HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) ANNUAL REPORT WORKGROUP MEETING
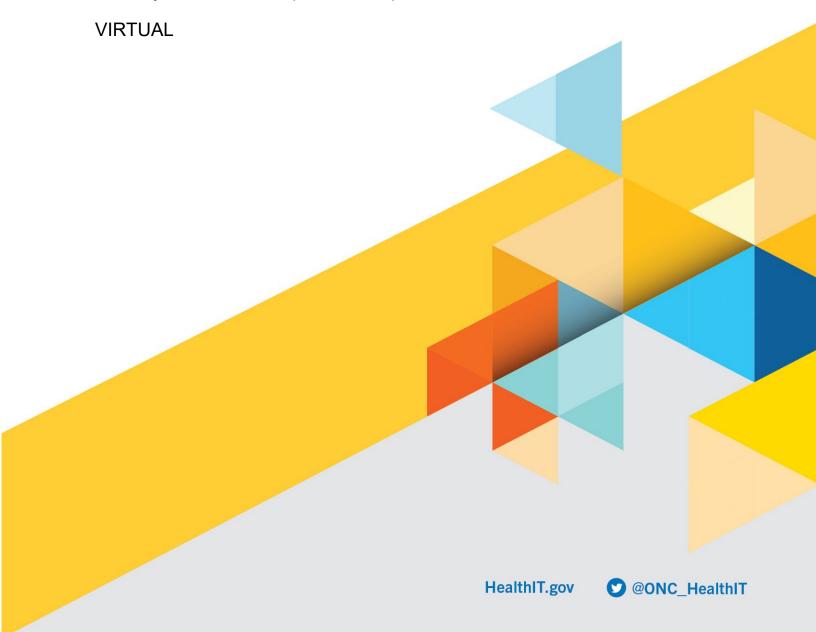
January 31, 2022, 3:30 p.m. – 5:00 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Aaron Miri	**Baptist Health**	**Co-Chair**
Jim Jirjis	HCA Healthcare	Member
Steven Lane	Sutter Health	Member
Brett Oliver	Baptist Health	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Michelle Murray	Office of the National Coordinator for Health Information Technology	Staff Lead

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

Mike Berry

Hello, everyone. Welcome to the HITAC annual report workgroup. I am Mike Berry, I'm with ONC, and we are glad you could join us today. I would like to welcome our chair, Aaron Miri, along with our workgroup members Brett Oliver and Steven Lane. We hope to have Jim Jirjis joining us shortly. I will turn it over to Aaron.

Opening Remarks, Meeting Schedules, and Next Steps (00:00:32)

Aaron Miri

Thank you. Let's get into it then. So, welcome to the last day of January, which is always fun and interesting. Here we are getting into the thick of it, and hopefully we get to goal.

I want to thank Michelle and the ONC team for their phenomenal work. I think even when we saw with the HITAC the other day, we still got some good feedback, so let us get this across the line. Let us get into it.

First, opening remarks, discussion of the HITAC report, and then of course open up to comment.

All right. Next slide. We are here. The first meeting. So really it is updating the draft and getting feedback, last pertinent comments from the HITAC, I did see a few things come across from Mr. John Kansky and others. So, a lot of folks reading the report, commenting, and adding their two cents and kudos to this team the work has been done.

We will take 17 February meeting approval for the final HITAC annual report. I will be honest, I always miss the days when we did this in person, because I always thought these discussions, the final ones to approve are the most fun. So, we will do it virtually this time of course, and get it to goal, and of course transmit this to (unknown name) (00:01:54) for his consideration to send onward, as per the law.

Again, we will go through and look at the list of all the members comments and any revisions. And then we will get approval on the February 17th meeting, and we will be transmitting it shortly thereafter.

All right, on to the comments. The fun stuff.

Michelle Murray
Do you want them to bring up the screen of comments?

Aaron Miri
Yes, please.

Michelle Murray
We will do that.

Discussion of the Draft HITAC Annual Report for FY21 (00:02:38)

Aaron Miri
All right. As always, we have color-coded cells here to keep to task and make sure we are oriented.

The first one comes from Hans, around the health IT infrastructure landscape. Again, if it is this green color, at least it is to me, maybe because of my screen calibration, maybe a light teal color. ONC looked at it and thinks makes sense to some degree that we considered as is.

But for interoperability, Hans is commenting that he really wants to add the word 'access' and 'exchange of information' for research purposes, as you see and red under the projection there. I think it is more of a semantic thing, but I think it is important because it is how we get to the data. I do not see any issues. Any issues with the group?

Steven Lane
No, that makes sense.

Aaron Miri
All right. Next one, health IT infra structure gaps and opportunities, et cetera. Again, from Hans, we appreciate him. He is so thoughtful with his comments.

It is written comment for future discussion is record completeness, how to achieve completeness for record of a patient across data sources without compromising the identified data cannot come together until it is aggregated across sources? ONC recommends placing this at the top of the list for the FY22 report.

If I had to guess what Hans is alluding to, I do not know, I have not spoken to him, but it seems related to sending data or some sort of granular consent, as far as I can describe. What do you all think?

Steven Lane
I think he is just getting at, as it suggests, the notion of completeness. The question of course is that you do not know what you do not know, so you never know what could be missing.

But I think it is something that we should consider in the future. You know, how to assess completeness. You know, as we get into some of the PP2PI discussion on granular privacy restrictions, there is the whole aspect of that which is to say that, well, there is something we are not sending you. This is the type of data it is, but we are not going to tell you the data, we are just going to tell you there is some meds missing or there is a problem missing or something like that.

I do not know if that is relevant here, but it certainly is the first thing that comes to my mind. I am not sure how else you can get at record completeness.

Aaron Miri

Defining EHI? You could say the DRS and EHI elements within the DRS. Let's stop using actions words. The designated record set, what is electronic health information within that, therefore all those components can be another way. Jim?

Jim Jirjis

I interpret his comments more as across data sources, right? So, we can have a designated record set, but if you have four places that a patient has been, and three of them are contributing records in the fourth is not, then you have an incomplete record.

Not that any given entity did not designate a record set, but maybe it is both, Aaron.

Speaker

Somewhat like you are aware that there is data from a given source, and you do not have it. You do not have it from an NRS, a national record locator service, but you do not actually have the contents of those encounters and those results.

Speaker

Let us have a use case. Let us say that an organization now, in the course of seeing patients, is getting USCDI information back, and identifies that their relationship with the patient, the patient has a mild heart valve abnormality, and they have an operational campaign to make sure that patients like that see a cardiologist.

If our records are complete, then we have the confidence that there is not already a cardiologist following the patient for that problem.

But maybe that foresight that is not contributing information means that we have an incomplete national access to the full data record set, and therefore bad decisions might be made.

Aaron Miri

And I think that jives with what I was saying. The only way to know that it is incomplete is to have some indication that result exists someplace or data exists in place but that you do not have it.

I think it is worth talking about for next year.

Aaron Miri

What do you think? You're trying to say something, right?

Brett Oliver

I was going to agree with you, I think it is a matter of defining what each of those categories mean. So that when you say that for the organization, for instance, is not contributing. What are they contributing?

Whether they have got it or not, we need to know that this is what it is supposed to be, or this is what is expected.

Aaron Miri

And they even know what they are supposed to contribute? As I'm going through this with my organization, we are trying to define all the EHI elements to make sure we are in compliance for this October, it is amazing even getting vendors to agree and understand what they should be contributing to this total sum of data to compute the record. So, it is everything about a patient, there is so much variability. It is crazy right now.

Jim Jirjis

Aaron, to add to that, we are with you. I know that Steven Lane's group is doing it, too. As we go through the possible EHI from the (unknown term) (00:08:20) record, many of us will be using the feasibility

exception for some of those data elements. There may be a mosaic of differences between providers on what is a feasibility exception, so you do not have the confidence that you are fully receiving everything, because it is infeasible, etc.

It is not complete yet, so still can't make good decisions. A great example is Health Guerilla. If you have a company who is looking for gaps in care, they are only going to be as accurate and precise with no false positives or negatives, if they have a complete record.

Otherwise, it will look like there is a colonoscopy gap when in fact there was a colonoscopy, but the site that did it said it was infeasible.

Steven Lane
It will be an interesting area to drill down.

Aaron Miri
All right, so we will table that, Michelle. But it is a good one. We really should look at that.

Next idea here in our feedback. I'm sorry, that was a green one. This is the bidirectional comment.

The health IT infrastructure gaps opportunities. The comment is a gap focused on data going back to community, really about bidirectional feed. This goes along everything we have been saying. It needs to be a two-way street versus a one-way street. So, he is adding that in that red text.

Steven Lane
I love Hans, he is brilliant. When I think about population reporting, I always think about it going one direction. And I have been a vocal champion of bidirectional public health data exchange.

But I always thought of it from the perspective of the individual patient. I have a patient; I want to know what public health knows about them.

But the idea that even as an organization or an entity, I might have a population of patients and I want to know if public health knows about all of them.

So, the idea of being able to pull population or bulk level data from public health into, say, a provider, I think that is brilliant, and I have literally never heard that mentioned.

So, I think that is what Hans is getting at here.

Aaron Miri
Seems to be. Makes complete sense.

Jim Jirjis
Some of the discussions we have at the CDC and White House task force and stuff, when asked for feedback, we said look, we are spending all of her time contributing info, but we would like to benefit from the info, for example during COVID, to know exactly what the status was in our city.

And I think it may also be a response to that request.

Steven Lane
For sure. Whether you are a provider, pay-vider, a payer. You can imagine a lot of situations.

Aaron Miri
I would say if you have a bidirectional, why could a patient (indiscernible) (00:11:19).

Steven Lane

Absolutely, but that is on the individual. But thinking about population level data. Hopefully we are not going to have patients pulling down all of their neighbors.

Aaron Miri

You never know, sophisticated patients these days!

Steven Lane

On to Mr. Kansky!

Aaron Miri

Hold on a second here. So, Brett, are you good with this one?

Brett Oliver

Yeah, absolutely. One hundred percent.

Aaron Miri

Perfect.

Steven Lane

Aaron, you are the best. Get all the voices.

Aaron Miri

I got to get all the voices. That is the goal here.

Steven Lane

You got three of us, you can do that, right?

Aaron Miri

Absolutely. Infrastructure gaps targeted at public health, Mr. Kansky's comment here: a written principle of (indiscernible) (00:12:00) agreements is that there is general agreement that inaccuracies in public health infrastructure; HITAC should help explore the options to inform stakeholder agencies or at least recommendations. So, it has multiple approaches here.

Option 1: CDC, federal government would create a top-down infrastructure. He said please no.

Option 2: the existing nationwide infrastructure of EHI should be the basis of nationwide public health reporting.

Option 3: statewide health data utilities, HIEs, aggregate data from EHR should exist in each state and be the basis of nationwide public health reporting.

There will be a little difficult, considering the variation of data mapping and data calibration in states.

It says the recommendation from ONC is, we should discuss along with recommendations for opportunities and recommended HITAC activities that follow. So, these three or others, or a combination of such, right, generally is that we need to start figuring out what the rules of the road are, is what I am reading into this from Mr. Kansky, and I don't want to say the accrediting agency, that is terrible words, what does the oversight group help us develop? I think that is what he is trying to ask.

Steven Lane

I think there is more to it than that. It is interesting how these are presented as distinct options, suggesting one might be choosing between them. But I think, in my opinion, the way he phrases Option 3 suggests, as I know John, he thinks is a good idea, that every single state should have a designated health data utility.

That they either can or must leverage to support this public health interoperability. I think there are a lot of ways, there are a lot of opinions about that. Whether that something that should be supported in those states or regions where it exists and has been proven to be functional, whether it is something that should be required. I know in my state there is a handful of folks were trying to force everybody to drive their data through a regional HIE instead of directly to the state where that can be done.

I agree there are a number of options that could be used here, I also agree we should support the use of various options where they are fruitful, but I think that there is a lot of devil in these details. I stop short of feeling we are in a position to require this in every corner of the land simply because we do not have partners in those positions that we could really always rely on.

Aaron Miri
Good point. Jim?

Jim Jirjis
One question I have about this is I am not sure what the difference between option two and option three is. If we look at TEFCA and if you have a (unknown term) (00:15:00), because one of the things we suggested was using the existing infrastructure of TEFCA and USCDI and one notion could be that you have a (unknown term) (00:15:12) that is dedicated to public health. That does not mean that state HIEs cannot be participants.

I'm trying to figure out, is the comment here, to me that would be creating a whole different system and do not leverage what else is happening in the country. So, is the question here does HITAC provide guidance and recommendations for hearing what the public 9indiscernible) (00:15:44) already being built? What is the question?

Aaron Miri
Typically, what we do is we basically try to double-click and say what is here, what are the ingredients that go into the sausage? And then from that it eventually derives into a work group to really go double-click on it; or we come up with recommendations as to an approach. I do not know what our authority is going beyond that more than an investigative and figuring out and saying what are the bugaboos of potential barriers.

Michelle, maybe you can elaborate on the comment. We have done a lot of this. We do listening sessions and more with the NCVHS to learn more which seems to be in line with what John is recommending we do. Were we missing something? Because it seems like we are on the path to eventually get to an approach. We just don't know what the approach is yet.

Michelle Murray
Part of the answer might be in his comments that came right after this one where he actually wrote a couple of opportunities and asked for us to include them in this topic. They are partly to support the existing activities.

Steven Lane
Before we go to those, just in response to your comment, Jim, I think what he is getting at in option two is the currently existing infrastructure. I think he is talking about V2 interfaces, ECR via direct, use of the eHealth exchange hub in his option two. Leveraging transportive data directly from the EHRs into public health, and I think he is differentiating that from option three where you got this designated intermediary

where those EHRs are sending are sending to an HIE. But as you say, it could be to a (unknown term) (00:17:37) that is designated to then transmit the data on to public health. That is just how I read it.

Jim Jirjis

I agree, and what John is saying in the last sentence, right above the multiple approaches quote, is that HITAC should help explore about options and should inform stakeholders with education about the pros and cons of each approach. That sounds like a reasonable (indiscernible) (00:18:02).

Steven Lane

Once we understand it, we can communicate it, right?

Aaron Miri

Brett, were you saying something?

Brett Oliver

No, just saying clearly John was not saying these are the three ways to go or pick one. He is just giving some examples. I think more than anything to get the conversation going. I don't hear this as much, I do not hear as much talk about what infrastructure do we need, and mandate is not the right word, but recommend what floor is there? There is nothing more frustrating than being mandated to report data that is not bidirectional and you do not have the capability, or you do but your state agency cannot receive it.

Aaron Miri

2022 CMS fee schedule requires public health to be sent in now, to some degree. It is not robust; it is not a huge record set. It is the beginnings of something, so what does that eventually start opening a door to? We do not know. TBD. And a quality data, TBD, I do not know how some rural hospitals can pick up on something very highly (indiscernible) (00:19:01) surveillance data that is highly needed. I do not know. TBD on a lot of this stuff.

Jim Jirjis

I am sorry, I did not mean to interrupt you. I was going to say part of the feedback we gave to the CDC and others in the space was this notion of every state trying to do it their own way differently. But there are some core things like defining a data set. What are the standard methodologies? One of the strongest (indiscernible) (00:19:38).

Steven Lane

Finding acceptable transport methods.

Jim Jirjis

One of the things we said was it should not be many to many. Every single provider is trying to figure out how to get to every single state their data. There ought to be a trusted intermediary. That does not mean it is an entity. It could be a set of transactions that are defined enough that every single state is focusing on the same data, same data definitions, and are sharing it bidirectionally in the same manner.

I do not think we are going to get there by consensus without some facilitative governmental role. That is my (indiscernible) (00:2017).

Steven Lane

Certainly, we have been discussing the opportunity for ONC to wade into the pool of specifying minimum standards for public health exchange potentially certifying public health data systems. I certainly hope that is going to be seriously considered in the future.

One thing that strikes me in John's second bullet here on page three at the top. He says, improve bidirectional interoperability between public health and HIEs. Here, again, similar to my comment earlier

about population data from public health back to stakeholders. I do not know that there are many HIEs that are receiving data from public health except insofar as they might be facilitating bidirectional exchange to controlled substance system or something like that.

I am curious what he is thinking. Should a regional HIE, like his for example, able to query public health on their own, not at the behest of an HIE member, but as the HIE to query data and pull it into their system. Again, that is a novel concept for me.

Jim Jirjis

Seven, I think that is the future because if I see what is happening here is what we are trying to do is reduce the cost of defining, managing and making the data available, right? Many HIEs, as you know, most of their value is creating this one record. They have to do some mapping if they want to do anything with it.

I think in the future the data itself is going to be increasingly usable and fluid and many of these HIEs are going to have to pivot to what business value they provide, and therefore it needs to be bidirectional. They are going to need access to data in an appropriate manner so they can determine how to best serve the communities well. Their purpose will shift from aggregators to users of data.

Aaron Miri

So, we look at this next comment, which Michelle said would inform the previous comment which I think is smart that I am reading it here. Again, also from Mr. Kansky.

It starts illuminating but we are speculating here. Opportunities proposed by John Kransky, help relevant agencies like the CDC, CMS and others by exploring and sharing findings and approaches to achieving national paid public health reporting, improved bidirectional interoperability. Exactly what you were saying, Steven. Public data health systems can leverage potential data flows from the EHRs and others for testing, especially vaccination status etc. back to providers of the HIE.

I think what John is pointing towards is exactly what we have been talking about. What do we not know? What do we not know to inform an approach to do something like this? I believe that is what he is saying. Thoughts?

Steven Lane

Agree. I think identifying the gap in the opportunities as a focused work effort around HIEs, again potentially leading to some recommendations or even requirements for what it is that they should be able to do and how.

Aaron Miri

If even look at that next one under their same thing. Explore different approaches national public health data infrastructure, usually a federal top-down decision-making leveraging EHRs, HIEs. Same thing, another approach. One begins to think, is this a specified workgroup looking at this, subgroup of TEFCA that is focused on public health data reporting, I do not know. But it is very interesting.

John has a great point; we do need to put meat on this.

Steven Lane

I do not think there is any question that there needs to be a workgroup and it should have representation from the TEFCA team from HITAC to potentially from our interoperability standards workgroup and certainly from the CDC, ONC, public health data system, modernization group. I would hope that we would not have multiple groups trying to find this elephants bellybutton. We have to bring all the interested parties together to do this.

Brett Oliver

I was going to say before you made that recommendation that really feels big enough for a workgroup, I like Steven's idea of bringing existing workgroup members together, but if we do not do it the individual states are going to get further and further away from each other down different paths, making it more difficult to bring everybody together.

Aaron Miri
I think Michelle, recommendation on these three we look at them as we agree with John that there needs to be some urgency and focused effort on this. I think the recommendations we already made in the report workgroup support and call attention to it saying we want a more focused effort learning, potential work group to get to a synthesized recommended course of action.

Michelle Murray
In the past they have steered us away from naming task forces (indiscernible) (00:25:46) decision. I think getting to the activity of what is it you want to come out of the task force?

Steven Lane
Focused effort.

Aaron Miri
Right. Some focused effort.

Steven Lane
And collaborative. Collaborative with all the agencies that have an interest in this.

Michelle Murray
If you look at the activity that is in the line second from the bottom of that page on John Kansky, what language would you change there?

Aaron Miri
Explore different approaches, I would say explore different collaborative approaches. I like Steven's word there.

Michelle Murray
Decision makers is my word because he didn't have a noun in there to make it parallel with the other two. That was my contribution. If you want a different word, that is fine.

Aaron Miri
Good.

Steven Lane
It says leveraging EHRs. Obviously, this is going to leverage EHRs, but I guess the question is it EHRs and federated interoperability solutions. Again, when he says HIE he is using it as a noun, and that is a specific technology solution.

Aaron Miri
Leveraging EHRs, existing health IT systems, that sort of thing.

Jim Jirjis
Do we also think the only hesitation with the word "existing" may be other things that come on the other side of firing phases and entities like (indiscernible) (00:27:31) that are aggregators that become kingpins? I am wondering if it is more than just existing. Maybe it is empowering EHRs HIEs and other technology providers without interoperability.

Aaron Miri
That is a fair point.

Steven Lane
Some of this could be done by (unknown term) (00:27:57) independent of existing HIEs.

Back to Hans.

Aaron Miri
Opportunity of public health data recommended HITAC activity. Hans is saying proposed guidance for operational standards were addressing implementation variation of public health data and exchange. It is just access and exchange, versus public health data exchange. Some of the theme of his earlier comment, which I appreciate.

Steven Lane
They should be able to access our data and political systems, and vice versa.

Aaron Miri
Yes, that makes sense to me. Any objections? All right. Next.

Steven Lane
Of note, we are covering access and exchange, but not use. We are not suggesting that HITAC has anything to say about how public health is using the data that they access and exchange, which I think is appropriate. It is not our place.

Aaron Miri
That is right. Next section here.

Steve Eichner –

Steven Lane
He giveaway in a recent email that he sometimes goes by the nickname of 'Ike'.

Aaron Miri
I love it.

Steven Lane
He and I have agreed in meetings that he will be Steve and I will be Steven, to keep that straight.

Aaron Miri
We have two Aarons now.

Steven Lane
You guys are up the creek.

Aaron Miri
We have public health data, let us see here. Recommended HITAC activity, provide guidance for operational standards.

His comment there is a revision of proposal and provide guidance for policies and operationalizing standards to address implementation variation of public health data access and exchange.

Steven Lane

That's beautiful. And I think that goes to what (unknown name) (00:30:29) keeps raising, that the policy levers are huge. And he says operationalizing guidance for policies and guidance for operationalizing the standard? I think so. I am just trying to work to the sentence structure here.

Aaron Miri

Yes, so policies…

Steven Lane

He probably needed another word in there. It would be, "Guidance for policies and for operationalizing standards."

Aaron Miri

Can you put two fors in a sentence like that?

Steven Lane

Absolutely.

Aaron Miri

Michelle? You have one engineer and three doctors.

Michelle Murray

It is a problematic structure, and I think the change improves it. Thank you.

Aaron Miri

I think this is fine.

Steven Lane

Is a subtle yet meaningful improvement.

Aaron Miri

Are we good?

Brett Oliver

I am good, I think it belongs back in that bucket of this may be a work group that we suggest.

Aaron Miri

You have your hand raised.

Jim Jirjis

I am waiting for the Clem one, sorry.

Steven Lane

Was going to say that there is interesting that there is overlap, but there is probably some difference between these discussions of public health and the discussions of HIEs. There is clearly an overlap because HIEs have shown real value in supporting public health exchange.

But I think that, as I have said repeatedly, I think there may be an opportunity for ONC to provide guidance and/or certification requirements for public health data systems, and there may be similar opportunities for them to provide guidance and/or certification for HIE data systems.

And they are not the same thing, obviously. Those are kind of different.

Aaron Miri

So, it is Clem. We had recommended a listening session to better understand barriers. His concern here is with our comments earlier about the minimum necessary data sets.

He expressed concern about focus on minimum necessary, what constitutes minimum necessary contributions to public health in addition, it can lead to all free text information being excluded, which may implement important public health information. I am not totally understanding that, but all right.

Provision proposed by ONC convene a listening session to better understand barriers to sharing clinical data sets with public health authorities.

Jim Jirjis

A comment there. So, the way things are working there right now with USCDI in the CommonWell, it is pretty much the entire package we get. And that cannot happen in public health.
So, I disagree with him a little, because I think that there is a definition of what data is relevant for public health. And what I understood is that the challenges were about how to actually deal with defining and executing on the minimum necessary data.

Because right now, if you are to use the exchanges, the existing TEFCA infra structure model, you might get more than what is necessary that is transmitted, and I interpreted this as being really important to understand the challenges with illuminating a data set.

Steven Lane

I think the issue here is that HIPAA specifies that when exchanging data with public health for nontreatment purposes that you must adhere to minimum when necessary. And I think is a fairly short reference in HIPAA.

If there are public health nurses or clinics, or public health hospital, that that is treatment, and you do not have to worry about minimum necessary.

But as soon as they are doing case investigation, or epidemiologic intelligence, or the other kind of things they do, then we are stuck, per HIPAA, with the minimum necessary restriction on the providers.

So, I think Clem's point, I am not sure it is well-founded, is that he is appropriately concerned that there would be a loss of data completeness if we could not share notes, because lots of critical information is in notes and not only discrete data elements.

It's not that notes are inherently in or out when we talk about minimum necessary. If you are doing epidemiologic intelligence, notes may be in. All you need is for the public health entity to state, to declare, that what the data they are asking for is minimum necessary.

We have been having this conversation for two years now. And our hope is that there will be something coming out of OCR to help to clarify that.

But you know, on the counter argument is that many members of the public are understandably anxious about too much of their personal data being reported to the government, right?

There is this inherent governmental anxiety in the US. So that is where the minimum necessary comes from. Nobody is saying that public health should not get the data they need to do whatever it is they are saying they are doing, but we do not want to send them excessive data or unnecessary data for nontreatment purposes.

Aaron Miri

Right.

I am looking at the revision proposed by ONC saying clinical, and striking minimum necessary, to sharing clinical data sets with public health authorities.

I can see the merit in that, and that we would not automatically be jumping to the conclusion. What I think what you are alluding to, Steven, well, if we want to follow HIPAA, maybe there are certain circumstances that HIPAA allows for.

Are there is a PHE that allows us to do it, or whatever else. I can appreciate that.

Brett Oliver
I read minimum necessary as the minimum necessary for the problem that public health has on their hands there. If you take that out and just leave clinical data sets, that is a wide-open door that I honestly disagree with. I do not think that is a good idea at all.

Steven Lane
I agree with Brett.

Jim Jirjis
I concur, and it is a very legitimate concern that the public would not just want too much information shared.

Let me flip it. If I am a public health department, I do not want entire tomes of data I am not going to use to sent to me. I want it purpose specific.

Aaron Miri
So, what if we said to sharing clinical data sets with respect to HIPAA or guidelines or something to that effect. So, we are embracing the notion that there may be other critical elements that, depending on the circumstance, are shared, but we are being mindful of HIPAA. (Multiple speakers)

Jim Jirjis
I like that, could a word to fix all this be, convene a listening session to better understand various to understand the 'appropriate' critical data sets?

Speaker
How about appropriate and compliant?

Steven Lane
I think the way it is worded presently is all right. I love Clem, but I do not think the addition of the word clinical or the striking minimum necessary adds clarity to this.

I really do think this was to get at how can we deal with this HIPAA requirement, which most of us feel is reasonable, in a way that also supports public health and getting the data that they need?

This really came up early pandemic, when we spun up a new policy with care equality, to say that public health could request a standard CCD, so long as they declared that that was the minimum necessary for the work that they were doing on case investigation.

And that policy passed. And nobody ever took advantage of it. I am not aware of any public health entity that did that. In every case I was aware of they worked with EHR vendors and others to get to define what is the minimum necessary data they needed. Whether it was electronic initial case report, or some bespoke document type that they spun up in New York, or another place, Chicago, and that was their declaration that this was the minimum necessary that we needed.

Those were not scalable solutions because again, they were very bespoke, and the requirements of individual states or regions. In some cases, a city.

Again, I think that we had phrased initially is all right. And I really appreciate Clem's concern, but I do not think is a well-founded concern. I do not think the fact that something is in a note necessarily means that it will be lost forever.

Jim Jirjis
I concur, and I would be a little stronger to state that not only is it all right to the way that the wording was, that it will detract from (indiscernible) (00:39:28), because this links it to the HIPAA requirement.

And by removing minimum necessary, it removes the heart of this piece here. And that is that there is a HIPAA obligation to be minimum necessary.

Aaron Miri
Let me push back a little bit here. From the academic, medical center perspective in my prior life, there was a component of FERPA that had to be compliant with.

In order to get some of this data, there were different levels of rigor and different levels of access allowed for FERPA than there was for HIPAA. Different folks could access student records or certain sections of student records which would intersect with their medical records to some degree or another. They were a patient as well as a student.

It becomes murky if we focus only on HIPAA, but the compliant way you went about it, when you said compliant earlier, that comment, I think allows us to point to many different regulations that may need clarity in the future, to what Steven is saying. That is my two cents.

Jim Jirjis
What you are saying that by saying minimum necessary that it focuses on HIPAA. There may be other considerations. Maybe the language is understanding various sharing the appropriate subsets.

Aaron Miri
That's right.

Jim Jirjis
So that is HIPAA, but it also includes FERPA and others. Good point.

Aaron Miri
That's right.

Brett Oliver
So, you are all saying that the precedent that comes with minimum necessary is only with HIPAA?

Aaron Miri
That word came from HIPAA.

Brett Oliver
I have worked with some great public health folks in my state, but I will tell you what, they want more. I hear what Jim is saying, they do not want a tome of data.

But I also feel like they just want more, they do not think about how it is gathered. I am painting a broad brush, I understand that this is not 100% true across the board, but I will give you a real-life example.

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We had some telehealth parity law go into play before the pandemic hit. Literally a month before it was to go into effect, Medicaid, or state Medicaid office said that we needed the provider to enter an ambulance code.

As a provider, I did not know what an ambulance code was. But it is basically asking where the service was rendered both (indiscernible) (00:4153). I asked simple questions like, do our EHRs, there are 52 in the state of Kentucky, do we even have the ability to enter that? What are you trying to get out of this? Well, we would just think it would be an interesting academic (indiscernible) (00:42:08) where we are getting here with (indiscernible) (00:42:09). You are asking the end-user to do something else, and you do not even know if the capability is there.

And they are good people, please understand, but that is just a micro example. The minimum necessary strikes very hard and sound with me. But if you think that maybe 'compliant' would cover the same thing but with a broader understanding, I'm find with it.

Jim Jirjis
I like the broader understanding.

Aaron Miri
So, I think we have agreement on compliant. Michelle, does that make sense to you?

Michelle Murray
Can somebody read back now what you are thinking?

Aaron Miri
So, basically understanding Barry, is sharing clinical data in a compliant manner. Something to that effect. I am saying this too wordy, but that is what we are trying to get at, which is sharing data but being mindful of the regulations that are there. So, you say minimum necessary, now it is a compliant manner. However, we word that.

Speaker
Would you like to include parenthetically, e.g., minimum necessary under HIPAA?

Michelle Murray
That would help.

Brett Oliver
Just so we know what we are referencing, without limiting it to that.

Steven Lane
As an e.g., instead of exclusively.

Aaron Miri
Makes sense. Michelle?

Michelle Murray
Yes, that is good. Thanks. We are not saying appropriate. Just the complaint piece?

Aaron Miri
Compliant.

Next one here with Hans, against more vernacular. Producing styles and exchange by exploring the roles of HIEs and other exchange network and promoting the interoperability of public health data and clinical data sets systems.

Steven Lane

Is networks the right word or should we use networks and frameworks? I mean, if we just use the root word framework it assumes the networks that part of the framework. You could say network/frameworks.

Aaron Miri

I like that. Not a lot of people understand the subordinate hierarchy that you are referring to, but you're right. If we say both that is fair comment.

Steven Lane

We always want to support the opportunity for HIEs to add value and help be part of the solution, for sure.

Jim Jirjis

One question about that, when we say we always. We have these HIEs that are nouns, there may come a time when the data is such that the HIE nouns as data aggregators become unnecessary, right? There may in fact be apps. If you look at Health Gorilla their goal is to become the source of truth for the longitude of records for patients in the US. You can imagine a world where the HIE nouns are something our grandkids are looking back on in history lessons.

I do not want to say HIE nouns are going to be important, but we want to add wording that deliberately does not just focus on HIE nouns, but other potential…

Steven Lane

We could say HIEs, and other health data utilities.

Aaron Miri

We need to stay with the HIE nomenclature because it is written in 21st-century (indiscernible) (00:47) and others, they do reference it. We need to stay true what is there. Agreeing with you about where it is going, Jim.

Jim Jirjis

Put an "And." If we are myopically focused on the nouns, we may miss the opportunity for (indiscernible) (00:46:00).

Aaron Miri

Fair point. Other data aggregators or whatever you want to call them. That is fair. With all respect to the companies like Health Gorilla and others, they are doing great work. While I have heard many people say they want to be the aggregator, Experian, others and not to talk about vendors, but there is a whole lot of hope.

Jim Jirjis

We are saying as the data gets more machine understandable and these interfaces occur, the marketplace for those apps is actually very likely to actually occur.

Steven Lane

If you use that term, health data utility which seems to be more and more en vogue, in my mind it could include organizations that function as HIEs today and provide utility services. And it could include those aggregators you are describing, or Health Gorilla-type organizations that also provide utility services.

Leveraging the terminology 'health utility' ends up being more inclusive. So, I would add that. HIEs, health and utilities and other data exchange frameworks because then you are getting at the care equality, the subservient or the component networks and also direct trust, which sort of provides its own network/framework for interoperability.

Aaron Miri

We want to be inclusive. That is our point. Michelle, is that clear as mud?

Steven Lane

We will add in health aid utilities, and we are going to add in the work "Frameworks".

Aaron Miri

HIEs, health utilities, and frameworks.

Steven Lane

I would say data exchange networks and frameworks. I think that covers the waterfront.

Aaron Miri
Michelle, good?

Michelle Murray

I believe so.

Aaron Miri

Our next one from Hans. Written comment here on gaps in public health. This is related to ELR, electronic lab reporting. Areas of inconsistency with chronology appears to be the least variant other than which tests are recordable, less variations and codes self, varying uses of HL7syntax, increase alignment on federal standard to start, then deviations and already common data. Vary approaches for additional data that should not be part of ELR or where it should or could be done the same by all.

This gets really, really deep. We stood up to (unknown term) (00:48:42) to do it ourselves. We realized this quickly, the inconsistencies that were there. I appreciate that it should be a separate topic altogether, like next year to talk about. This is deep.

(Multiple speakers)

Brett Oliver

It is too deep for me, I am out.

Jim Jirjis

Is this trying to say that we need to address the variation?

Aaron Miri

I think what he is saying is there is different syntax. The reason why if you take COVID for example, they were adding to as they were going on. The World Health Organization didn't give an ICD code for COVID for months after it was declared a pandemic. Same thing with the vaccine shots. They were late to the game with that.

It gets difficult when you start trying to link these things together with records. I think what he is saying is how is there not a standard approach with some sort of defined timeline or whatever else, both technical and non-, so that there is sort of a general approach of how we go about this. It is difficult.

There are certain rules, there are certain European rules, it gets deep.

Steven Lane

This is all about electronic laboratory. I am trying to understand what are the three areas of inconsistencies that he is referencing?

Aaron Miri

Which tests? Variation and (indiscernible) (00:50:11) test, it looks like the third one is variation in use of the existing HL7 syntax. That is why we are at three. I think what this points to is that electronic laboratory reporting just needs to be something we talk about in-depth next year from all dimensions.

Steven Lane

Agree.

Jim Jirjis

Now I see it.

Steven Lane

His sentence structure leaves a little something to be desired.

Aaron Miri

I think he was thinking as he was writing. I get it, I do the same thing. Wordsmith hurricane kind of thing.

Steven Lane

I had a friend, he was a journalist and an alcoholic, and he would say write drunk, edit sober. Get your ideas down and then go back and clean it up.

Aaron Miri

Yeah, like what was I thinking? It is a sign of brilliance in there. Michelle, are we in agreement to table this one, but it is important so we definitely want to look at it.

Jim Jirjis

Can I ask again? What are the points we made about ELR is that we have 220 some different labs that do COVID testing for us, right? You know how many of them actually report the results using a terminology standard? Zero. Zero! So, for one of the points I was making, I do not know if this was part of it, was how do you actually (indiscernible) (00:51:48) standards group, but is his point how do we tighten the standards? Because the issue of how do you encourage the lab testing companies to utilize terminology standards, improve the use of terminology standards in ELR recording. We were not even seeing them try.

Aaron Miri

I think it is all of the above. I think you are right. What is the carrot and stick to make you do it, and then if you are going to do it what's the playbook? I think it is both.

Jim Jirjis

Do we have the 'what will make them do it,' or is that more of a different (indiscernible) (00:52:25)?

Aaron Miri

I do not know, that is a good question.

Steven Lane

You are right. The opportunity is not just how do you improve the use, it is through policy and incentives, right?

Jim Jirjis

That's my point. To me, that is the bigger discussion. No one is even trying this, and we are going to fine-tune the syntax to something no one is even trying to do.

Aaron Miri

It is easier to find a covered entity. Come on, we all know the answer to this one.

Steven Lane

What about improve and incentivize the use?

Aaron Miri

We could. Improvement, incentivize.

Steven Lane

Rather than parking lot this, how about we actually propose that change for this year?

Aaron Miri

We can do that, but this is one of those we should really look at for next year. I think we should still refer to it. Well, we do that in previous reports. We talk about going into deeper conversation about it later on in the next report.

Jim Jirjis

The only question I have about when you say next year is, like right now we have the CDC and others. There's a bunch of people moving forward trying to figure out the infrastructure for this exchange, right? States are getting money and hiring people. One thing I was saying is we will end up with far more sophisticated systems that are variable do not talk to each other.

Aaron Miri

Sorry, when I say this year, remember we are talking about last year's report, finishing it up this year. So, I do not mean it in literal terms, it is what happened last year to clean it up so that this year we are hitting the ground literally with this topic. So, you are right, Jim, I do not mean to say it is pushed out another year.

Jim Jirjis

Sorry about that.

Aaron Miri

Good point though.

Jim Jirjis

Eventually, says Aaron.

Aaron Miri

Next one here from Clem. Explore whether there are data needs versus which saying explore data needs. I mean, along COVID.

Brett Oliver

Where we are not sure there are gaps?

Aaron Miri

There are gaps, let us be honest. We have major issues documenting this.

Steven Lane

There is no data on long COVID.

Jim Jirjis
Respectfully decline his edit.

Brett Oliver
Some interesting studies came out, I saw one in preprint today.

Steven Lane
This was the Seattle piece.

Aaron Miri
They could say explore what the data needs for existing programs are. So, it might be the wrong word, but (indiscernible). We are not saying they do not exist, but they could be variegated issues. I could agree with that.

Jim Jirjis
I could agree with that. In other words, that will change over time. Explore how to support the varying data.

Aaron Miri
Something like that. Whatever the right word is.

Steven Lane
I was going to say, what is the word "Programs" refer to?

Jim Jirjis
I think research programming. My fiancée is in charge of a bunch of research at ANU and COVID. So, there are programs in place that are focusing on understanding long COVID syndrome, or understanding later…

Aaron Miri
And there is one COVID clinic, a lot of systems launch that for patients that is specific for treating chronic illness, especially chronic condition, comorbidity clinic where you had COVID, and you have multiple issues that are persisting. We have a small one here in Florida, but I know other areas have large ones.

Steven Lane
I think we are rejecting the suggestion of whether there are data needs.

Aaron Miri
I disagree with the notion that there potentially is not; there are issues period. There are gaps. Tons of gaps.
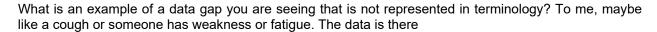
Steven Lane
ONC, Michelle, you guys recommended accepting this change, but it sounds like we are suggesting otherwise.

Michelle Murray
You have the right to do that. Our thinking was we are still trying to find a compromise, but also, he was trying to say that are the gaps different than for other diseases? I think you are saying from your work experience that yes, you are seeing something new and different.

Jim Jirjis

What is an example of a data gap you are seeing that is not represented in terminology? To me, maybe like a cough or someone has weakness or fatigue. The data is there

Aaron Miri

It is just incorrectly coded. Long COVID was not even an ICU code for a long time. It just came out a few months ago. I am sure there are tons of people that were documented records of chronic conditions thinking, oh you just have emphysema or something, but in fact it is long COVID. I am just making that up.

Brett Oliver

What about the 270-plus labs that are not reporting to Jim the results?

Steven Lane

Another key data element related to long COVID in particular is duration of illness and duration of symptoms. That is actually not in USCDI. That seems to me a data gap. Or data a need if we are talking about a chronic or subacute version of an otherwise acute illness. That is why say, what do we know about long COVID? We do not have standardized data to capture that.

Brett Oliver

We need a standardized definition to being with, right? And then work on the data. I do not feel like we got that yet.

Jim Jirjis

It is hard to know what they mean. I posted somewhat humorously in the chat this recent news about the gut microbiome being a cause of long COVID, right? I playfully…

Steven Lane

It has been found to be associated in pretty rigorous study, right?

Jim Jirjis

But does that mean we have a data representation? Is this some data that is not cover right now that is going to come out of this? Is that what they mean?

Steven Lane

It is what we said. Explore the data needs and existing programs. I think conflating needs and programs in one sentence is a little confusing.

Brett Oliver

Is it the data needs of existing programs?

Aaron Miri

If we go back to the genesis of what we are trying to say, we are in agreement that there are existing gaps. And it is really, what is it? We do not know. We do not know what they are, because it is so varied.

Steven Lane

What if you flipped it around? What if you explored existing programs and data needs? That makes a little bit more sense to me.

Aaron Miri

All right. I can get behind that.

Jim Jirjis

All right.

Aaron Miri

There is your answer, Michelle.

Michelle Murray

That works for us, thanks.

Aaron Miri

All right. Next one from Mr. Hans.

(Indiscernible) (01:00:05) gaps, public health, information exchange, and facilitate care, the opportunities improve clinical documentation (indiscernible) (01:00:13) long COVID has a (indiscernible) (01:00:14) conditions. So, his says: would be good topic to understand whether this is a new flavor of electronic initial case report, or investigative queries, or something new?

Steven Lane

Here again, I think that long COVID is something new. It is this subacute, chronic manifestation of an otherwise acute disease. The EICR is specifically the initial case report. Investigative queries, I think he is referring to case investigation.

So certainly, part of understanding long COVID might be public health entities querying providers or patients or payers for additional data regarding this disease episode.

(Reads) "Approved clinical documentation standards for patients with long COVID, and as a blueprint for other conditions…"

So, ONC recommended putting this on the list of topics for this coming year.

Jim Jirjis

I thought it meant that this could be a model for the next pandemic that comes up. What processes do we have in place to be agile as our data needs evolve?

I thought he was saying that we should view this as a new flavor of electronic use case, when new things emerge in public health.

Aaron Miri

If I can propose, it sounds like the reason ONC is saying let us talk about this, let us go through this, with the previous one we just talked about, figure out what it is, what if anything, and then we can determine from the gaps, what can we do with it?

Jim Jirjis

 Yes.

Steven Lane

And I think it is a model we have not talked a lot about, this notion of acute illness transitioning into a chronic illness. I am thinking about Lyme disease. A lot of Lyme disease is acute and simple and moves along, and some people end up getting stuck with chronic Lyme symptoms.

And there are similar examples, where you have this differentiation between acute and chronic disease, that may well have the same ICD code.

Jim Jirjis

The model I am thinking of is severe pneumonia and childhood leading to bronchiectasis later that is a chronic disease. There are a few of those.

Steven Lane
For sure.

Jim Jirjis
Then we can move on. To me, what it seemed like he was trying to say is can we use this long COVID thing as a model for how we systematically support new clinical entities that emerge with data standards, etc.

Aaron Miri
I would agree that we should table that one. It is important, but we should find out more. We should define this better.

Everyone is in agreement. Let us go to the next one.

Ability patient matching, recommended HITAC activity to define core data elements to support patient matching across health systems, including demographic. Proposed by ONC revision defined governments best practices at registration and other relevant collection points to improve the data quality of the core, standard data set of elements as defined in USCDI and Project USA to support matching across a health system.

So, this is more specificity.

Steven Lane
Specifically calls out Project USA, which seems appropriate at this point.

Now when you talk about best practices at registration and relevant collection points, that is great. I do not know what the word governance is doing there.

Aaron Miri
Yes…it is just best practices.

Jim Jirjis
I think it is best practices.

Aaron Miri
I would strike the word 'governance'. Brett, do you see differently?

Brett Oliver
I do not.

Aaron Miri
Michelle, I think we are in agreement to strike the word 'governance'.

Michelle Murray
So, say defined best practices.

Brett Oliver
And I certainly do not support the governance piece, but in his spoke comment "recommendation be tailored to address the governance for data collection at registration." I do not know how you do that, how many different…

Steven Lane

I guess you may be thinking operationally at whatever site is collecting this data, so how do you assure that it happens?

Aaron Miri

For us, we resort to some biometrics for our numerous sites to make sure that we are gathering the correct proper demographics every single time on the registration you present. So, when you show back up, so you are scanning your palm and the information is there again. So, we are trying to standardize it that way for the millions of patients we have. But everyone is different.

If he is going for that…

Steven Lane

And what we are referring to really here is the data elements in Project USA and assuring that they are collected appropriately and documented appropriately, maintained.

Again, I would leave out the word 'governance'.

Aaron Miri

Let us go to the next one, from Hans.

Interoperability, information blocking, all right. Written comment: Should there be summary reference in this table to focus on USCDI, USCDI PLUS, EHI, EPHI. I think there needs to be more letters in that one, to be honest with you. As a key area of (indiscernible) (01:06:13) standards, focus to grow in to. Revision to the recommended HITAC (indiscernible) (01:06:19) proposed to convene a listening session to assess the establishment of measures of the impact of the information blocking departments for the ONC Cares Act (indiscernible) (01:06:26), including the traditions from USCDI to the full scope of electronic health information across the industry's conjunction efforts, ONC measurement efforts.

Yes.

Steven Lane

I really appreciate the suggested edits on the part of ONC. Because that is really what so many of our groups have been asking for, for some time. I do not know that it exactly gets at Hans's question, but he was asking this question last year as well.

"Summary reference in this table…" I do not quite get what he is saying, but I really like the edit.

Aaron Miri

The edit is good!

Jim Jirjis

I thought what he was getting at is the murkiness that comes with USCDI and USCDI Plus, and what is being expected of EHI. Is he saying there ought to be a listening session so we can be more deliberate about how we transition from USCDI to full EHI? This gets back to our gap analysis, is there work to do to close the gap on the understandable differences between USCDI and EHI?

Aaron Miri

If you take the (unknown term) (01:07:42) list for EHI, which is what we used as our starting point, and crosswalk where are the elements and make sure you can get them, it is amazing what one follows the other. So, as you make this happen to the point of it, this should cover it, I would think, get to that transition they were just talking about, Jim.

Jim Jirjis

I think so. The proof is in the pudding. We are all going through that EHEMA, EHRA stuff list to figure out where we are going to use the feasibility exception, right?

What data do we actually have; what data do we have, but it is going to take a huge lift until the EHR, and other vendors actually make it externalizable.

Aaron Miri

And the EHR vendors are literally telling us that they do not know, and they have no idea if they will even make the date. That is literally what we are being told.

Jim Jirjis

And to me, there is a hunger for a pathway. If that is what he is talking about, hear hear. Being deliberate about what is next.

Aaron Miri

But let us be clear, October is around the corner, and it is February, basically. I keep telling our vendors and partners that we can't wait until July and August start this if they keep saying too bad, we do not know.

Jim Jirjis

Feasibility exception is what that means.

Aaron Miri

You have to show the work to be able to claim that, but yes. All right, Hans.

The interoperability one? Should health equity be a topic on its own as it evolves, what data is best captured where needed. Okay, so this is about increasing health equity across population situations.

So, it should discuss it was a broad (indiscernible) (01:09:30) interoperability targeting area or focus on certain subtopics. ONC recommends placing the suggestion on a list of potential topics for FY22 Annual Report. I thought health equity was a major focus for the HITAC this year. Maybe I am wrong?

Jim Jirjis

I thought it was too, but there is a difference between just calling it health equity. What ONC's role is to figure out what data is important to support health equity efforts. Am I misunderstanding?

Because health equity has to be addressed far beyond just the data, right? But are we looking for health equity and what data elements are necessary? Should health equity be a topic? Of course! Who is not going to want health equity? But we are talking with the data and standards. Is that what it means?

Steven Lane

The way that Hans put it is what data is best captured where? How do we share it? Where is it needed?

Aaron Miri

Yes.

Steven Lane

To support specifically health equity. Is this SDOH? Race and ethnicity? What is the data that supports health equity?

Aaron Miri

That is why the ONC is talking about it in the next report and breaking it down into sections. I can see that. This is another very deep topic.

Jim Jirjis
So, postponement to this coming year?

Steven Lane
This year.

Aaron Miri
Let us keep going. We are getting close to time. We have seven to go.

Interoperability. Standards, priority use cases, (indiscernible) (01:11:13) referrals. Should this be more general around integrative clinical and administrative workflows which is close to referrals, (unknown term) (01:11:19), cost transparency, good faith estimates. Wow.

As written, this follow-up was identified by the HITAC through its ISP Taskforce in '21. ONC place this suggestion. This is a big one. It is important, but this is not something we can just solve.

Jim Jirjis
Agreed.

Steven Lane
(Unknown term) (01:11:41) referrals is one piece of a bigger puzzle.

Aaron Miri
We agree with you, ONC on the steps for this one. All right, Mr. Ike. See, now I start calling him that, with his comment here.

Hans first, sorry. Do we need to consider privacy and consent directives to support that at a national level? There are various issues on flight, recent LEAP funding, etc. Initiatives, data segmentation.

Wow. Alignment of innovation and regulation, yeah, this is not an easy answer either. I hate to keep kicking the can, but it is true. These are big topics.

Jim Jirjis
Just a quick question. We are talking about privacy and consent directives. Is that something that, what you call, Sequoia? Is that something that HITAC should try to independently solve, or is that something that has to be rooted in workflows?

Because I would think TEFCA, the Sequoia would help us with that.

Steven Lane
I do not think it is on the front burner for TEFCA.

Steven Lane
Privacy and consent directives. What does that mean?

Aaron Miri
I think you are right; we do not know what the right answer is there and we need to look at this, and I would say talk to OCR and get their take on some of this.

Jim Jirjis

For example, let me make sure I understand. When the patient decides to "opt out" we are waiting for Sequoia to tell us what that looks like? Is that with this is talking about? Or is that different?

Steven Lane

I think when you talk about consent directives it is about opting in/opting out of exchange either broadly or at the episode level, or the visit level, or the result level. Or opt out of releasing data related to STIs, it could look lots of different ways.

Aaron Miri

I think we should put this on the list for next year and double-click on it to get these answers, I do not think we can answer here.

Next one here. H access to information. There is not as much attention to the role as individual patients (indiscernible) (01:14:20) need greater accountability where, to whom, and why the (indiscernible) (01:14:29) of information. Hear, hear. And there are a variety of policies that could be used to achieve that goal, some of which would be significant impact on supporting research.

Jim Jirjis

To comment from me I agree with ONC it is important because as we have information blocking rules our ability to even to audit, why did someone release my data to so-and-so is going to be really important. It is this year's work though.

Aaron Miri

Something for that Steven and Brett? Are you good?

Steven Lane

It does make me think. There is the accounting for disclosures and requirement under HIPAA, and one wonders whether there might be a need or an opportunity to revisit that. Under what circumstances can an individual request an accounting for disclosures and what kinds of disclosures need to be accounted for? HIPAA was written a long time ago in a paper world, in fact.

I think that is probably part of this discussion, but I agree this should be tabled and brought back next round.

Aaron Miri

Okay. Scroll down, please. We have some red text here. In the past the agency has accounted clinicians who are hesitant to send their patient's medical records to an outside entity. However, clinical data sets have become better defined and bidirectional exchange has improved.

Can we agree? I mean, this is the story of what happens when we actually get this right. Am I reading this right?

Steven Lane

I think this is referring to the EI CR in particular where we specify the data set for that, for ELR, for syndromic. It is true that in the past the clinicians were hesitant. Now this does feel safer I think to clinicians as the standards have evolved. This is asking for a new federal education initiative, as there was one, has helped clinicians. This goes back to the minimum necessary topic to discuss in earlier.

Yeah, I think the additional text is fine.

Jim Jirjis

I do not quite understand. Is he just fine tuning to be accurate?

Steven Lane

I think is giving us a little bit of credit for the hard work.

Jim Jirjis

I vote for credit to be given.

Aaron Miri

Next one. Next one, I think there are a wealth of other examples that are demonstrating (indiscernible) (01:17:38) standards and (indiscernible) (01:17:40) to public health for further refinement, improvements, (indiscernible) (01:17:45) public health for alternative ideas.

Brett Oliver

I find that a bit ironic. There is a plethora of stories. I know of you know some of them. I do not remember what story he is referencing; I will be honest.

Aaron Miri

Steve is a smart guy, so he has something specific in his mind.

Steven Lane

Why do we not ask him?

Jim Jirjis

The way I asked him is if things happened over the last couple of years where we were able to pivot and provide standards that positively impact public health therefore giving us the confidence that further refinements (indiscernible) (01:18:29).

Aaron Miri

Can we ask Steven to clarify? We are getting close to time. Clarify via email some specificity. We want to listen to him but maybe if he can write it up and give us specifics, we can get to goal on this quickly via email.

Michelle Murray

I did do that with him, but he did not follow up this last week in a timely way. He promised some stories, not trying to call him out here, I know he got busy and was going to reach out to some colleagues and they were busy. So, it did not come to fruition, but he is throwing it out there. (Indiscernible) (01:19:01) and meanwhile help find solutions that work with what we already had. I do not think there is pressure anymore to do that. (Indiscernible) (01:19:11) if you want.

Aaron Miri

I think for next year we can always incorporate when he finds next year. I can appreciate the overwhelming amount of information it is.

Moving on. These ones I think these are just administrative. Is that right, Michelle?

Michelle Murray

I had to reach out internally to get an approval to make the question changes or not.

Aaron Miri

I see that we went from specificity, it is nothing, okay. I do not see anything here that is wonky. Any issues? This is just more finesse. Next section.

Is that it?

Steven Lane

That is it.

Aaron Miri

We are at the point for public now, I think. Is that right? Mike?

Public Comment (01:20:20)

Mike Berry

Sure, we can do public comment. If you are on Zoom and you would like to make a comment, please use the hand raise function which is located on the Zoom toolbar at the bottom of your screen. If you are just dialing and only on the phone press *9 to raise her hand. Once called upon press *6 mute or unmute your line. Let us see if we have any comments. I do not see any, but we will leave it for me a few minutes and give it back to you, Aaron.

Steven Lane

We skipped over a comment for Hans if we go back to that last page. Page 9. The written comment. Curious as to why additions to CCDA guidelines were not included. I think we kind of skipped over that. Just the top line showing on the screen. Written comment as to why additions to CCDA were not included.

I think the point he is making is that the EICR exists within the clinical document architecture. And getting ECR off the ground and involved a lot of people enabling their systems to generate a EICR to send through the platform to public health.

He does not have a suggestion the way because in the line below, so I am not sure exactly what he is referencing.

Aaron Miri

We can ask him.

Steven Lane

There was clearly something on page 12 that he just thought there could be an acknowledgment of the work that was done. It would be good to go back, Michelle and see what he was pointing at there.

Michelle Murray

It is on the activities it is kind of tied to ONCs work directly. I'm asking leadership at ONC if they want to cover here or not.

Steven Lane

Got it, perfect. I just did not see which edit you were suggesting.

Aaron Miri

I appreciate you catching that, good eye, sir. I have a trained surgeon for a physician. I think with that.

Steven Lane

Are we good? I am going to go make myself some coffee.

Aaron Miri

Mike, are we okay to adjourn five minutes early?

Mike Berry

Definitely. Thank you, everyone. Appreciate your time today.

Aaron Miri
Stay safe.

Adjourn (01:23:15)