the agenda. I know we had one other item that we possibly wanted to discuss here today that got raised. Do we have time to do that right now or is that something we need to ask people maybe to –

Sheryl Turney
I think we can do that. I think that's more important than reviewing the outline. So, we'll move –

Alix Goss
Yeah. But I want to make sure that we absolutely share the outline so that people are aware of what's going to come across their desk in their homework come Friday.

Sheryl Turney
Yeah.

Alix Goss
So, thank you for managing the time there. We do have public comment at 4:20. I do remember that part. So, let's ask Andy to come back on to center stage and see if we can't put a little framing around a new principle for us to consider.

Andrew Truscott

Sure. Thanks for that. It's a pretty straight forward thing. I think that on recommendations, we should be focused upon the end results we're looking to achieve as opposed to prescribing necessarily how to achieve them because I think there are many ways to skin these cats. And we don't want to be inadvertently either felt to be overreaching or to have the unintended consequences. For example, we were using the language seamless log on earlier. Sorry, we're using seamless sign on. Actually, there are a lot of ways of achieving the same end goal. That was kind of my sentiment there. And I'd be interested in what others think.

Sheryl Turney
I agree with you, Andy. I think we should be using words like without additional burden and things of that nature rather than some of the prescriptive that we have. But at the same time, we were asked, especially by HITAC last time, to be clear about if we're making a recommendation whether it's a policy or a standard or something of that nature. But I do agree with the way in which we're doing it. We need to make sure we're not prescribing a particular solution.

Andrew Truscott
Yes, thanks, Sheryl. I think the second part of that and where I was commenting earlier was we said something about data models. I'm not sure that we would be recommending – maybe we would in which cases, let's discuss. But I'm not sure we would be recommending the creation of The Data Model for a particular purpose. We would be creating or causing to be created illustrative data and/or information models I think. Is that fair?

Alix Goss
This is Alix and you broke up a little bit for me in that sentence, the last sentence that you said. I feel like I think I heard you and I feel like I would have to carry this conversation forward into the review of the recommendations to date to see how to balance this because I feel like it's hard for me to think about this comment without looking at the body of work that we've already synthesized to see if we've tripped into what you're trying to avoid us tripping into.

Andrew Truscott
Yeah. I've reviewed everything that's been created so far. I haven't been that vocal until today really or a couple of other times. And I don't think we have. I think it's just that every now and then, it's just looking at the way we phrase something so that we're not recommending something gets created, which might have the unintended consequence of forcing some kind of effort to be done that actually doesn't need to be done because we can keep things, implementation guidelines set up – maybe I'm not being clear. I wouldn't mind somebody else chipping in if they agree with me and just want to phrase it better.

Alix Goss
I know we have a couple of folks in the cue.

Anil Jain
I'm sorry, did you say me? This is Anil.

Sheryl Turney
Yes.

Anil Jain
Okay. So, I think, in general, I agree with what Andy is saying. But I think we have to just go back, for example, to the comment I had made around single sign ons. I wasn't saying we should be using single sign ons. I was simply giving as an example. And I think it's important for us to focus on what outcomes we want. But then, to also provide some real examples of how that could be achieved without picking winners and losers of how one might implement something like that. So, I agree with Andy. But I think without example, without tangible examples, it's really hard to get down into what is it we're really trying to say. Because otherwise, it's just a bunch of goals without guard rails and without some way to point to what's actually happening today and what it is that we really want different. So, there might be areas where we'll need to get not into the exact implementation but examples of how there are disparate ways of doing the same thing.

And in some cases, that's fine. But in other cases, those disparate ways of doing things is what's causing the problem. And so, I don't know how you get at what we're all trying to achieve without, once in a while, getting into the how and not just focusing on the outcomes. But I'm going to pause there.

Andrew Truscott
So, if I could just respond to that very quickly. I agree with Anil. I think we need to give examples. We just need to be clear that these are examples. These are not directions.

Alix Goss
So, I'm going to defer my comment to Jocelyn. She had her hand up.

Jocelyn Keegan
I'm just working on getting myself off of mute. So, I really appreciate the points that are being made here. And I think, to me, that the specificity of examples is important. And I think as we think about the construct of the report, there should be a place for us to provide exemplars but that our focus needs to be on what is the outcome and the policy that we think should be enacted. And the how isn't, I think, for us to be prescriptive except by examples unless there's a place that we have consensus that we should be prescriptive. And I guess maybe I think, Andy, that's part of what we're going to be doing as part of the actual editing of the report. I think calling that out as a focus area for us, the laws on intending consequences that we should always be mindful to make sure that we're separating out. For example, not this is the way it shall be done.

Report Outline and Framework for Moving Ahead (01:13:01)

Alix Goss
Jocelyn, that concept of Andy is really helping us to hone our pencil thinking going into this first real draft of review of a draft is such a gift. I was exactly where I wanted to head and say this is a really good stopping point for us because I think it provides a natural glide path to us pivoting to the next documents that we can cue up before we go to our public comment period in five minutes. And so, it looks very small on my screen. But the point being I wanted to show you the report outline is on one page. And I will make it bigger but I wanted you to see before I honed in on a portion so that Sheryl and I can walk you through this that this is, essentially, an outline. I won't necessarily call it a table of contents because it's a little bit deeper than that. But it is, in effect, the structure that we are proposing and the document that we are producing for your review will follow this. And with that set up, Sheryl, I'm going to make it bigger.

Sheryl Turney

I'll talk us through it. And my suggestion is let me get through the narrative that I've prepared for this and then, we'll go to public comment. And then, we'll come back and see if people have questions. But this is where we are with time. But essentially, what we drew was the thought process. We looked at the interoperability of intersection, which drove us to integration, which drove to improvement. And, essentially, we're saying clinical administrative data are not interoperable, which leads to burden at points where the data needs to intersect in support of healthcare such as for authorization. So, making the data and related policy frameworks interoperable will allow integration at these points of intersection and allow more effective and efficient use of data and resources to improve care delivery and health outcomes. That's the overarching theme. And so, what we've done is identify that we have front matter, which is our ONC charge. And we reviewed that multiple times.

We will have a forward by the co-chairs, which is Alix and I and then, the task force membership. Then, we're going to go into the executive summary. And here, we're really going to build on the fact that we've got this problem that we're going to define. And here is where we talk a little bit about how ONC can create a competitive marketplace to encourage IT developers to create innovative solutions that will enhance the quality of care and improve patient engagement while reducing unnecessary burden among stakeholders. And this is going to focus on what is the problem, what we have looked at in terms of the solution.

We will be talking a little bit about the purpose behind NCVHS, which serves as the statutory public advisory body to the secretary of Health and Human Services for health data and focus on their aspect of implementing HIPAA where HITAC really focuses on the ability to inventory the kinds of information that each party will provide for supporting an interoperable environment and ensuring that all of the components within the ecosystem will be able to implement the health information technology infrastructure both nationally and locally and advance the electronic access exchange and use of health information. So, we talked about that. Then, we focus on the standards analysis. And this really comprised of us coming up with the data classes, the work that we did to analyze the standards, the invitation to all of the partners and stakeholders who came and spoke to us that represented all of the different types of work that they're currently doing.

Our analysis of these standards and stakeholders and what that means to the overall landscape. And the ability to use these components to outline and drive our ideal state and our guiding principles and our recommendations. Then, we move on to our findings and recommendations, which include a description of our ideal state as well as the guiding principles. And we had eight guiding principles that we defined, which may be supplemented by the work that Alix reviewed with you earlier today on the broader intersection. And then, focus on all of the recommendations that we made. And I think we had 12 or 13 recommendations that also might grow as a result of the work that we did today. And then, we will have some amount of summary and conclusion. But that's just a brief overview of what we will be including in the report. And I think we have now one minute to go to public comment. So, let's do that and we'll come back for questions.

Alix Goss

So, while we're cuing that up, I just want to do one last little thought here while they're cuing that up that one of the appendices will be the meeting presentation summaries we released for task force review. A complete summary of all the presenters. And we thank those individuals that gave us feedback. We're

incorporating that and that will become an appendix of probably about 30 to 40 pages alone for summarizing that. Lauren.

Public Comment (01:19:12)

Lauren Richie
Great. Thanks, Alix. We'll ask the operator to open the line.

Operator
Yes, thank you. If you would like to make a comment, please press star 1 on your telephone keypad. A confirmation tone will indicate your line is in the cue. You may press star 2 if you would like to remove your line from the cue. And for participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys. Once again, it is star 1 on your telephone keypad.

Lauren Richie
Thank you. And do we have any comments in the cue?

Operator
There are no comments at this time.

Lauren Richie
Okay. Back to you, Alix.

Sheryl Turney
Alix, do we want to throw back the outline?

Alix Goss
Yes. But that would be up to the Excel. I didn't stop sharing. Did you stop sharing my screen?

Next Steps (01:20:18)

Sheryl Turney
They're making it bigger. Okay. So, let's open it to the task force. Any questions or comments on the outline of the draft report? The expectation is that we are going to work with the editor after today's meeting, Alix and I, and get a draft of the report out to everyone by Friday so that you can review it, provide your comments. And then, the next couple of weeks we will spend iterating the changes related to the final draft, which are due to be delivered to HITAC by October 14.

Alix Goss
So, what that really means is that we would like it if folks could find time next week to review the compiled draft report that will follow this outline because so far, I'm not seeing any hands come up, Sheryl. So, I'm perceiving that as support for the flow that you walked us through. And thank you for Andy giving us a checkmark thumbs up. And so, what would happen is we'll work through the initial draft, try to clean it up as much as possible. And there will be instructions that we'll send out for how we will ask you to review and comment on it. But we may also have a scenario that we envision of needing to ask folks to give us some very specific content or concepts to bridge gaps that we identify or to help bolster up a particular section.

So, we've noticed in our review with the editor that there are some questions from somebody who has not actually been in the weeds of trying to pull all of this together. Instead of trying to make up what we think are the linkages, we're likely to ask some folks who have done some synthesizing work to date to maybe give us the missing concept.

Or if we point something out, we want to ask you about it just to make sure that we're not misinterpreting what people may have submitted. And so, we will provide a complete draft that likely has some comments and maybe points out a request to those who have done a tremendous amount of work. And we just want to make sure that we're not monkeying with things that you may have intended as we try to wordsmith for flow and one voicing.

Sheryl Turney
Very well said, Alix. I still see no hands raised. Why don't we go to the next slide then in the deck? And we can review the next steps. Have there been any folks that have raised their hand for public comment?

Operator
There are no comments at this time.

Sheryl Turney
All right. So, just to recap, we've done the prior authorization synthesis. We've done meeting presentation summaries and reviewed those. Now, we've reviewed the report outline. Now, we're going to work on incorporating the broader intersection content. And then, we're going to distribute a complete initial draft by October 2. The next two weeks are going to be focused on getting your input on that draft and iterating that draft to a state that we'll be happy to present to HITAC. Also, in the meantime, Alix and I will be working on the deck that will go to HITAC for the update of the recommendations to them. And then, our expectation is to review this at the HITAC meeting on October 21. And then, discuss the comments that come back from HITAC with this group on October 27. Any questions on our next couple of weeks? All right. I guess that's a wrap. Alix, would you like to end with any comments?

Alix Goss
At this point, I'm just eager to get the complete draft in their hands and have them give us another round of really thoughtful comments and feedback. I really do think that we are on the cusp of pulling together a report that can help move the needle, not only on prior authorization but help inform downstream efforts that further advance the intersection of clinical administrative data and that the organizations that have authority can actually help move the needle by further collaboration, which is what got us to this task force in the first place. So, I'm getting really excited for what's going to happen over the month of October.

Sheryl Turney
Well said. I'm giving you a hand.

Alix Goss
Thank you. Right back at you, Sheryl.

Sheryl Turney

I see no one with their hand raised, so we'll turn it over to Lauren for the next meeting. But thank you, everybody. Thank you, everybody for not only today but your input, your commitment to this long time period to get to this point and help us keep it going so we can come up with the best product possible.

Lauren Richie
Thanks, Sheryl. And we shall meet again next week on October 6. Thanks, everyone. Have a good day.

Adjourn (01:26:23)