ANSI Antitrust Policy

ANSI neither develops standards nor conducts certification programs but instead accredits standards developers and certification bodies under programs requiring adherence to principles of openness, voluntariness, due process and non-discrimination. ANSI, therefore, brings significant, procompetitive benefits to the standards and conformity assessment community.

ANSI nevertheless recognizes that it must not be a vehicle for individuals or organizations to reach unlawful agreements regarding prices, terms of sale, customers, or markets or engage in other aspects of anti-competitive behavior. ANSI’s policy, therefore, is to take all appropriate measures to comply with U.S. antitrust laws and foreign competition laws and ANSI expects the same from its members and volunteers when acting on behalf of ANSI.

Approved by the ANSI Board of Directors May 22, 2014
To ensure the success of the industry’s shift to Value Based Care

Transform out of Controlled Chaos:
Develop rapid multi-stakeholder process to identify, exercise and implement initial use cases.

Collaboration:
Minimize the development and deployment of unique solutions. Promote industry wide standards and adoption.

Success Measures:
Use of FHIR®, implementation guides and pilot projects.
Da Vinci 2021 Multi-Stakeholder Membership

**PROVIDERS**
- athenahealth
- Cerner
- Epic
- healow | Insights
- veradigm
- MultiCare Connected Care
- OrthoVirginia
- Providence St. Joseph Health
- OHSU
- Texas Health Resources
- UC Davis Health
- UNC Health Care
- Weill Cornell Medicine

**EHRs**

**PAYERS**
- *Anthem*
- *Blue Cross Blue Shield of Alabama*
- *Blue Cross Blue Shield of Tennessee*
- *Cambia*
- *Cigna*
- *HCSC Health Services Corporation*
- *Humana*
- *Independence*
- *UnitedHealthcare*

**DEPLOYMENT**
- Availity
- MHIHN
- CHANGE HEALTHCARE
- Cognizant

**VENDORS**
- casenet
- cognosante
- edifecs
- infor
- InterSystems
- juxly
- mcg
- OPTUM
- surescripts
- ZeOmega

**INDUSTRY PARTNERS**
- HIMSS
- HL7 International
- NCQA

*Indicates a founding member of the Da Vinci Project. Organizations shown in primary Da Vinci role. Many members participate across categories.*
### Use Case Focus Areas

**Quality Improvement**
- Data Exchange for Quality Measures STU2
- Gaps in Care & Information
- Coverage Requirements Discovery STU2
- Documentation Templates and Rules
- Prior-Authorization Support

**Coverage / Burden Reduction**
- Member Attribution
- Risk Adjustment

**Process Improvement**
- Clinical Data Exchange
- Payer Data Exchange
- Payer Data Exchange: Formulary
- Payer Data Exchange: Directory
- Payer Coverage Decision Exchange
- Patient Cost Transparency

**Use Case**
- HL7 Standards Progress
- Publishing
- Balloting
- Build
- Future

**Aligning with Rules**
- Named or supports final CMS or ONC rule
- Aligned with specific ONC or CMS rule
Sample Project Timeline

IG Development
- Discovery
- Assemble Team
- Requirements
- RI Tech Approach

RI Development
- Build Initial RI
- Test RI
- Update Final RI
- Build Data Set
- Build Test Set

Project start

Week
- 0
- 2
- 4
- 6
- 8
- 10
- 12
- 14
- 16

Represents 4 weeks
2 - 4 sprints

Specify profiles, ...
IG Framework
Create Draft IG
Revise and Finalize IG

FHIR Gap Analysis

Work with appropriate HL7 workgroup for IG sponsorship and input
How Da Vinci Solves Business Challenges
# Patient - Payer Data Access APIs

| Use Case          | Status   | Core Capabilities                                                                                                                                                                                                 | Regulatory Impacts                                                                                                                                                                                                 | Implementer Progress                                                                                                                                                                                                 |
|-------------------|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Payer Data Exchange | STU1     | Enables a health plan to share key clinical data and patient history with application of patient’s choice.                                                                                                         | CMS Interoperability and Patient Access final rule (CMS-9115-F) – enforcement begins on July 1, 2021 – use to make patients’ clinical (USCDI) data available via Patient Access API.                                               | 6 Connectathons  
Active implementations underway, emerging vendor and payer go lives in preparation for 7/1 rule.                                                                                                                |
| Formulary         | STU1     | Enable payers to share drug estimated cost and information (drug formulary) for patients/consumers applications. Improves clarity of patient cost under current or potential health plan. Improve consumers ability to shop plan coverage better.                    | CMS Interoperability and Patient Access final rule (CMS-9115-F) – enforcement begins on July 1, 2021 – use to make formulary information available via the Patient Access API and via publicly accessible API. | 6 Connectathons  
Active implementations underway, emerging vendor and payer go lives in preparation for 7/1 rule.                                                                                                                |
| Directory         | STU1     | Enable patient to more easily understand what providers, facilities, pharmacies are in the network covered by the current or potential future plan. Increases transparency of available service providers at patient specific level.          | CMS Interoperability and Patient Access final rule (CMS-9115-F) – use to make provider directory data available via publicly accessible API.                                                                         | 6 Connectathons  
Active implementations underway, emerging vendor and payer go lives underway.                                                                                                                                   |
| Patient Cost Transparency | Discovery | Provide data exchange standard in support of payers and providers to display cost information to patients in advance of services.                                                                                  | Rules Impact Evaluation Underway  
  • Consolidated Appropriations Act HR-133 (No Surprise Billing)  
  • CMS Transparency in Coverage Final Rule (CMS-9915-F) 1/1/2022  
  • Hospital Price Transparency – 1/1/2021 | N/A                                                                                                                                                                                                            |
Implementation Guides (IG) Options for Patient Directed APIs

FHIR IG

- Da Vinci Directory (PLAN NET)
- Da Vinci Formulary
- Da Vinci Payer Data Exchange PDEX* for Clinical Data
- CARIN IG for Blue Button ® for Payer and Pharmacy Claims Data
- CARIN Real Time Benefit Check for Pharmacy

FHIR Resource Definition

- Patient Direct API 1/1/21 Directory Access API
- Other related regulation

FHIR Accelerator Commentary

1. CMS has proposed use of specific guides in December Reducing Burden NPRM
2. FHIR Community is working collaboratively to ensure the specific guides meet needs of the final PAAPI rule and the proposed rule
3. All guides are Draft Standards for Trial Use (DSTU and approved or moving towards a published version of STU1.
4. NOTE: Da Vinci Directory and CARIN Real Time Benefit Check for consumer facing applications does not fall under 7/1/21 Patient Directed API regulations but is called out in NPRM and as a resource on other proposed rules
5. CMS has added provider to payer and payer to payer requirements to leverage this subset and additional named FHIR IGs.
Health Record Exchange (HRex)

Benefits
- Creates a consistent framework to exchange clinical data between Providers and Payers
- Enables consistent, constrained use of FHIR and US CORE profiled data specific resources across all Da Vinci data exchange Implementation Guides
- Focuses on nuance of resources like Provenance which differs by collection source, or resources currently not yet in USCDI and US Core e.g., Coverage
Payer Data Exchange (PDex)

Benefits
- Creates a full picture of all patient activities
- Providers may be unaware of all the patient clinical activities outside their facility
- Addition of payer-based data expands the scope of information available to the patient and provider to support clinical decision-making and care planning
- Improves quality of information shared by using FHIR standard

Provider data from CDAs and other sources
- Alerts (e.g., ADT)
- Immunizations
- Laboratory (e.g., national labs)
- PBM (meds)
- EOB
- Adjudication
- Claims

System of record
Data Extract Definition

PDex Information Sources/Flow
Payer Data Exchange (PDex): Provider Directory

Benefits

• Provides a standard approach for requesting and receiving Provider information based on a patient’s Insurance plan
• Enables directory to be called as a service by applications for integration of provider search into workflows
• Supports patients’ ability to find providers across multiple plans
• Increases transparency to patients about provider availability in their plan
Payer Data Exchange (PDex): Formulary

<table>
<thead>
<tr>
<th>Medication Copays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med</td>
</tr>
<tr>
<td>Med1</td>
</tr>
<tr>
<td>Med1</td>
</tr>
<tr>
<td>Med3</td>
</tr>
</tbody>
</table>

What are my medications?
Medication1, Medication2, Medication3
RxNorm

Tell me about Medication1
Medication1 info
Tell me about Medication2
Medication2 info
Tell me about Medication3
Medication3 info

Electronic Health Record from Provider

Formulary Service

Benefits
- Enables patient and provider applications to understand basic information about their plan or potential plans formulary coverage
- Patients can understand the tier and alternatives for drugs that have been prescribed, and to compare their drug costs across different insurance plans
- Improve transparency for patients shopping new plans, or seeking to understand alternative options vs current PDF
- Free data to be used by consumer facing applications to improve shopping options

Mobile app determines the cost of each medication under patient's current health plan
### Payer to Payer APIs

<table>
<thead>
<tr>
<th>Use Case</th>
<th>Status</th>
<th>Core Capabilities</th>
<th>Regulatory Impacts</th>
<th>Implementer Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer Data Exchange</td>
<td>STU1</td>
<td>Enables a health plan to share key clinical data and patient history with application of patient’s choice.</td>
<td>Rules Impact Evaluation Underway CMS Interoperability and Patient Access final rule (CMS-9115-F) — use to make patients’ clinical (USCDI) data available to new Payer, named specifically as a proposed resource in 2020 NPRM CMS-9123-P</td>
<td>6 Connectathons</td>
</tr>
<tr>
<td>Coverage Decision Exchange</td>
<td>STU1</td>
<td>Ability for payer to share active treatment to increase continuity of care. Includes current utilization management decisions and supporting data. Focus is to reduce rework by patient and provider when patient changes coverage</td>
<td>Rules Impact Evaluation Underway Functionality meets requirement for January 1, 2022 initially introduced in CMS Interoperability and Patient Access final rule (CMS-9115-F) — use to make patients’ clinical (USCDI) data available to new Payer, referenced as a resource in 2020 NPRM CMS-9123-P</td>
<td>6 Connectathons</td>
</tr>
</tbody>
</table>
Payer to Payer Exchange:
On the Way to Patient Access & Portability with FHIR APIs

1. Establish Patient Access
   - Patient Access via 3rd Party Apps + FHIR APIs

2. Establish Patient-Directed Portability
   - Patient Access Enhanced by FHIR-Enabled Payer-to-Payer Exchange

Patient Access and Portability with Longitudinal Health Records through Standards-based FHIR-enabled APIs

Realizing the vision of patient access and interoperability
- Regulations that set the vision and participation in an interoperable healthcare ecosystem
- Standards for implementers – built, tested, and refined by implementers to coalesce information and exchange methods
- Technology and policy to promote privacy, security, and personalized experience for patients, caregivers, providers, payers, developers in an innovative community

Timeline:
- 2021
- 2022
- 2023
- 2024
- 2025
- 2026 ...

16
Opportunity to Further Interoperability

• CMS Regulation for Payer to Payer sets a minimum bar for electronic data exchange
• Advanced interoperability requires codified data that is computable
• Da Vinci community members are promoting early adoption of Payer Data Exchange (PDex) as their FHIR API of choice for January 1, 2022 deadline
• Goal is to voluntarily meet and exceed rules set by CMS for patient access via 3rd party applications, where minimum is FHIR API

While technical term is payer to payer, this work will improve patient’s portability across payers, and reduce burden on patient and providers to reshare critical clinical patient information.
Payer Coverage Decision Exchange

**Benefits**
- Supports continuity of treatment when patients enroll with a new payer by enabling a transfer of “current active treatments” between the prior payer and the new payer
- Reduces the need for providers and/or patients to resubmit supporting documentation to the new payer in order to continue patient treatment
- Reduces interruption in care plan and medication adherence
- Reduces waste and rework by all parties

**Diagram Description**
- **Patient enrolls in new plan**
- **Member Authorization**
  - **Current Treatments**
  - **Conditions/Diagnoses Supporting Each Treatment**
  - **Clinical Guideline References (where appropriate)**
  - **Scope of Prior Authorizations (where appropriate)**
  - **Supporting Documentation**

**PAYER 1**
- (“new payer”)

**PAYER 2**
- (“old payer”)

**Notes**
- PAYER 1
- PAYER 2
<table>
<thead>
<tr>
<th>Use Case</th>
<th>Status</th>
<th>Core Capabilities</th>
<th>Regulatory Impacts</th>
<th>Implementer Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>STU1 Published</td>
<td>A defined format to send unsolicited notifications to the appropriate actors when</td>
<td>May be leveraged to meet ADT notification for select health systems</td>
<td>6 Connectathons</td>
</tr>
<tr>
<td></td>
<td></td>
<td>triggered by an event or request. Provides enough information to understand what</td>
<td></td>
<td>In wait mode until FHIR subscription model is matured in R5.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the notification is about.</td>
<td></td>
<td>Several community members have leveraged this utility IG across several early adoption FHIR project.</td>
</tr>
<tr>
<td></td>
<td>STU1 Ballot</td>
<td>Ability to enable provider to share clinical data to payers, other providers in</td>
<td>None</td>
<td>9 Connectathons</td>
</tr>
<tr>
<td></td>
<td>Reconciliation</td>
<td>workflow</td>
<td></td>
<td>Multiple early adopter projects in flight across several workflows.</td>
</tr>
<tr>
<td></td>
<td>STU1 Published</td>
<td>Enables a health plan to share key clinical data and patient history with application of patient's choice.</td>
<td>Rules Impact Evaluation Underway CMS proposed extension of this IG to support Provider to Payer exchange of prior authorization data in December 2020 NPRM CMS-9123-P Specific guide named in NPRM</td>
<td>6 Connectathons Early adoption underway. Some delay for provider implementations due to COVID response and impact at provider organizations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide data exchange standard in support of payers and providers to display cost</td>
<td>Rules Impact Evaluation Underway</td>
<td>Public calls TBD</td>
</tr>
<tr>
<td></td>
<td>Discovery</td>
<td>information to patients in advance of services.</td>
<td>• Consolidated Appropriations Act HR-133 (No Surprise Billing)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• CMS Transparency in Coverage Final Rule (CMS-9915-F) – 1/1/2022</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Hospital Price Transparency – 1/1/2021</td>
<td></td>
</tr>
</tbody>
</table>
Notifications

Site Where Notifiable Event Occurred

Potential Interactions:
1) Push to “registered” member (perhaps via payer care team information)
2) Push to intermediary

Any care team member can be connected directly or via an intermediary (e.g., HIE)
### Reducing Prior Authorization Burden

<table>
<thead>
<tr>
<th>Use Case</th>
<th>Status</th>
<th>Core Capabilities</th>
<th>Regulatory Impacts</th>
<th>Implementer Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Requirements</td>
<td>STU1 Published</td>
<td>Enables exchange of coverage plan requirements from payers to providers at the time of treatment decisions, patient specific with a goal to increase transparency for all parties of coverage that may impact services rendered i.e., is prior authorization required, are there other predecessor steps; lab tests required, physical therapy</td>
<td>Named in the NPRM CMS Interoperability and Prior Authorization (CMS-9123-P) by January 1, 2023, FHIR-based DRLS API</td>
<td>9 Connectathons Early adopters and pilots underway</td>
</tr>
<tr>
<td>Discovery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation Templates</td>
<td>STU1 Published</td>
<td>Builds on CRD to specify how payer rules can be executed in a provider context to ensure that documentation requirements are met. Provider burden will be reduced because of reduced manual data entry, i.e., electronic questionnaires from payers, extract data to pre-populate response</td>
<td>Named in the NPRM CMS Interoperability and Prior Authorization (CMS-9123-P) by January 1, 2023, FHIR-based DRLS API</td>
<td>8 Connectathons Early adopters and pilots underway</td>
</tr>
<tr>
<td>and Rules</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior-Authorization</td>
<td>STU1 Published</td>
<td>Defines FHIR based services to enable provider, at point of service, to request authorization (including all necessary clinical information to support the request) and receive immediate authorization from Payer (incorporates HIPAA Tx standards)</td>
<td>Named in the NPRM CMS Interoperability and Prior Authorization (CMS-9123-P) by January 1, 2023, FHIR-based electronic Prior Authorization Support API</td>
<td>6 Connectathons Early adopters and pilots underway</td>
</tr>
<tr>
<td>Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DRLS = Document Requirements Lookup Service (DRLS) is CMS’ name for the combination of CRD + DTR.

Coverage Requirements Discovery, Documentation Templates & Rules, & Prior Authorization Support

- Improve transparency
- Reduce effort for prior authorization
- Leverage available clinical content and increase automation
Coverage Requirements Discovery (CRD)/ Documentation Templates & Rules (DTR)

Benefits

• Takes guesswork out of patient specific coverage by sharing authorization or process requirements in workflow

• Improves transparency of patient and procedure specific rules to provider and patient

• Exposes information about patient benefits when care team is most likely with or near patient, so options can be discussed and decided upon
### Use Case

<table>
<thead>
<tr>
<th>Use Case</th>
<th>Status</th>
<th>Core Capabilities</th>
<th>Regulatory Impacts</th>
<th>Implementer Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Exchange for Quality Measures</td>
<td><strong>STU2</strong> Published</td>
<td>Focus is on creating a framework to make quality measure collection, attestation and proof identifiable, collected and transported between trading partners in a repeatable way. Work underway to expand examples.</td>
<td>No current regulatory impacts</td>
<td>8 Connectathons In production across multiple payer-provider sites. Often initial use case selected for high financial and shared value across trading partners.</td>
</tr>
<tr>
<td>Gaps in Care &amp; Information</td>
<td><strong>BALLOT</strong> Reconciliation</td>
<td>To support value-based data exchange by: Represent open and closed gaps in care Define how providers and payers can be informed of gaps and closings Define a close the loop framework between vendor/payer and providers.</td>
<td>No current regulatory impacts</td>
<td>9 Connectathons</td>
</tr>
<tr>
<td>Clinical Data Exchange</td>
<td><strong>BALLOT</strong> Reconciliation</td>
<td>Ability to enable provider to share clinical data to payers, other providers in workflow.</td>
<td>No current regulatory impacts</td>
<td>7 Connectathons</td>
</tr>
<tr>
<td>Member Attribution</td>
<td><strong>STU1</strong> Publishing</td>
<td>Provides ability for trading partners to validate patients/members in common to ensure for secure transfer of correct population. Developed to streamline matching for DEQM use case. Expanded as applicable across many FHIR APIs</td>
<td>No current regulatory impacts</td>
<td>3 Connectathons In production or early adopter projects across multiple payer-provider sites. Seen as a utility across many early adopters.</td>
</tr>
</tbody>
</table>
Data Exchange for Quality Measures

1. Submit

Aggregator or Provider

Submit Measure Data

OperationOutcome

Payer

2. Collect

Payer

Collect Measure Data

Return Measure Data

Provider

3. Subscribe (future)

Aggregator

Subscribe for Measure Data

OperationOutcome

Provider

Benefits

- Quality measures are defined as computable artifacts
- Framework automates data collection and quality measure reporting
- Eases the burden of identifying quality measures applicable to specific patients
- Minimizes the burden of manual data abstraction for measure reporting

Benefits

- Quality measures are defined as computable artifacts
- Framework automates data collection and quality measure reporting
- Eases the burden of identifying quality measures applicable to specific patients
- Minimizes the burden of manual data abstraction for measure reporting
Gaps in Care

**PAYER**

Analysis triggered (e.g., patient enrollment, scheduled, etc.)

**PROVIDER**

Request triggered (e.g., patient visit, eligibility check, manual, etc.)

Based on measure criteria, payer determines qualifying patient data is missing

**Provider System/EHR**

- Receives list of patients/gaps
- Automatically or manually queried for missing data or exceptions
- Missing Data Found
- Service performed

Patient list with gaps identified

Provider sends new data to payer

**Benefits**

- Facilitates the exchange of gaps in care and quality measures between providers and payers
- Identifies gaps based on patient criteria and contractual agreements
- Supports the exchange of clinical data to close clinical and information gaps prospectively vs retrospectively
- Leverages the FHIR-based, quality measure framework
- Reduces manual data retrieval and cost associated with current practices
- Gets the right triggers to right end users in patient care workflow increasing probability of positive impact
- Improve quality of information shared by using FHIR standard
- Can be used for single patient or with population of patients
**Member Attribution**

**Benefits**
- Allows the provider and payer to establish and maintain an accurate list of patients that are attributable to the provider
- Attribution list supports exchange of other information including gaps in care and quality measures
- Creates common format across payers and providers, reducing waste and maintenance

**Diagram:***
- **PRODUCER** (e.g., Payer)
  - Producer creates initial attribution list
  - Producer adjusts algorithm/list
  - Producer starts sending list on agreed upon cadence
- **CONSUMER** (e.g., Provider)
  - Consumer receives list & historical information
  - Consumer reconciles list via their own attribution algorithm
  - Request Changes needed
  - No changes needed
  - Consumer loads data to various systems to support various use cases

---

27
## Emerging or Future Use Cases

<table>
<thead>
<tr>
<th>Use Case</th>
<th>Status</th>
<th>Core Capabilities</th>
<th>Regulatory Impacts</th>
<th>Implementer Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Adjustment</td>
<td>Discovery</td>
<td>Creating standard methodology (format) for payers to communicate coding gaps to providers for an individual or a group of patients.</td>
<td>None</td>
<td>Public calls started in March 2021</td>
</tr>
<tr>
<td>VBC Cost Performance Reports</td>
<td>Identifying Participants</td>
<td>Timely and accurate information exchange within the performance period. Focus on information that only a payer would have financial targets, spend, CCFs and quarterly quality payments. Information at lowest level of granularity. Access via APIs.</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Performing Laboratory Reporting</td>
<td>TBD</td>
<td>Goal is to share clinical details of specific lab results between providers, payers and lab partners. Only a small fraction of lab data flows today. Define framework to expand breadth and scope of data exchange.</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Patient Data Exchange</td>
<td>TBD</td>
<td>Enable exchange of patient reported data to payer and provider partners.</td>
<td>None</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Join the Da Vinci Community
Da Vinci Community Support

Most Recent Slides and Updates

Objective

Da Vinci is a private sector initiative that addresses the needs of the Value-Based Care Community by leveraging the HL7 FHIR platform. Join us on the Welcome page.

Join us for the monthly public Community Roundtable

- **Next session:** January 27, 2021
- Standing day/time is fourth Wednesday of the month from 4-5:30 p.m. EST
- Missed a session? Prior session recordings available on the video presentations page.

Select your tracks and register now for HL7’s Virtual FHIR Connectathon 26

- January 13-15, featuring three days of hands-on FHIR development and testing.
- Implementers and developers can gain hands-on experience developing FHIR-based solutions.
- Review event details and register now! Early Bird Registration is available until December 30, 2020.

Reminder: Vote for the 2021 January Ballot Cycle by 1U

- Da Vinci Implementation Guides included in this cycle CDERs
- For more information, 2021 Jan Announcement for Consensus Group

ONC/CMS Rule Updates

Da Vinci Response to CMS Reducing Burden NPRM

Patient Access API - New Q&A Page here!

Da Vinci is seeking answers to open questions and clarifications needed on the implementation and operational needs of the...

Page Tree Navigation Easily
Find Nested Content like Da Vinci Calendar

Community Announcements, Updates and Resources
Implementation Guide Dashboard

Quick Links & Look at All Implementation Guides

Link to Implementor Support Page
Implementor Support

FHIR 101 Resources

What you need to know about Da Vinci Use Cases

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Objective</th>
<th>Relevant Use Case(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage/Benefit Reduction</td>
<td>To implement prior authorization for home oxygen therapy, hospital admission</td>
<td>US Core/USCDC</td>
</tr>
</tbody>
</table>

Quality Improvement

Example: Drug medication reconciliation, colorectal cancer screening

- To conduct a quality improvement project on drug reconciliation

Member Access

Example: "Become a Health Care Provider"

- To enable members to access their medical information

Example diagram:

- Patient Access and Interoperability API CMS/VINN Sailing Support

Refer to CMS Interoperability and Patient Access Final rule

Implementation Guides

Overview of Implementation Guide

- Contains rules about how FHIR resources are used to solve a problem

Process Improvement

- To support business process

Clinical Data Exchange

- To support clinical data exchange

Learn about Implementation Guides

Overview of Implementation Guide

Demystifying the Implementation Guide: Data Exchange for Quality Measures (DEQM) by Linda Michelson

https://confluence.hl7.org/display/DVP/Da+Vinci+Implementer+Support
Join the Community

Sign Up for Listserv for Project Updates
Orientation Resources for Public New to Da Vinci

Create an Account to Watch Key Pages

Getting Started

1. Register for Confluence
2. Sign up for Listserv
3. Find Implementer Pages
4. Download IGs and Resources
5. Watch for Meetings, Connectathons
6. View Demo and Testimonial Recordings
7. Access Reference Implementation Code, Sandboxes
Membership Support
### Summary Ways to Engage

<table>
<thead>
<tr>
<th>Type</th>
<th>Cost (000s)</th>
<th>Vote on Operating</th>
<th>Number of Sponsored Providers*</th>
<th>Pledge Resource</th>
<th>Access to Playbook</th>
<th>Access to Use Case Artifacts</th>
<th>Provide Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>$10-90</td>
<td>1</td>
<td>1-2</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Partner</td>
<td>In Kind</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>By Partner</td>
<td>By Partner</td>
<td>By Partner</td>
</tr>
<tr>
<td>Clinical Advisory Council</td>
<td>None</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Use Case Clinical Advisor</td>
<td>None</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community</td>
<td>None</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

- Premier and Associate Members have the opportunity to nominate partner organizations to join the Operating Committee (proxy membership) and must be approved by the operating and steering committees.
- Clinical roles are appointed or contracted.
Project Structure

• All members sign identical Statement of Understanding between member & HL7
• Initial agreement 2-year commitment
• All outputs to HL7 open-source licensing for public use
• Coordinate closely with HL7 standards development process to obtain workgroup ownership of Implementation Guides
• Commitment to implement in 2021

Da Vinci expanding 2021 membership. Focus on missing stakeholders: small and community-based providers, regional, Medicaid, CHIP, QHP Plans, missing integration partners; EHRs, platforms, population health. Contact davincipmo@pocp.com if interested.
Clinical Advisory Council
Dr. Steve Waldren, AAFP
Dr. Ed Yu, Sutter Health

Governance Structure

Operational Committees

- **Clinical Advisory Council**
  - Dr. Steve Waldren, AAFP
  - Dr. Ed Yu, Sutter Health

Steering Committee

- **Payers - 3**
  - Sagran Moodley*
  - United
  - Kirk Anderson
  - Cambia Health
  - Mike Funk
  - Humana

- **Providers - 2**
  - Deepak Sadopagan
  - Providence St. Joseph
  - Dr. Michael Myint
  - MultiCare

- **IT Vendors - 2**
  - Hans Buitendijk**
  - Cerner
  - Ryan Bohochik
  - Epic

- **CMS - 1**
  - Alex Mugge
  - CMS

- **HL7 - 1**
  - Dr. Chuck Jaffe
  - HL7

Operating Committee

- Use Case 1
  - Project Lead
  - Jocelyn Keegan
  - Dr. Viet Nguyen
  - Program Manager & Technical Director

- Use Case 2
  - Project Lead

- Use Case n+
  - Project Lead

Deployment Committee

*Chair  **Co-Chair
## Existing Provider/Payer Membership Model

<table>
<thead>
<tr>
<th>Level</th>
<th>Cost (000s)</th>
<th>Operating Committee Vote</th>
<th>Sponsor Partners*</th>
<th>PMO Opportunity</th>
<th>Pledge Resource</th>
<th>Access to Playbook</th>
<th>Access to Use Case Artifacts</th>
<th>Provide Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premier</td>
<td>$90k</td>
<td>1</td>
<td>2</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Associate</td>
<td>$75k</td>
<td>1</td>
<td>1</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Deployment</td>
<td>$75 or 90</td>
<td>Sponsored Partner</td>
<td>1-2</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sponsor</td>
<td>$50k</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sponsored</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Member</td>
<td>$10k</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Contributor</td>
<td>In kind</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Structure and Operational Role Attributes

STEERING COMMITTEE

- Senior level executive, can make decisions and commit organization resources
- Driving interoperability strategy within home organization and responsible for coordination with industry
- Final vote on budget approval and high-level direction setting based upon Operating Committee direction
- Technology and business ownership to drive “business case” approval

OPERATING COMMITTEE

- Prioritization of use cases and project focus, approval for “in kind” and project fees
- Leader and/or influencer across home organization
- Work closely/aligned with senior leadership at home organization, can queue up commitment and decisions and drive to conclusion
- Understands and will own HL7 standards relationship, commitments
- Roll up sleeve and problem solve use case development and inventory, priorities, details
- Identify and gain access/time for “in kind” resources for priority use case work
Clinical Advisory Council – strategic clinical advisors for the Steering Committee and PMO
Use Case Clinical Advisor – participates in use case development as clinical SME
The Clinical Advisor provides strategic advice to the Steering Committee and Program Management Office on relevant industry direction, clinical workflow, prioritization of specific use cases and other topics relevant to Da Vinci decision making.

<table>
<thead>
<tr>
<th>Level</th>
<th>Fees</th>
<th>Advisory Council Seats</th>
<th>Access to Use Case Requirements</th>
<th>Training and Support</th>
<th>Participation In Marketing Activities</th>
<th>Provide Feedback on Use cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council</td>
<td>None</td>
<td>Individual</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Use Case</td>
<td>Non</td>
<td>None</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
New Membership Recommendation Template

Process

1. Member Completes
2. Submits to PMO
3. Review/Update
4. PMO Submits Final to Da Vinci Steering Committee for Approval
ANSI Antitrust Policy

- ANSI neither develops standards nor conducts certification programs but instead accredits standards developers and certification bodies under programs requiring adherence to principles of openness, voluntariness, due process and non-discrimination. ANSI, therefore, brings significant, procompetitive benefits to the standards and conformity assessment community.

- ANSI nevertheless recognizes that it must not be a vehicle for individuals or organizations to reach unlawful agreements regarding prices, terms of sale, customers, or markets or engage in other aspects of anti-competitive behavior. ANSI’s policy, therefore, is to take all appropriate measures to comply with U.S. antitrust laws and foreign competition laws and ANSI expects the same from its members and volunteers when acting on behalf of ANSI.

- Approved by the ANSI Board of Directors May 22, 2014
Company Name

Mission:

Vision:

Basic Description of Core Business Related to VBC

Use Cases: List Da Vinci use cases prospective member will participate in and plans to implement in 2021.

Experience: Describe role as adopter of new technology, workflows and standards. Describe current state in FHIR community and/or subject matter expertise to bring to Da Vinci work.

Senior Management: Key leadership supporting goals of DV and VBC, potential commitment to leadership of membership category beyond in kind on projects specific work. Demonstrate support for organization to participate in connectathons, early adopter with sufficient resourcing and internal support. Advocate for getting partners to the table.

Pilot Potential: Describe potential pilot projects, geographical placement to existing or new to Da Vinci organizations with a highlight toward provider.

Relevant Disclosure: Any potential conflicts or opportunities, unknown aspects of organization relevant for Da Vinci Steering and PMO to be aware of i.e., ownership stake in partners, ability to bring subsidiaries to bear on program.

Lines of Business or Wholly Owned Subsidiaries:

Company Links: Key URLs

Requested Approval Level:
- Premier
- Associate
- Sponsor
- Sponsor(ed) – Denote Sponsoring Org
- Deployment Member
- Refer to Community Member
- Differ to 2022

STATUS: To Be Completed by PMO
- Approve
- Pended
- More Information Requested

Provider/Payer Links:
- URLs to key parts of partner orgs

Primary Sponsor: Current DV members
Secondary Sponsor: Optional current DV member
Add 1 -2 Slides Max

- Include in graphical or text format
  - Geography
  - Lives Covered
  - Key partners in market
  - Key technologies in use (companies and named technology i.e. Aegis for Testing Suite and early adopter of CCDA across 15 provider/payer partners)
  - Size of organization
  - Breadth/focus of core services
  - Relevant Organization Breakdown, included parts of org likely to participate in Da Vinci actively

- Screenshots of existing content/demographic information is fine
- Goal is a summary view of assets and breadth new partner offers
Da Vinci Program Manager:
Jocelyn Keegan, Point of Care Partners
jocelyn.keegan@pocp.com

Da Vinci Technical Lead:
Dr. Viet Nguyen, Stratametrics LLC
vietnguyen@stratametrics.com

Da Vinci Project Manager:
Vanessa Candelora, Point of Care Partners
vanessa.candelora@pocp.com