Annual Report
Work Group

Transcript
September 20, 2018
Virtual Meeting

Operator

All lines are now bridged.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Good morning, everyone. Welcome to the HITECH annual report workgroup. We will officially call the meeting to order starting with a brief roll call. Carolyn Peterson?

Carolyn Peterson – Individual – Co-Chair

I'm here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Aaron Miri?

Aaron Miri – Imprivata – Co-Chair

I'm here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Christina Caraballo?

Christina Caraballo – Get Real Health – Annual Report WG Member

I'm here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Brett Oliver?

Brett Oliver – Baptist Health – Annual Report WG Member

Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Chesley Richards? Okay. We'll circle back and see if Chesley joins a little bit later. With that, I will turn it over to our co-chairs to kick us off.

Aaron Miri – Imprivata – Co-Chair

No problem. I want to thank everybody for joining the call. I know several of you have to go relatively soon, so we'll try to, maybe, go through this a little faster, so we can get the bulk of the activities in and sort of just refresh from previous discussions. Carolyn, anything you want to add to that?

Carolyn Peterson – Individual – Co-Chair

I don't think so.

Aaron Miri – Imprivata – Co-Chair

Okay. Let's go right into the meat of it. We'll go ahead and go to the next slide. As we had talked about what our scope was. Really trying to look at and figuring out based on what 21st Century Cures requires us to do: the analysis, the assessment, looking at gaps, so the ideas. We went through this in detail with the HITECH and got some great feedback. Next slide.

Again, today, we will have an overview of where we are from a progress perspective, what our structure looks like, then the landscape analysis, the gap analysis, recommendations for addressing

those gaps, and then suggestions for the HITECH initiatives, along with all of the supporting detail. The structure seems to get a lot of approval from the HITECH. I think folks want some more detail in it, which will go into some of those ideations further along in this discussion. This is what we are looking at from an overall structure of the report. Next slide.

All right. Let's look at feedback from the committee discussion last week or so. Next slide. All right. Overall, the committee felt very comfortable with where we were going with things. Again, the structure made sense to folks, logically. It really was an opportunity to discuss future state. A lot of very excited discussion around the table about what a health IT could look like one day, which is always a fun thing to ideate on. Folks really wanted to focus in on measurement. As we had talked about on these calls, being the first time through, we really wanted to talk through, how do we set that watermark? Carolyn did a great job of articulating that point of this is a way for us to throw a measurement in the sand. Really, for us to look at that as we further go on and see what we succeed in, so both realistic and stretch target. Really, an empirical measurement of achievement and really establishing that in also future objectives. What will really move the needle.

There was a lot of discussion also on what had been done previously. This is something I said on this call, which is I don't want to lose sight of the excellent work that some of the prior FACAs had done on the standards committee and the policy committee. Really being able to tether our current work to those iterations in the past and give the complete body and work along with what the OMC teams have done over the many years. We really want to address, also, a lot of definitions of what things like interoperability actually mean. As time goes on, these definitions evolve, so it's important for us to really be specific so that as we look back in later years, we know exactly what we were referring to when we are thinking about interoperability.

Then of course, some of the business impacted: business models and provider efforts and those sorts of things to shared data. Brett, you had spoken up on this point about looking at overall, what does that mean for a clinician? What does that mean as we go along the path of how this could affect, positively or negatively, clinician workflow? Next slide.

Some themes that we wanted to talk about here. The HITECH looked at from a discussion of what interoperability actually means. These are themes that we want to consider as we look at the various dimensions of, how do we measure ourselves? What do we want to focus on in the future? A lot of this really boils down to things we've seen in the news related to, say, patient matching or standards or health IT safety, such as the opioid crisis. All the way through future items, such as, where are we going with mobile devices? How is telehealth going to concern us in the future? As we move the ball there, is that going to drive some concern or questions around business drivers and making sure that we realign those? We're looking at the unintended consequence of technology, perseverance, and adoption.

Again, we talked about, what do we think of that interoperability state in one, to ten, to five years? Is that an appropriate timeline? Should we keep it more at a reasonable two-three years? What does that look like? Overall, the HITECH is trying to look at this comprehensively, which I really appreciate the thought, and trying to think of this from multiple dimensions and multiple actors. Next slide.

All right. Carolyn, do you want to pick it up from here?

Carolyn Peterson – Individual – Co-Chair

Sure. Let's go forward. As a general overview in terms of what we are putting in the landscape analysis for the structure. Looking at the legislative requirements, of course, that's what's in 21st Century Cures as well as the current ONC and HITECH priorities. We need to make sure we cover all the things that the HITECH has done this year as well as the workgroups that are in progress and things that we're setting up to start in 2019. For each priority target area, we need to lay out the background and the current state. We may need to describe some recent advancements for some of the topics and provide some examples from stakeholder groups.

We had decided to include some examples at our last meeting because we felt like that can help make it clearer. For example, how a particular situation affects, say, payers or patients or some other of the stakeholder groups that we want to not forget in our analysis. The next slide, please.

We can start, now, into looking at some of these particular topics with regard to interoperability. Some of the current state topics and advancements with existing exchange, I've heard, between direct trust and HIEs, vendor networks, C-CDA, and so forth. We have ONC's proposed regulations covering open API's information blocking and other health IT topics. We did get some more clarity around the information blocking earlier this week. That's good to feel like we will definitely have something we can include in the report and not have to leave a space until the very last minute. The draft trusted exchange framework, standards and implementations, specifications to support priority uses of health IT. That would be the USCDI, the standard priorities, and then HL7 staff healthcare, interoperability resources require a standard for transferring electronic medical records. Next slide, please.

Then this brings us to another topic: privacy and security. In some of the current state things were thinking about: the OWASP 2.0 security profiles for authentication, privacy and security protections, more patient-generated health data, promote monitoring data and other telehealth data. Things that are happening outside the clinician's office or the institution. We have user controls, mental health, and behavioral health information sharing. This can include things like the interoperability frameworks, care quality. Outside IT activities that address opioid epidemic and social determinants of health. The HHS office for civil rights consumer and provider guidance for mental health and behavioral health, and then the SAMHSA guidance for 42 CFR part two. These are some of the subpoints that we had

discussed in our previous meeting. We should also probably do a mental check to be sure there's nothing else that we think needs to fit in this bucket since we'll be getting into the writing shortly. It's good to get the planning out of the way first. Our next slide, please.

Then continuing additional topics: privacy and security concerns that arise from increased health information sharing for research. Things like Apple ResearchKits, PatientsLikeMe, 23andMe, the new All of Us program. Think about improved patient matching and verification, PCOR patient matching, aggregating and linking projects, and then other things that we all may be aware of just in our own daily lives. Of course, disaster planning for health IT, the HIPAA security risk assessment tool. Next slide, please.

Now, we come to patient access to information. We get into some current state topics. We've got the Blue Button initiative and My Healthy Data at CMS. Data collection using mobile and wearable devices, something irrelevant for us here because it needs an FDA pre-certification program. Use and sharing of PGHD. Again, we've got the ONC PCOR PGHD policy white paper is a practical guide and the patient engagement playbook. Then changes to current procedural terminology code set. These are some resources that we can mention. I don't know that there's, perhaps, a lot to be said about things that have been done in the past, like the playbook. We definitely want to make sure people are aware of them by making that readily accessible through this report. Next slide, please.

Then further use and sharing of SDOH data, things like LOINC and the efforts to address health inequities. Finally, emerging platforms for data sharing by patients and caregivers. This could be things like Apple HealthKit and OpenNotes. Next slide, please.

Do we want to stop right now, Aaron, or do you want to go through all the slides and then circle back?

Aaron Miri – Imprivata – Co-Chair

We can stop right here if you want to. I think if we keep going, we're just going to be talking to the group. Let's talk and see if there any questions first.

Carolyn Peterson – Individual – Co-Chair

Okay. Questions?

Aaron Miri – Imprivata – Co-Chair

No. Okay, let's keep going, then.

Carolyn Peterson – Individual – Co-Chair

Okay. Do you want to take the next section, or do you want me to keep going?

Aaron Miri – Imprivata – Co-Chair

Go ahead, and we'll just go halfway, and then I'll pick it up at the end.

Carolyn Peterson – Individual – Co-Chair

Okay. We don't want to bore anybody with too much of one voice.

Aaron Miri – Imprivata – Co-Chair

Right.

Carolyn Peterson – Individual – Co-Chair

Who has the proposed gap analysis structure? Then for each of the priority target areas, gaps identified, opportunities identified, and then recommendations for addressing the gaps and opportunities. Let's go to the next slide.

Again, with interoperability, some of the gaps that we identified previously. These ongoing efforts regarding open APIs, information blocking, the tests, and then the standards and implementation specification. There's a lack of knowledge about user experience of health information exchange. We have unmet needs of these additional care settings and stakeholder groups, a delay in timeliness between issuance of guidelines and development of technology, the need to increase the level of interoperability to improve data quality, prominence, and usefulness, and infrastructure needs to stakeholder groups, especially as they relate to broadband access. Next slide, please.

There are some opportunities around interoperability, establishing usability metrics for health information exchange. We had talked a bit about that at our recent in-person meeting with the HITECH, and this is definitely a concern and a priority to the full committee. Expansion of priority use cases to meet needs of additional care settings and stakeholder groups. When addressed, alignments of timeliness and guidelines and development of technology. The incentives for change across stakeholder groups to improve level of interoperability and data quality. Support for increased broadband access across stakeholder groups, especially with regard to underserved populations. That

could be things like people living in rural areas, or people in urban areas where, perhaps, the broadband access isn't so good, or the infrastructure doesn't exist. The next slide, please.

Coming to privacy and security. Some of the gaps that we've talked about are the variability of information sharing policies across states, lack of knowledge about HIPAA, and confidentiality with regard to substance use disorder, patient records, the lack of user controls, sharing and disclosing information. Sometimes the implications of the European Union GDPR and the privacy shield. Also, the implications of California Consumer Privacy Act of 2018 and assumedly any other state laws that seek to do similar things. Widespread adoption of cyber security framework. There's the lack of user awareness in education about privacy and security settings. Implications of emergence of the Internet of things. What does that mean for people, and how will that affect healthcare and the kinds of things we need to do as a part of the formal healthcare structure, like exchanging information? The next slide, please.

Here are some opportunities that we've identified related to privacy and security. We have this increased uniformity of information sharing policies. Education about HIPPA and confidentiality, some of those – the implications of the regulations. Granular levels of consent to share and disclose information. Addressing implications of the GDPR and the privacy shield. There's certainly been some uptake and some concern about that among industry. Addressing implications also of the California Consumer Privacy Act. Support for widespread adoption of cyber security framework. Education of tech users about these privacy and security settings, especially as they relate to social media. Consider what to regulate about the Internet of things. Continue to improve patient matching when data is being shared. Nest slide, please.

Now, we're coming to the patient access to information. Some of the gaps that the workgroup has identified so far are the lack of patient and caregiver access to patient data, the use and sharing of PGHD and other data that's coming from mobile devices. They need to improve alignment of timing of planning activities with the operational impact of tech development. There's the potential for lack of net neutrality due to market forces. Unmet infrastructure needs for underserved populations. Accessibility and usability of patient portals continue to need improvement. Patient awareness and education about health IT resources, in particular, the things that ONC can help people find their solutions. The next slide, please.

Here are the opportunities that relate to those gaps. The support use of APIs to improve access to patient data. Consider the workflow and technology improvements to increase the use and sharing of PGHD and other mobile data. We can better align timing of planning activities with operational impact. Consider the implications of varying experiences with net neutrality at the local, state, and national levels. And support infrastructure needs for underserved populations. Consider improvements to accessibility and usability of patient portals. I would argue as well, other interfaces that people are

using quite regularly to their healthcare. Patient and caregiver education about health IT resources. The next slide, please.

Now, we come to the recommendations for addressing gaps in opportunities. That is part of what we want to determine today.

Christina Caraballo – Get Real Health – Annual Report WG Member

Carolyn?

Carolyn Peterson – Individual – Co-Chair

Yes.

Christina Caraballo – Get Real Health – Annual Report WG Member

This is Christina. Before we move on, there was just one note I had. Under the interoperability gaps, we didn't put patient matching and identification management or identity management. We had it under the opportunities under privacy and security, but we might want to just add that to interoperability, as well.

Carolyn Peterson – Individual – Co-Chair

Yes, that sounds like a great idea. How do we want to start out with this section? What are you thinking, Aaron?

Aaron Miri – Imprivata – Co-Chair

Well, we can go back and talk through and deal with what Christina was talking about, this ideate on various items here. I also want to give the group a chance to think about it, also and if necessary, email in further ideas. I guess I would ask, does anything jump out as an obvious? Maybe we can go back one slide and rejig everybody's memory.

All right. Let's see here. Right. Looking at it, our question that we had here was to really start thinking about the complexity of patient access information. What are all the different dimensions that are keeping patients from being able to really be engaged? This could go a zillion different directions. To the degree of it it's, what can HITECH do to help further along the consumer population to want to access their data? Does it make it easier with technologies, like what Apple's doing or others? Is it more a prevalence of, maybe, reimbursement changes to allow for this? What do we need to do? I can

tell you that as a – I put my hospital CIO hat on, just getting patients to sign up for a portal, just to make meaningful use, was a barrier itself. Now, having them being able to access the data appropriately and ubiquitously is that much more of a higher bar. What can we do? We'll start thinking of it that way. I'd be curious, Brett, from a clinical perspective, do you have thoughts on this?

Brett Oliver – Baptist Health – Annual Report WG Member

Yeah, exactly, Aaron. I think the value of their own data, if we could come up with examples of use cases to make it important to them if that makes sense. Why would I care? The doctor's going to call me with my labs, or the nurse will let me know what that value was. Why should I care? To help educate them on the coming wave of applications that will be able to apply things that we're not even doing now to that data. Again, I think the gap would be the understanding of what this could do for them.

Aaron Miri – Imprivata – Co-Chair

That's a good thought. That's a very good thought. Okay. Just thinking through that right now. Carolyn, I know you have a lot of experience with the various dimensions from a patient perspective. How do we begin to measure this, I guess is my question? What would be a smart – give an example of a smart metric related to patient access. Is it number of patients that were able to interact with the clinician, like Brett's bringing up? What are you thinking?

Carolyn Peterson – Individual – Co-Chair

I think, certainly, years ago when we were getting started, the notion to getting people to sign up for a portal was the first obvious metric. I agree with Brett that it's a challenge, for one thing. Honestly, if someone signed up and they never use it, the fact that they signed up is irrelevant and not very helpful in terms of thinking about improving care. At the same time, I can see where for a hospital or another institution, trying to measure portal use over time and quantify who's using it and come up with, what's a meaningful level of use? Is it logging in twice a year? Some people really don't need to go to the doctor or don't go often even if they do need to. There are fewer opportunities. In some sense, I almost wonder if it's more helpful to measure the time that the portal was online and was working properly. The people who do want to use it, if the system isn't working right or if there's a lot of downtime, then that's another barrier for their intended use.

Aaron Miri – Imprivata – Co-Chair

That's a good point. One of the things – and I'm just thinking of real-world examples. We set up at a couple of organizations. It almost seems like every time I set up a portal and I started interfacing with lab results or X-ray or even discharge information, invariably I always have patients call back in saying, "What does this actually mean? What do you mean that my X, Y, Z value is X, Y, Z?" It almost had to be had be – reconnect them with a clinician to explain what they're actually reading. There wasn't a way

to actually – for them, I'll say in English, to understand in layman's terms what they were actually seeing. I'm just pontificating here. Is there a value in showing me that clinical validation that yes, the patient understood that their, I don't know, potassium levels are high or whatever? What do we need to actually move the needle? Going back to what the HITECH brought up the other week. What are those relevant measurements to show patient engagement? What do you think?

Carolyn Peterson – Individual – Co-Chair

For one thing, it's really hard to get through to your doctor to have your doctor explain the results. That's maybe not, necessarily in all cases, something that's appropriate. Certainly, if you had some kind of test that's going to determine whether you have a particular type of cancer or narrow down the diagnosis to the point where you know you need scans or something else, that's probably an interaction where you do want to be talking with your doctor. If it's something like routine blood levels that you have checked every so many weeks or months and it's just a matter that you need to know, yeah, I'm doing a good job. Or, no, they're too high. I need to grind down on it some more. In that case, perhaps, the best use of time and resources is to have an institutional person who follows up with those kinds of inquiries and can say, "Yeah, this is what it was. What it means is that you have to keep working on it." Or, "No, it's fine. Everything's great. Good job." Then you get into the human factors and organizational issues of, will all providers feel comfortable with someone explaining test results to their patients, even though they know that it's hard to find time to do that?

Brett Oliver – Baptist Health – Annual Report WG Member

What about even what's allowed by different state medical boards? You start to run into those issues. It's tough because there's so many different workflows in giving lab results back. I've been doing this for 20-plus years. When I first started, it was very common for physicians to just say, "We're going to check these tests" – you name it, fill in the black – "And we'll let you know if anything – if you don't hear from us, everything's fine."

Carolyn Peterson – Individual – Co-Chair

Yeah.

Brett Oliver – Baptist Health – Annual Report WG Member

That made me nervous as a cat, quite frankly. What if I never see the result? Where's the fall back on that? Since that time and the location that's decided in which we live, that that's changed. Even though we're going to post your labs on MyChart through our SR portal, you're still going to hear from us about those labs. It's interesting, Aaron, that you had that experience and said you were getting a lot of callbacks. That's definitely been a physician pressure point or anxiety about giving patients access to more information. Well, I'm just going to be spending more time explaining these trivial things that don't mean anything. That's not been our experience. Now, again, maybe if you've got workflows

where you're calling them, and it's just that the portal is more of a resource that they can refer to, or they're with another clinician who doesn't have access to those labs, they can pull them up.

Also, use of the portal, there's kind of two levels of it. You've got those that signed up before that were early adopters of our first portals. They're almost the harder ones to get reengaged because it just wasn't all that useful for them. Now, we've got all this new functionality. We can do video visits and interact with your clinician, this and that. They're almost the harder ones to sell than the second group that never signed up for that early around and that get in and say, "Wow, this is fabulous. Yeah, this is much more than what I thought. It's not just a listing of my labs." I'd want to think about how we can – what's the metric used that meaningful information is being exchanged? That's tough.

Christina Caraballo – Get Real Health – Annual Report WG Member

Brett, I think that's a really good point. I think we need to focus less on how many times I log into the portal and more on what's available to me when I login. What features are there? What tools enable me to interact with my data? Is information that I want available to me when I login so that it's meaningful to me? How many points of access does a patient have? If we could measure that, that would be great. When I'm thinking about that, I'm wondering exactly how many portals do I have to login to get my information from all different places? We've identified that as an issue. Can we, in this work, really paint that picture so that we can move more to a place where I'm able to use less of a single portal and use APIs to be able to have different tools and places that I interact? Where all my information comes into one place. I think that's where we're going to start to make an impact and less on just measuring simply logging into a portal.

Aaron Miri – Imprivata – Co-Chair

Great points.

Carolyn Peterson – Individual – Co-Chair

Yes, I agree.

Aaron Miri – Imprivata – Co-Chair

Okay. What if we took the opportunity, then, to think about this on the side, some specifics. Then over the next week or so, let's email in, and maybe we could ask – I don't know if there's a way for us to – I just feel like this topic is so important as we move the ball forward that it may be even worth posing it out also to the HITECH and see what their thoughts are on different dimensions for patient engagement and patient access, that sort of thing. I don't want us to get caught up in the whole trap of exactly what happened before, which was how many people signed up for a portal? All of you are exactly correct. That's a very basic model for measuring. It really doesn't move the ball forward.

Brett Oliver – Baptist Health – Annual Report WG Member

Yeah, I agree with you, Aaron. I think that's a good approach.

Aaron Miri – Imprivata – Co-Chair

Okay. Carolyn, should we move forward, or should we continue to think through this?

Carolyn Peterson – Individual – Co-Chair

I'm just looking at this list and trying to think about anything else. In the fifth bullet point, there's this mentioning of supporting infrastructure needs for underserved populations. Are there other thoughts related to underserved populations or other things we can be thinking about? We talked about bandwidth access. What else should we be thinking about? Perhaps, saying something about availability of telemedicine consults or supporting infrastructures that can expand processes around telemedicine into areas where they don't exist now and would be useful.

Aaron Miri – Imprivata – Co-Chair

That's true. When I think of infrastructure, I think of physical construct. Is there a cable, literally, in the middle of nowhere to allow for people to get high-speed Internet? I guess to your point, we could tie infrastructure also back to use case. Is telemedicine available for a rural part of the country due to a lack of physical cable plans or something to that effect?

Carolyn Peterson – Individual – Co-Chair

Yeah. I hope that we can avoid getting stuck in the box of terminology where it's like, "Well, that's not strictly infrastructure, so it's not going to get recognized as a need or an opportunity." It's great to have the physical infrastructure, but if the resources haven't been allocated or there are laws or we've always done it that way, that prevent useful things from happening, then that's something to think about, too. It's still a barrier for the patient and the provider.

Aaron Miri – Imprivata – Co-Chair

Good thought. That's a good thought. Brett, from a clinical perspective, if you're engaging with a patient that lives in a very rural part, what are some of those common headaches that you run into? Is it simply go to your local CVS to pick up a med and there's no CVS nearby? What is it that drives you nuts, as a clinician, for your underserved patients that you see?

Brett Oliver – Baptist Health – Annual Report WG Member

In our organization, we do have a fairly substantial rural population in the eastern part of our state. Western as well, but eastern is what I'm more familiar with. It's probably the Internet access being able to deliver the same care. Not as much telemedicine, which is certainly the future, and I want to. It's actually just even running clinics. We have, say, for instance, remote cardiology clinics where the staff and the cardiologist will go, yet they can't even log into our EHR from where they are because they don't even have – there's not even a cell phone signal from where the clinic is. You have a whole spectrum of infrastructure needs. It's not just, well, they don't have access to Internet at home because they can't afford it. It's not even available. Even in the towns where they're having a clinic, they're not even going to their homes and finding out they don't have Internet access or cell service. That's probably the biggest one.

I think also with this big push towards having information in a portable manner with devices, even though the iPhone and android and things are becoming ubiquitous, we still have a pretty large percentage that don't have a cell phone or have a flip phone. I think we'll identify that as another gap for patient access to information. They don't have the tool with which we're pushing things toward, for instance, Apple Health Record. Yeah, maybe they can go online, but if they don't have a phone, they likely don't have a computer. Again, even if that infrastructure is in place for the Internet.

Pharmacy-wise, **[inaudible] [00:34:31]** specifically. Most of all the pharmacists are connected. I can at least e-prescribe that way. I rarely run into that problem. The bigger issue from that is when I discontinue a medication. There is a charge. I can enter in, oh, this blood pressure medicine, you come back in a week. You know what? It gave me a cough. We need to change that. I'll change it, and I'll also discontinue via the same system, but there is 1 out of 1500-plus pharmacies in the state of Kentucky that has that functionality turned on because there is a charge of 25-50 cents to have that prescription functionality turned on. They're there to fill medication. There's no motivation to pay extra to make sure it gets turned off. There are some technology issues, and I probably got sidetracked a little bit on that. I don't think it's patient access for this particular gap analysis that we're looking at.

Aaron Miri – Imprivata – Co-Chair

Yeah, but you know what? You just brought up an excellent, excellent point. You're right, even in Texas, we have a disparity when it comes to being able to do something like – to your point, e-prescribe and cost. This cost of exchange and this cost of information access. Quite frankly, there's certain populations that simply cannot afford it. They just cannot afford it. There are certain pharmacies that are out there, the mom-and-pop ones in very rural parts that just can't afford it. Carolyn, this may be something for us to consider and look at is the implications of the varying costs of infrastructure in underserved populations. Not just the cable plans or the cell signal there, but are the costs in alignment with what that underserved population can afford? Or something to that effect.

Carolyn Peterson – Individual – Co-Chair

Yeah, that's a really good point. We've been talking about in terms of the rural context, but just sitting here thinking about, say, a person who can't drive anymore. For health reasons or whatever else, they've been becoming more isolated from the friends and the broader social group they had 5 or 10 years ago. Even for that person, having some kind of a telehealth or some sort of in-home link to providers would be beneficial in the same way that it benefits the rural person. Because they struggle to get out and get to the clinic or to the pharmacy to pick up prescriptions or whatever else.

Aaron Miri – Imprivata – Co-Chair

Yeah, good point. Good point. Actually, I want to marinate on this one a little bit more. I just think there are a lot of items here that it's worth us calling attention to, and it is impacting care. Let me ask a quick question here, in general. Do we save the chat and public comments for the end? Is that how this works, Lauren?

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

We currently have it scheduled for, I believe, 12:20 or 10 or 15 minutes before. We can just hold until then.

Aaron Miri – Imprivata – Co-Chair

Perfect. Okay. I just wanted to make sure we don't lose sight because I see a public comment here. I just want to give it respect. We'll address that question at the end there. Okay.

Brett Oliver – Baptist Health – Annual Report WG Member

What about the thought – and I'm not sure where this would fit it in in terms of the gap. What I'm seeing happen, as we continue to flounder with national standards for interoperability, the capitalistic model in which we live, which I fully support, is the monetization of this data. I don't even know if that's the right term. I get vendors all the time coming to me and saying, "Hey. Your ER physicians needs this, this, and this. We could package that and sell it to you, essentially." They have a slicker presentation than I just said. I can see that really leading to gaps in information. My hope is that there's as free exchange of information as possible, understanding I don't live in utopia and there are costs to some of these infrastructure changes. Do we see that as a potential gap that maybe we don't have now because the gaps exist? As these companies start closing the gaps, but at a price, does that leads to problems?

Aaron Miri – Imprivata – Co-Chair

Good question. Basically, to paraphrase, you're asking the question as to – as there's more data liquidity, and therefore, there's more valuation to that data because now we can extract more meaningful bits of information, will organizations hold it hostage, essentially, for purposes of monetization? Is that what you're asking?

Brett Oliver – Baptist Health – Annual Report WG Member

Not necessarily hold it hostage, but there's a cost to what the company is going to do. If there's a spaghetti network of piecing together all the information that I need – and I'll use the emergency room as an example. They would want to see the PDMP data when you show up with some acute pain complaint, maybe any recent ER visits that are not a part of my system, that I don't have easy access to. There are companies out there that are out there now packaging that and saying, "We will run a query. As soon as the patient hits your door, we'll have an interface with your system, and we'll run the query. We have this way of pulling all this information and putting it in a package for you." Because of the spaghetti network of interoperability that we have now or the lack thereof, I can't do that simply on my own. Well, there's a charge to that. Will there be some emergency rooms, then – well, I'm an independent hospital. I can't do that. Or choose not to, and there's a gap because of the delay of a national standard or what have you. Does that make sense? I'm not saying they're intentionally holding it hostage. They're just going about and saying, "Hey. We can provide you this service." Not everyone's going to be able to afford that service if there's not a higher level of interoperability that they're able to get that information from.

Carolyn Peterson – Individual – Co-Chair

Yeah, that makes sense.

Aaron Miri – Imprivata – Co-Chair

That does make sense. I'm just trying to think; how would we measure that? What would you think, in your mind, would be –

Brett Oliver – Baptist Health – Annual Report WG Member

That's a good point. I'm not sure if it's measured, but I thought it might be something we could call out as a potential gap.

Aaron Miri – Imprivata – Co-Chair

I think it's definitely worthwhile mentioning. Absolutely. I'm trying to also say, is there even a component of that we could measure? I do think there's an issue that's occurring and that's also going to grow to get bigger, which is there are types of companies and types of organizations that do hold

the data hostage because there's a valuation they place on it. That's the reality of it. Claims data for various clearing houses, they will not share that data unless you pay a premium for it, and/or you have to subscribe to some service they offer because they're monetizing that. That is their business model. How do you free the data without disrupting business models? How do you measure that?

Brett Oliver – Baptist Health – Annual Report WG Member

Yeah, that's a good point.

Aaron Miri – Imprivata – Co-Chair

Okay. Let's see. What else? Carolyn, what else on here do we want to talk to?

Carolyn Peterson – Individual – Co-Chair

Is there anything that we haven't considered specifically relevant to APIs? I'm trying to think. Nothing's hitting my mind, but certainly, that –

Aaron Miri – Imprivata – Co-Chair

No. I think the ONC, especially as seen by Dr. Rucker and Dr. Vermin and others have done such a great job of vocalizing APIs in the recent news that I think everybody's talking about it now. Versus a couple years ago, no one even knew what it was. I know the culture is moving in the right direction of using APIs. I know the vendors are starting to listen, which is really positive. In my mind, I look at it going great. In a couple of years, we're going to get there to where the highways are built to share data. I don't know that there's a way – how do we measure that? Should we measure it to the terms of meaningful data is exchanged via APIs, certain types of data? I don't know. How do we measure usage of APIs?

Carolyn Peterson – Individual – Co-Chair

I'm not sure that that's even a good use of time at this point. Perhaps, when some particular uses of APIs have been identified or risen to the surface. I was thinking, in general, have I seen any particular legislation or initiatives or whatever related specifically to this in the last, say, six to nine months? Or that there should be some thinking about what that means, operationally. Honestly, I'm not coming up with anything. If no one else –

Aaron Miri – Imprivata – Co-Chair

No. The last legislation I saw referencing APIs was 21st Century Cures. They really call it out. I did a big cheer when I read that. I haven't seen anything recently, but I'm sure there's things coming.

Carolyn Peterson – Individual – Co-Chair

Okay. Then accessibility and usability are always ongoing challenges. There's W3 guidelines, but again, I'm not sure how HITECH or ONC are in a position to do something about that beyond stating the importance of continuing to push for improved usability and accessibility.

Aaron Miri – Imprivata – Co-Chair

Right.

Carolyn Peterson – Individual – Co-Chair

Should we go to a different subject other than patient access?

Aaron Miri – Imprivata – Co-Chair

Yeah, let's move forward. Let's keep going.

Carolyn Peterson – Individual – Co-Chair

Okay. Which one do we want to go to now?

Aaron Miri – Imprivata – Co-Chair

Interoperability or privacy security, I'm good with either.

Carolyn Peterson – Individual – Co-Chair

Yeah. Let's go to interoperability. That's a big one.

Aaron Miri – Imprivata – Co-Chair

Okay. Do we think there's anything missing off of this slide, I guess is the first question, right?

Carolyn Peterson – Individual – Co-Chair

Yeah.

Aaron Miri – Imprivata – Co-Chair

Usability metrics, which I think is a recommendation here, in our public comments we're going to talk about later. Expansion of the use cases, alignment of timeliness, incentives for change, and then the – getting back to that broadband access. I'm being perfectly candid here, I feel like there's an obvious item here that, for whatever reason, is not coming to my mind that we may be missing. I can't seem to see it. I'm looking at this slide going, I know there's something here that we haven't just brought up yet. It feels like there's something missing.

Carolyn Peterson – Individual – Co-Chair

Well, we have the summary for the HITECH meeting. We can go back through the comments about that discussion and see if there's anything there that we haven't gotten on the slide.

Aaron Miri – Imprivata – Co-Chair

Yes.

Carolyn Peterson – Individual – Co-Chair

That was quite a long and detailed discussion. We may have to pull some things out of the notes on that.

Aaron Miri – Imprivata – Co-Chair

Yeah, we even talked about leveraging standards like OWASP 2.0 and others, standardizing across those, standardizing across various USCBI nomenclature, all sorts of things. Okay. Is there anything clinically, Brett, that you think, from a clinical perspective, that we should really hone in on when it comes to interoperability? Again, think of it in the terms of, how could we measure, too? What would you look for?

Brett Oliver – Baptist Health – Annual Report WG Member

Oh, gosh. I think this is a good outline. The biggest problem that we experience, right now, is just CCD information, believe it or not. These are certified systems, but this data point is not mapped to this other data point. There's, literally, not a way to do it without a separate interface. When you're trying to do clinically integrated networks, and the docs just – just to get them a CCD on that data has been a

real challenge and not one I anticipated happening. I thought we were past that, but clearly, I was naïve.

Aaron Miri – Imprivata – Co-Chair

Yes. I've seen that, too. Good point. Do you have the debate – let me ask this question because it also, I think, relates back to interoperability and could relate back to patient access, as well. Brett, have you had a debate in your organization about how much of the CCD to actually give the patient on discharge? Do you give them everything, or do you give them just the summary and discharge notes?

Brett Oliver – Baptist Health – Annual Report WG Member

You mean after a visit or after a hospitalization?

Aaron Miri – Imprivata – Co-Chair

Yeah, exactly.

Brett Oliver – Baptist Health – Annual Report WG Member

Some of the demographic exchange is probably not there that you would see just on some standard C-CDA material. It's trying to be a little bit more clinically relevant to them, with patient instructions and, certainly, the task that they've had done, medication they've been prescribed, diagnoses. I don't think we would have things like allergies and their address, follow-up appointments. Things like that happen at discharge, but some of those things are not even on our USCDI roadmap yet.

Aaron Miri – Imprivata – Co-Chair

Got it. Got it. I'm just thinking in my head, is there a measurement for interoperability here based upon a standard criterion set that the patient gets every single time? Which would come from multiple systems, obviously, to be interfaced back out. I'm just trying to think outside the box here. Are there other dimensions here to look at? So, we can say, "Hey, yup. Check the box. This was measured." That we could have a statistic measurement for it.

Brett Oliver – Baptist Health – Annual Report WG Member

If we could certify these EHRs. If they're saying they're interoperable with each other at just the basic C-CDA information level when they're truly not. I feel like these smaller practices, they took their federal money, they did their best in terms of vetting the EHR. They're certified. They can exchange data. Then they sign up for our clinical integrated network, and we can't get the data. Well, they don't

have the resources. Quite frankly, for dozens of practices, we don't either to, then, go and reinvent the wheel and figure out how we're gonna get their data into our data so we can aggregate, report on, etc. The metric of true C-CDA information exchange, if that was able to, that'd be a great starting point just to prove that they're actually able to do that.

Aaron Miri – Imprivata – Co-Chair

I like that. Maybe as our first bullet point, we have a sub-bullet with that. Can you exchange C-CDA data – I don't want to say the word "meaningfully" because I feel like that word's been burned out over the years but – meaningfully with each other?

Brett Oliver – Baptist Health – Annual Report WG Member

Yeah. They are just a true exchange of those 22 data points or whatever we decide on USCDI. The system, it's not accurate. It's almost like saying, "Well, we exchange information" – and I probably used this example before, but it's an ADT notification that someone was somewhere. I guess at some level, that's important. If I don't have any information about that visit, it's really not moving the clinical needle. You can say, "Oh, yeah. With certain systems, we can exchange the C-CDA information." Yet, if you can't do it universally and there's not a universal way of doing it, this is not –

We have Epic. We're an Epic shop. It's not that Epic can't do it. It's just however this information is presented – and forgive me for not understanding the technical pieces to it, but it's not the same. We can't make it the same. In my mind, the C-CDA is there's very prescribed bits of information that should all be in the same format, and they're not. Somehow, we've let that slip through the cracks in terms of certifying. From a clinician standpoint that doesn't have an IT background, you tell me my EHR is certified and can exchange information like that, then I'm looking at my bigger organization and saying, "What's your problem? My guy says he can do it."

Aaron Miri – Imprivata – Co-Chair

Good point. Very good point. Carolyn, what's your take on that?

Carolyn Peterson – Individual – Co-Chair

Yeah, I agree. That makes good sense to me. The gap between what we think we have and what we actually can use is often an issue underlying a lot of these things.

Aaron Miri – Imprivata – Co-Chair

I like Brett's way of saying that. It's almost like a disparity between certified and reality. I don't know how you – I'm not a wordsmith by any stretch of the means, but that measurement, that gap measurement as to yes, we check all the boxes, and so we got certified against criteria. It doesn't mean a can of beans to the clinician because it doesn't actually function in the real-world setting. That gap, I don't know how we word it, but I like that.

Carolyn Peterson – Individual – Co-Chair

I would just call it the reality gap, honestly. Maybe that's a new term that we contribute to the discussion. The operationalization, the difference between what you say you've got, what you should have, theoretically, versus what actually plays when you plug it in.

Aaron Miri – Imprivata – Co-Chair

That's exactly right. I like that, the reality gap. All right, trademarked. We're going to start using that. I like that. Okay. We're going to add that as a sub-bullet, then, to this first bullet item, then. The usability metric, the reality gap. Then we can think through exactly how we do that. Whether it's just looking at – we'll start with the CCD, or we'll start with some other measurement criteria. We could talk through with the HITECH, but I think, A.) It meets a lot of the needs I'm hearing from my clinicians, like Brett, saying, which is this is garbage, Aaron. What's going on here? Then, B.) As a CIO, when I go back to the vendor and say, "Hey. What's going on here?" Well, we're operating within normal operating parameters. I like that. We call it the reality gap. We can begin to call attention to this, which is really need to talk about this.

Brett Oliver – Baptist Health – Annual Report WG Member

Yeah. It's the perception of what the average person would expect certification to mean and the reality of what it means.

Aaron Miri – Imprivata – Co-Chair

Very nice. Okay. That goes on this. I like this a lot. That's a great topic. Okay. Carolyn, do we want to go through each one of these, or should we just keep talking? What do we think?

Carolyn Peterson – Individual – Co-Chair

We're just about at the top of the hour. We have the public comment coming up in about 25 minutes. Are there any other – we probably should go look at privacy and security and be sure we don't overlook that.

Aaron Miri – Imprivata – Co-Chair

Yeah, I would agree with that. I think we can further fruit on the interoperability of the privacy and security. Okay. Let's have a little fun with this section. In talking through this, the general thematic issues here: what does it really mean now that companies like Apple have a band on a watch that could send you back in ECG? What does it mean that states like California are passing IOT bills and consumer privacy acts and things like that? What does it mean that GDPR is in play? Actually, the EU is passing even further legislation related to GDPR either here or in the very new future. How does that all affect us and that discrepancy, again, that gap. Are there other items around privacy and security? Let's be a little more granular. Are there items around privacy and security that maybe, Brett, you're hearing from patients as they come in or others that could affect us? Is it the temperature of the breaches that have been occurring recently and folks now being reluctant to do anything electronically? I don't know. Let's talk through it. Are there other items here that we want to talk through that are opportunities from a privacy and security perspective?

Brett Oliver – Baptist Health – Annual Report WG Member

I haven't found at least – I'm probably speaking way too much about just myself because I haven't queried the organization and my colleagues. I haven't found my patients to be particularly bothered by that. It's almost like it's happening somewhere else on a national level, or maybe they're not putting any context. I do think that the fact that their data, let's use iPhone – or I'm sorry, the Apple Health Record on your iPhone. Let's consider that that it may not fall under HIPAA. We've had to be really clear because we do participate with it as an organization that you're leaving. This data, once it leaves, we're not responsible for it, protecting it. Is there a good understanding? I think there's a pretty gap of understanding.

Everyone knows that when they see me and they tell me something or we have a lab value that's sent to the – there's laws around that. I'm not reviewing that even to your spouse without written consent. Is there that same understanding – and I would say no – with this new wave of pulling your data out into an app or something along those lines that may or not – I'm not sure I understand the laws well enough to know what protects that or what doesn't. We had to be sure we were clear, as an organization, to the patients. There's a big disclaimer before you sign up for Apple Health Records, or MyChart for us, is this is not our thing. They're asking for your data, not us, and we don't know what they're going to do with it. I think there's a gap there at least.

Aaron Miri – Imprivata – Co-Chair

Yeah. That's a very good point. I think it goes back to that third from the last bullet about education around privacy and security. Although this is not social media, this is consumer health media. What does it actually mean? Do people actually understand what they're consenting to? Make no mistake about it, companies like Amazon and Apple and others do a phenomenal job with the data, but they

take that data and a do a zillion things with it. Are you consenting to that? Do you realize what you're consenting to? It's a very good point.

Brett Oliver – Baptist Health – Annual Report WG Member

Honestly, there's a gap for me, personally, is understanding what does HIPAA cover in that regards or not or whatever? The corresponding regulations.

Aaron Miri – Imprivata – Co-Chair

If you had a question, who would you go to? Would you go to the OCR? Would you go to the FDA? Who would you query?

Brett Oliver – Baptist Health – Annual Report WG Member

Yeah, great point.

Carolyn Peterson – Individual – Co-Chair

All of those issues will just multiply and blossom if additional states start passing legislation similar to that California act. Then you have differences among states. What happens when an organization works in multiple states and you potentially have information crossing state lines? You could just legislate certain solutions, like the laws that apply are the ones that were in effect in the state where the data was created. We don't have those today and probably won't for a while. It might be hard to ever get there, depending on politics and just the realities of different stakeholder needs and goals.

Aaron Miri – Imprivata – Co-Chair

You're exactly right.

Brett Oliver – Baptist Health – Annual Report WG Member

I don't know anything about the California law, but all I thought was, oh, my gosh. Now, we're going to have 50 of those things. Federal regulations, and how in the world are we going to keep track of all of that?

Carolyn Peterson – Individual – Co-Chair

It'll keep developers busy, that's for sure.

Brett Oliver – Baptist Health – Annual Report WG Member

That's true. Hey, Aaron, I'd like to bring something up under here that you mentioned. It was not during this meeting, but back when we had our face-to-face meeting. It was really under future things to talk about. I wonder, if under privacy and security it fits here in terms of there's – I don't know if it's a gap, but certainly, it doesn't exist right now. The safe harbor principle. It is very frustrating to, as an organization, work really hard for tons of resources, time, money, effort, into bringing your security levels up, and you never go to zero, or you never get to a four. Whatever your scale is. Then have parameters and standards set for your vendors. If the vendor has a breach, it's your patient data that's lost. You're responsible. I really thought quite a bit on that after you mentioned it at the meeting. Is a lack of some kind of safe harbor or floor standard, nationally, is that something that we should call out?

Aaron Miri – Imprivata – Co-Chair

You are exactly right. I can tell you, I've had this debate with numerous legislators and various federal officials. There are a variety of thoughts on it. It boils down to this one basic premise. If you set a floor, are you inadvertently legislating how a company should build its products? The government, obviously, doesn't want to be in the business of telling a private business how to conduct their business. To your point, are we at a tipping point as a vertical that we do need a minimum floor. To the point of what I brought there in the HITECH, therefore, some sort of safe harbor for organizations to say, "Hey, look, I've done my very best and stuff still hit the fan. Don't draft me like I'm negligent. Let's work together to help me get better at whatever it is."

I think it's a worthy discussion point. I have seen a lot of voluntary standards coming out recently, especially the FDA did a really good job when it comes to medical devices and at least starting to set up each parameter as a following in this cyber security framework and others. There hasn't been a – I'll use the word "mandatory" – floor or framework adoption. I know that at some point – and Carolyn, keep me honest here – we talked about frameworks and looking at that and adopting a framework. There it is. I see it right there. Fourth bullet point from the bottom there. Maybe we could use the sub-bullet to talk about the potential for additional safe harbor considerations for following a specific framework. I don't know. What are all your thoughts on that?

Carolyn Peterson – Individual – Co-Chair

That's an interesting idea.

Brett Oliver – Baptist Health – Annual Report WG Member

I like the specific guidelines. Yeah, some guideline that you could follow. We're still responsible. We still want to figure out how to make the system better. Something that you could defend yourself with, saying, "Listen. We were at this level-two national recommendation. That should count for something." We do due diligence with our vendors. We have certain parameters that you have to reach, but we're not in their offices. We're not with their servers. Especially as we move more to cloud-based things, it concerns me that our vulnerabilities increase without the ability to be on site and protecting it ourselves.

Aaron Miri – Imprivata – Co-Chair

No, you're right. While the business associate agreement – assuming you've done them, which if you haven't, do it with every one of your vendors – is in place, that's supposed to give you a level of cover. However, to your point, the data is still breached. There are still other questions that could come up and/or further investigation that could occur. Are there additional safe harbor considerations there? I think that's a really interesting point. I know we had talked about, maybe, talking to other agencies at some point in the future. That'd be a great question to pose and see how that would work. I, honestly, don't know the back-end operations of that. I think it's an interesting question we should ask.

Carolyn Peterson – Individual – Co-Chair

Is it something that we would want to park on a list of emerging issues? We've thought in terms of gaps and opportunities and things that we clearly see on the horizon, but then, there are other things where you think, well, if this and this happen… Or, in six months, we might have enough experience to know about this. You either think that we should be thinking about and revisiting, say, second or third quarter of 2019.

Aaron Miri – Imprivata – Co-Chair

Yeah, I like that.

Carolyn Peterson – Individual – Co-Chair

I don't want to say parking lot because sometimes the parking lot turns into the junkyard and things that go there never leave. We're clearly thinking two or three steps ahead. Maybe it's good to gather those ideas into a list where they can be acknowledged as medium term, upcoming things to think about or revisit.

Aaron Miri – Imprivata – Co-Chair

I think that's a very fair point. I like that. I do like that. I do have one item, though, that I have on my list here that I want to talk about maybe more near term. It wouldn't be for a parking lot, but something

for us to consider here. There's this notion of accountability that's beginning to come up on a privacy and security perspective as to if accountability needs to be held, who is accountable? I think this goes back also, Brett, to what you were bringing up here a moment ago, which is we have all these different groups leveraging data. Say, it's Aaron's data, and I've interacted with, say, 10 different systems and vendors and then, of course, the provider organization to see my lab results. I'm making this up. If that data is compromised or breached or modified or whatever, who is accountable? There are so many intersecting points.

To me, there needs to be a level of, okay, who really is Johnny-on-the-spot? Today, when there's even a question of – say, there's a technical issue. There's a lot of finger pointing because so many different groups intersect. There's not really a level of clear accountability. I think there is a value point for us to talk through here under privacy and security and say, "We need to hold or have clear delineated roles of accountability when it comes to privacy and security." What are all of your thoughts?

Carolyn Peterson – Individual – Co-Chair

It could be a really useful task to come up with a chart. It could be a work product, perhaps, of a small subgroup or of the full HITECH. If this is the issue, here's the party to be accountable, and here's the party to be responsible. We can talk through these things with some degree of confidence. Certainly, for consumers or, perhaps, for physicians who observed – or other providers in a large system who's observed what they think was some problem or issue related to the technology, it could be really helpful in terms of helping people pinpoint, who do I talk to? Where do I raise the flag? What can I expect in terms of who I'm working with? Where do I go if I don't see that that's ever been acknowledged or considered?

Aaron Miri – Imprivata – Co-Chair

Exactly. Exactly. I know that I keep going back to this FACA because the OCR was really involved and did a great job with us. On the ACI FACA, they did a great job of doing some sort of accountability matrix when it came down to HIPAA and what third party is responsible under HIPAA and which ones weren't. It was almost like the next generation of that chart, which is, okay, so now that we have that component, when it comes to dealing with ePHI, where is the accountability as you deal with multiple things now with the HealthKit or whatever else? Who's accountable? When Brett goes to sign up a new patient under HealthKit and is explaining to them, he could point to a chart, as a clinician, and go, "Look. My organization is not responsible. This is the responsible party. It is" – I'm going to just make this up – "Apple," or whomever. Just so you're clear on it. I think today, he brought this up, that people just don't know.

Brett Oliver – Baptist Health – Annual Report WG Member

Yeah. They think it's more granular than that. What's the accountability for the person receiving the information. I know we're talking more organizationally, leakage and breaches and things like that. If we start providing more information and we would hope that it would be good, as a provider, what's my accountability for that information? If I requested it, I ordered it, I asked for it, it's mine. If there's a lot of automation to some of this, like all of a sudden, I get mammogram reports on mammograms that I didn't order, maybe the **[inaudible] [01:09:36]** is my patient just got sent to me inadvertently. What's my accountability?

A huge stressor for my colleagues is, "I didn't ask for that information. I don't want it." They don't want to sign off on it. They don't want to say – because they're afraid it's a 50-page report, and I don't have time to read it all. What if there's something in there that implicates me? I'm not even seeing the patient for that. There's accountability on another level as well. Again, that may be put into the junkyard parking lot, whatever. This was brought to mind as you guys were talking.

Aaron Miri – Imprivata – Co-Chair

Great point. That's a great point. It's all of that, right? How do we begin to quantify and qualify accountability on all dimensions, both on a granular and an organizational perspective? I think that's an excellent item. We can start very simple. When I look at measurements and that, it's simply, do you have all of your data identified? Do you know what your crown jewels are? Where your ePHI is? The measurements could be very easy to begin with, and then go very granular down the road. I just think we need to move that ball forward. At some point, there's going to be a level of accuracy required. I think organizations, today, have been trying to sift through the sand. I can appreciate that, obviously, being an organization myself. We have to get specific. We have to understand where the data is. That's my two cents.

Carolyn Peterson – Individual – Co-Chair

I agree.

Aaron Miri – Imprivata – Co-Chair

Okay. Do we agree to add an item on here around accountability? We can further refine that as what we'd want to call it?

Brett Oliver – Baptist Health – Annual Report WG Member

Yeah, I like that.

Carolyn Peterson – Individual – Co-Chair

You call it the accountability finder.

Aaron Miri – Imprivata – Co-Chair

There you go. That's two items we trademarked today. We're on a roll. Okay. All right. I know we're getting closer to time. We've got about five minutes. Do we want to move on?

Carolyn Peterson – Individual – Co-Chair

Yeah, we need to think about whether there's anything else that we really, absolutely need to cover before we head to public comment.

Aaron Miri – Imprivata – Co-Chair

All right. Let's go through the plan, really quick. All right, next slide. We're, right now, at the fifth bullet point, that mid to late – I'm sorry, the September 20th item, obviously, we're talking through right now. Then obviously, we're going to be scheduling another meeting here in mid-October or late October. We had a meeting on the books for – I believe it was – what was that? Friday the 5th? Or whatever that Friday was. Which we'll be moving out by a week or two to give it some chance to do some more detailed assessment analysis and really provide more robust feedback back to this group. That is our next step is to have that meeting coming out. Then of course, going forward, Carolyn, anything you want to add to that?

Carolyn Peterson – Individual – Co-Chair

I don't think so.

Aaron Miri – Imprivata – Co-Chair

Yeah. I think what's important is that we, obviously, want to get this wrap – kind of get a rough draft together by the time the holidays roll around so that we all have a chance – all of us have a chance to look through it, add to it, HITECH looks at it, adds to it. Then spring will be here right before we know it, and we'll be kicking off the next generation of this workgroup sooner rather than later. We have to wrap up 2018 before we start 2019. It's going to be a sprint to the finish, but it'll be fun. Next slide.

All right. Do we have this meeting scheduled? October 17th?

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Yes. That's going to be scheduled for the full HITECH, yes.

Aaron Miri – Imprivata – Co-Chair

Okay, perfect. All right. This will be for the full HITECH one, which will we do that analysis, the gap analysis presented back to them. Then of course, the 14th, looking at this in an aggregate and then looking at the report in January timeframe. There's a lot of – obviously, October and November are going to be very busy. There will be a lot of emails probably flying around with ideas, like we just talked about today on the call. Get this to goal. Next slide.

All right. Before we do this, is there any other comments that we want to make? All right. Carolyn, if you're in agreement, we can transition to the next section.

Carolyn Peterson – Individual – Co-Chair

Yes, I think so.

Aaron Miri – Imprivata – Co-Chair

All right. Lauren?

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Great. At this time, we'll just open it up for public comment. Operator, can you please open up all the clients?

Operator

Certainly. If you'd like to make a public comment, please press star, one on your telephone keypad. A confirmation tone will indicate your line is in the queue, and you may press star, two if you'd like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys. Again, that is star, one if you'd like to make a comment at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Great. Thanks. Just for the record, I don't believe Chesley ever joined. We can catch him up sometime offline, after this meeting. Operator, do we have any callers in the queue at this time?

Operator

Not at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Okay. Before we close the public comment period, I do just want to give a little bit of time. I know it takes folks just a few seconds to dial in. If we do end a little bit early, Carolyn and Aaron, do you want to go back to any particular discussion items before we adjourn?

Carolyn Peterson – Individual – Co-Chair

I wasn't feeling like we jumped out of anything over quickly, but certainly, if Aaron wants to double back to something or Brett or Christina, we should.

Aaron Miri – Imprivata – Co-Chair

I'm good. Actually, I think we did a pretty decent job at coming up with two trademark new names or new descriptors and some good ideas there. I feel good.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Okay. Operator, last check. Any other callers in the queue?

Operator

No, we have none.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Okay. With that, we'll close the public comment period.

Aaron Miri – Imprivata – Co-Chair

I'm sorry. Let me ask a question. I see a public comment written in the chatroom that was here from Susan.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

The public members don't have the ability to speak. We leave it up to the discretion of the chairs, whether they would like to respond or address a question in the public comment chat feature. They don't have the ability to speak.

Aaron Miri – Imprivata – Co-Chair

Got it. Got it. I didn't know that. Thank you. All right. Well, I think it's a decent comment here, so I'll just read it out loud. Carolyn and Brett, let me know what you guys think here. The thought from one of the public members was that, perhaps, we have an IST taskforce that's focusing on the orders and results is their first priority. I think maybe that this group could come up with a meaningful metric around – and I believe this is interoperability. Maybe leveraging some of those taskforces to help us come up with what those metrics could be. I think that's a very fair question as we pose it back to the HITECH. Maybe at the next HITECH meeting, we can ask if any of those taskforces want to help us develop some criteria around things like interoperability or privacy and security or whatever. I think it's a very fair question. Carolyn, what are your thoughts? Brett, what are your thoughts?

Carolyn Peterson – Individual – Co-Chair

Yeah. I think that's a good point to follow up on.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

I expect that at our next HITECH meeting we'll have an update from the interoperability standards priority taskforce, just to update the committee on the progress they've made. Those taskforce meetings are open to the public, as well. We'll certainly circle back to the full committee when we get a little further down the road there.

Aaron Miri – Imprivata – Co-Chair

Yes, perfect. Okay.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Okay. Anything else before we adjourn?

Aaron Miri – Imprivata – Co-Chair

No. Good discussion. Thank you. Thank you, guys.

Carolyn Peterson – Individual – Co-Chair

Okay, good work.

Brett Oliver – Baptist Health – Annual Report WG Member

Yeah, I appreciate the discussion. Thank you.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Yeah. Thanks for your time today. We'll adjourn, and we'll talk soon.

Brett Oliver – Baptist Health – Annual Report WG Member

Thank you.

Aaron Miri – Imprivata – Co-Chair

Thank you.

Carolyn Peterson – Individual – Co-Chair

Thanks, everyone.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer

Thanks for your time. Bye-bye.

[Event Concluded]