Annual Report Workgroup

Transcript
April 10, 2019
In Person Meeting

SPEAKERS

Name	Organization	
Aaron Miri (Co-chair)	The University of Texas at Austin, Dell Medical School and UT Health Austin	Co-Chair
Carolyn Petersen (Co-chair)	Individual	Co-Chair
Christina Caraballo	Audacious Inquiry	Member
Brett Oliver	Baptist Health	Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Michelle Murray	Office of the National Coordinator	Staff Lead

Operator
All lines are bridged.

Lauren Richie - Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Good morning, everyone, and welcome to the Annual Report workgroup of the Health Information Technology Advisory Committee. Thank you for joining us here so early this morning. With us from the workgroup we have Carolyn Peterson, one of the Co-Chairs, and Christina Carlisle. Still waiting for a few other members to join, but we wanted to go ahead and get started and, hopefully, they will join us soon. So, with that, I will turn it over to Carolyn for a few opening remarks, and to review the workgroup schedule before we dive into the report for fiscal year 19.

Carolyn Peterson - Individual - Co-Chair
Thanks, Lauren, yes, it's pretty amazing to believe we are already talking about the report for fiscal year 19 when we seem like we just barely handed off the report for the fiscal year 2018. But the good news is that we have good feedback from members of the HITAC and so we are at a good place to start thinking about how to structure the upcoming report and what to include in it with plenty of runways to do whatever research or other work we need to do to ensure another really excellent report. In the past few days, the HITAC has transmitted the Fiscal Year 18 report to the national coordinator, and that will be moving on to Congress very soon. I see we're joined by Aaron Miri and Brett Oliver –

Aaron Miri - The University of Texas at Austin - Co-Chair
Hello.

Carolyn Peterson - Individual - Co-Chair
Nice to see them come this morning to our meeting.

Aaron Miri - The University of Texas at Austin - Co-Chair
Absolutely, good morning.

Carolyn Peterson - Individual - Co-Chair
Hey, so I was just welcoming everyone and letting them know the 18 reports have gone and here we are starting the 19 reports.

Aaron Miri - The University of Texas at Austin - Co-Chair
That's about how it goes. It's great.

Carolyn Peterson - Individual - Co-Chair
That's right. So, we have a discussion of potential topics and some planning for our presentation at an upcoming meeting and public comments. And I will pass the mike to Aaron, for any comments he has.

Aaron Miri - The University of Texas at Austin - Co-Chair

No, I think it's excellent, it's exciting times. I know that going forward, you know, 19's going to hit the ground running. I think there is a number of topics I look forward to adding to this report that I think it's important for folks to realize that we deliberately stayed away from because NPRM had not released others. And so, it's been a lot of questions as to will 19 pick up the ball from there, and I think that's a safe assumption. However, things are not yet finalized, whatnot we've got to work through the details, but the 19 reports should continue the trajectory we started, and it's exciting times, so I look forward to it.

Carolyn Peterson - Individual - Co-Chair
Yea. And we have Christina on the phone here.

Aaron Miri - The University of Texas at Austin - Co-Chair
All right. Okay, so, let's go ahead and move on to the discussion points, then. So, and looking at some potential topics for 19 report and thinking about what we want to add-on there, items that maybe the members asked for last time that we deliberately paused on, we can talk about that. Any other items we have heard feedback over the last couple of weeks since we finalized the report. Carolyn, anything you heard in your discussions with folks?

Carolyn Peterson - Individual - Co-Chair
Actually no, I've been really deep into the CMC workgroup with NPRM in and also the HITCC. So, to be honest, I haven't heard anything about the annual report. I think we are all pretty much in the workgroup.

Aaron Miri - The University of Texas at Austin - Co-Chair
That's true. That's very true. Brett, what about you? Any thoughts of items or things that maybe you heard in passing or items you definitely noted in the back of your mind over the past several weeks that we want to keep on our radar?

Brett Oliver - Baptist Health - Member
Well, as far as the topics for consideration that we had already noted and we've already partially covered the one, but patient matching just continues to be one. To get specific that seems to interplay with so many other issues and whether it's brought up saying, hey, we're annual report workers, you need to be looking at this or not, it seems to be one that either has to get outside, experts to come in and let us know where things live, and sort of address it at the HITAC or **[inaudible] [00:04:13]**, somebody that would – kind of like a domino at the bottom, the Jenga game.

Aaron Miri - The University of Texas at Austin - Co-Chair
Right.

Brett Oliver - Baptist Health - Member
Gets pulled out the wrong direction, and I think we'll – we could end up having to redo some work if we don't address it up front.

Aaron Miri - The University of Texas at Austin - Co-Chair

I know in the 18 reports we did reference the finalized report that came out of was it OIG, or – what was 21st Century Cures? They authorized somebody to go after, or look into it, or do a report. We referenced it. And I know we referenced it in the material. Darn, this is an early meeting, so my mind hasn't woken up yet.

Carolyn Peterson - Individual - Co-Chair
Jeffrey, what agency was that?

Aaron Miri - The University of Texas at Austin - Co-Chair
That's right, one of the agencies, they reported. I know we referenced the findings which basically surmised it to what Brett is saying that we need some sort of strategy to deal with that. And I think that's a fair topic.

Carolyn Peterson - Individual - Co-Chair
GAO.

Aaron Miri - The University of Texas at Austin - Co-Chair
GAO, thank you. Jeepers. GAO. And so, yeah, so, to the degree of looking at those and maybe if it's possible to hear from the folks who authored that report, and other – I know FEMA and others have been very vocal on the subject. I know in Texas, we have a major issue with the identification of patients, particularly as it relates to indigent care because one of the criteria from a state perspective is being able to actively identify them, to both provide them any kind of care that we need to. So, it's been difficult, given that there's such a large population of non-English speaking or another type of status type individual. So, to the degree I think it is, it is something to consider and think about.

A topic I've also heard resonate loudly is this out for comment FDA digital paper whatever is just-released about how to deal with AI, how do you deal with really bringing this into the healthcare realm, and it does a good job of going into some specific detail about weighing up the risk and, is it really patient life affecting, or is it more decision-support and that sort of thing. And I think it's an excellent authored paper that I do wonder how all of the other NPRMs and others will affect that. Because if you think about it at a very simplistic way, if not all of the data flows downstream, how can your algorithms for artificial intelligence or machine learning be accurate? Right? So, to the degree the risk that is introduced if there is not a consideration of the downstream effects of say, if the information blocking NPRMs aren't finalized in those components, it's pretty serious.

So, I think that report and there's others out there like that floating out there bring to life the need for truly liberated data, the use of the APIs, and all the other recommendations that we have certified and signed off on. Christina, I know you are in transit. Any comments from you?

Christina Caraballo - Audacious Inquiry - Member
You know, I was at a HITAC dinner last night and I don't know if this fits in the annual report group, but one thing that came up is that we're kind of all going really strong in our task forces right now, and we're coming up with a lot of really great recommendations but there are some crossover within our recommendations, and it would be really good for us to kind of synthesize across all of the task forces

and look at what we are kind of all doing in tandem, but on our own, and seeing how kind of all of the pieces fit together under the larger umbrella, and again, I'm not sure if that lives here. I think it could partially, as something we're looking at the kind of like a connect the dots on everything that's happening and making sure that we are doing that. That could be something that we put in the back of our head or focus on.

Aaron Miri - The University of Texas at Austin - Co-Chair
That's a great point. So, kind of look at the macro picture of all of the different Jenga pieces, too – now it's going to become our buzzword, Jenga. That's our theme for this year. No, I love it. That's great. So, I think there's –

Christina Caraballo - Audacious Inquiry - Member
I think that Aaron, so I think that actually ties into some of the things that we've discussed on our workgroup so far, which is kind of looking at what the different agencies are doing and how Health IT and what we are doing with ONC support, those efforts. So, I think it does kind of align with the kind of things we are doing and how Health IT and what we are doing with ONC support. Those efforts. I think it does kind of a line with things that we've brought up. Sorry, just adding that piece.

Aaron Miri - The University of Texas at Austin - Co-Chair
That's a great point. That's actually a very good point. The other component that is out there in discussions is how the other HHS agencies are all doing a great job of pulling together support, what's going on with CMS and ONC. Again, I mentioned the FDA. I know FTC has some certain actions they've been taking recently to mention items. Social security rural, I mean all of these different agencies are doing their part to part to step up and say, "Hey, you know, these are the pieces, the Jenga pieces that we hold you know, to put together to complete the picture." So, I think it's a great point that we could maybe look at the macro landscape and say, "Where are things?"

The other item I have heard floated, especially from healthcare CIO community is the urgency and the need for a true understanding of not only the data being liberated now flowing but what is your disaster recovery business continuity plans to make sure the data doesn't turn off in the event of an issue. In a very simplistic way if you think about from a regional perspective, even if, once the trust exchange framework is live and you have the data flowing, if an event of – in the event of a crisis, you know, if suddenly a section of that were to go down because of an issue, an event, that's a major issue downstream.

So, a lot of organizations are taking a look at, I know we are at the University of Texas to make sure that we've dotted the is, crossed the ts, we dry run our plans, really making sure that we understand because if that were to go down in the case of Austin, Texas, it would be a big issue because we serve a huge amount of community especially indigent care serving out our internal HIE multiple organizations. So, to the degree of it, I know that's an item that's going to resonate and come up over discussion, especially as things are finalized.

Brett Oliver - Baptist Health - Member
Yes, planning, and then liability with that plan.

Aaron Miri - The University of Texas at Austin - Co-Chair
Good point.

Brett Oliver - Baptist Health - Member
Yes, because I do know, you can't do everything at one time with disaster recovery business continuity, you know. Even if you had all of the resources in the world it's just really hard to do and to maintain. And so, what is the liability? What's the liability with open APIs, I think it kind of goes together a little bit, because you were talking about your area, but there could be algorithms ultimately dependent upon your data after it's been normalized and brought forward on a national scale, and then if you take out chunks of that algorithm, who is monitoring that? How does that -- that's going to potentially change the outcome of the data to change the patient outcome. Because it's kind of corollary to that FDA Request for Information. I'm also wondering, what's the liability, or what I have come to and I had a problem with some of the newer companies is they'll run some, I'm going to use like Pharmacogenomics as an issue.

There are two companies that I was looking at to integrate into our HER so that we've got the real-time point of care to help with that. One, I really like had some data, but has this black box that is proprietary, and they won't let you look at it. So, if my data flows in, and out comes this result, and it looks really good but it's very uncomfortable for a clinician to not be able to look at that. I get it. If they come up with this new – I mean, that's maybe that's how they make their money. So, is there a role, I'm throwing this out there, is there a role for the FDA or another government agency to vet that? And say, Brett, we've looked at it, it's up to snuff. I don't know if that's any better, so the government says trust us, it's okay, but these are going to come fast and furious and have the potential to really change how we deliver care at the point of care to people who have no idea what an algorithm is.

You know, well, that's not true. I'm hoping most of this – but you know what I'm saying. They don't know where it comes from, they're just saying wow, my EHR has told me there's a 99% chance that Aaron's going to have a reaction to this medicine, so I'm not going to prescribe it, I'm going to prescribe this one. Okay, that's a big deal. I don't have time, not the expertise to dig in and make sure the outcome – because it's upon me and my organization if we put it into play to validate it, and I just think it's coming to light because of all of this information exchange and the ability to say, well now we can take a social determinant of health, and put this into this aggregate, and now we give you a better patient outcome because of – okay, where's it coming from and how do we vet that if the companies that create them, it's proprietary and we can't look at it.

Aaron Miri - The University of Texas at Austin - Co-Chair
You know, I don't want to dovetail, this is about sort of the macro level but I wonder if that's a great discussion for later today around the information blocking, and those components of maybe other dimensions, because I think you are bringing up a great point as to what is the liability, and what is the responsibility of us as Health IT leaders and clinical Health IT leaders to say, hey, this is in the public interest or not, and in partnership with the larger government as a whole, to make sure that things are

vetted. Because you're right, the days of hey, just trust me, I got it, that can't fly. Right? That can't fly, that's a great point. That's a great point.

Carolyn Peterson - Individual - Co-Chair
And the regulatory environment may be right to do something about that because so much of what you just described really dovetails with the **[inaudible] [00:14:14]**.

Brett Oliver - Baptist Health - Member
Yes, great point.

Carolyn Peterson - Individual - Co-Chair
I was reading the book last weekend on the trial and it's in the sense of the black box, you can't peek in, trust us, especially when you think about malpractice and liability that flows down even into individual providers, people need some ground on which to feel like there is some science there.

Brett Oliver - Baptist Health - Member
Absolutely, and I mean, you could fool the number of very intelligent people, who believe half of the book that it's kind of scary how quickly and how fast things could go and how far they could go. This, at least, involves the bad blood book, revolved around an actual physical process. An algorithm is just information being sent. How quick could that happen? At least you had to say, well, you didn't draw the blood right, it was this, you had to give blood, now you're affecting care potentially and even at a population health level, would think that you're managing it halfway **[inaudible] [00:15:14]**.

Aaron Miri - The University of Texas at Austin - Co-Chair
That's a great point. You know, one of the arms that I've got involved with recently is our commercialization arm and arm partnership, again, University. It's very common, and the digital therapeutic arena and those conversations about IP, and understanding how those things flow, and I'm just thinking in my head how often that is coming out recently, and how much – how important that's going to – dimension is going to be to IR being crystal clear with people, particularly as NPRMs are finalized and APIs truly are more commonplace and whatnot. To the degree of it, I think that that's a fabulous topic we really should look at, or consider, or think about, and talk about more to understand a little bit more about it. I think that's a great statement. And where does HIPAA intersect with that? Right? And these other dimensions.

Brett Oliver - Baptist Health - Member
What is happening is that you, and I, and all the organizations are having these conversations every time. You can come up with process, we come up with process but then there's a little tweak to this and a little tweak to that and it's very resource intensive, and then you still end up at the end of the day still end up not confident with what you've got, what's my liability, and if I send this information out, where does my liability stop. From a clinician's perspective one of the things that constantly comes up someone sitting next to me at a HITAC meeting we'll say, don't let perfect be the enemy of good. We're dealing with patient information and how it can affect your health. I mean, no, we should try, if that potassium at 4.2, ah, it's 5.2, like, no, that's a huge deal. It's not like, oh, it's close enough to the point of the fairness. Let's just get 20 data points and we will pick the middle one.

Aaron Miri - The University of Texas at Austin - Co-Chair
No, that's interesting and actually, this topic came up on the pediatric workgroup that we are on and looking at the accuracy of how technology may be can't – it was that debate we had a couple of calls ago about hey, maybe we can't enforce the vendor to do this. And I made the comment of saying, let's not let technology be the inhibitor here. Let's try to make it as transparent and trustworthy as possible, at least propose how we get there. If it's a series of steps, fine, but I think to the degree of it, you're right. The trust at the end of the day is the essence of our healthcare ecosystem. If we lose that, or mask that or inadvertently mistake that, that is a disaster. So, I think it's a good point.

Brett Oliver - Baptist Health - Member
There's a lot of reasons why changing a clinician's behavior is like moving a tanker. There is more than one reason, but trust is huge. First, Brett, you should be doing this now. I've been doing this for 20 years; it's worked fine for me. So, you are exactly right, if we erode trust the first couple years that these things are out there, you're going to lose maybe a generation of clinicians that would really buy in. Now, some of that we won't have control over if it's embedded into our systems, but –

Aaron Miri - The University of Texas at Austin - Co-Chair
Yep.

Brett Oliver - Baptist Health - Member
It is an important non-technical thing that plays off of technical pieces.

Aaron Miri - The University of Texas at Austin - Co-Chair
Okay. So, we've talked about the black box effect in bringing light to that. We talked about potential HIPAA considerations around that, we talked about potential intersections with the FTC, at FDA and other agencies. We talked about understanding from a disaster recovery business continuity availability of data kind of situation. We talked about all of these, I think these are phenomenal dovetailed topics based upon previous years of things that are going to need to be looked at, and considered, and thought about. How do we do this? Is this part of our charge as HITAC to consider, and at what down streams? The other thing I would think is going to be this issue that I am even trying to tackle right now, which is globalization, and data flowing overseas and the number of patients that we see as a major metropolitan city. And that country sees, and the rules governing that data and truly the ambiguity when it comes to what happens for a European student, patient, citizen, and they are here and they go back, is it just GDPR?

Are there other considerations? How do we make sure data flows back to where they came from and vice-versa? It's a constant conversation that we are having that is only going to magnify, especially in this wonderful country of ours that is truly the hub of so much, particularly when it comes to health care. So, how do we make sure that there's a complete circle? Because at the end of the day, you are going to get a complete record otherwise. As a clinician you are going to be, how fast and how digital? This is not good. To the degree, there's got to be a level of either partnership, understanding, awareness. I don't know what that is, but it is a consideration. So, I know we talked to a few folks the last go-round with an ARG about what we're doing in Italy and other things. It would be interesting to hear more about that, it would be interesting to hear more about what are other countries doing and

are their other lessons to be learned, other lessons that the NHS has learned having with their spy network, where they're able to share that kind of data rapidly. Things are like man; this was a huge bug a boo. I wish we knew this ahead of time, great. Let's identify it and think about it. But we will suffer the same things, potentially. Other comments? Good morning.

Unidentified speaker
Good morning, how are you?

Aaron Miri - The University of Texas at Austin - Co-Chair
I'm good, thank you. So, we're going through topics here of items that we have heard over the past several weeks and others, and before we go open up the agenda from last time of items deliberately earmarked to come back to.

Christina Caraballo - Audacious Inquiry - Member
Do we want to run down the list to see if there is anything that we may have –

Aaron Miri - The University of Texas at Austin - Co-Chair
I think that's a great idea. That's a great idea.

Brett Oliver - Baptist Health - Member
So, you're saying be organized in our discussion?

Aaron Miri - The University of Texas at Austin - Co-Chair
I haven't had coffee yet. So, I will hedge my bets.

Aaron Miri - The University of Texas at Austin - Co-Chair
Do you mind starting that one?

Carolyn Peterson - Individual - Co-Chair
Yeah, so, starting at the very beginning at the top of the HITAC comment, a number of comments, price transparency and patient access to price information. Patient matching, we already rehashed that. Address policy and trust issues for open APIs.

Brett Oliver - Baptist Health - Member
This is the one Ken was very passionate about.

Carolyn Peterson - Individual - Co-Chair
And I think that's probably going to be pretty fertile ground there since it's a component of NPRM.

Aaron Miri - The University of Texas at Austin - Co-Chair
Is it also a component of some of the charges for the USCDIworkgroup and looking at some of the components there or no?

Carolyn Peterson - Individual - Co-Chair

Christina?

Aaron Miri - The University of Texas at Austin - Co-Chair
I know she's in transit, so –

Carolyn Peterson - Individual - Co-Chair
Probably coming up the tunnel. We can check with –

Aaron Miri - The University of Texas at Austin - Co-Chair
Yeah.

Christina Caraballo - Audacious Inquiry - Member
I could not get off mute. So, Aaron, repeat the question on correlating to USCDI for API.

Aaron Miri - The University of Texas at Austin - Co-Chair
It was a comment during the last HITAC. Ken had really spoken passionately about it and I think everybody agreed with him, it was just about timing at that point. Where the comment was formal guidance being provided compliance with relevant privacy and security regulations such as HIPAA on the use of prior APIs such as in smart or fire applications or CDS hook services. And what he was saying was that with the advent and the adoption of API, is there a bifurcation between what HIPAA provides and covers and what it doesn't, and how do we get that out to the Developer community and how do we better understand that? And are there other standards need to be developed to support HIPAA, and make sure that it's not just you have a highway with two-lane traffic, bidirectional traffic, but have speed limits, per se? My question was, is that part of the USCDI workgroup to look at those considerations, or is it truly standards-based work for USCDI?

Christina Caraballo - Audacious Inquiry - Member
I think that's going to be more of interoperability standards priority task force. When you think about the USCDI, and don't hold me to this, but thinking out loud, USCDI is more about getting that base standard, not standards that we need, but data classes that we need. So, what kind of data do we want to collect? And it's less about the transport or how we transport the data, and more about what data. So, I'm not sure. It's something we could talk about in the expansion process, and this is kind of goes back to my original comment earlier today on how we need to look at the crossover, but I do see it definitely fitting probably of the Interoperability Standards priority task force.

Aaron Miri - The University of Texas at Austin - Co-Chair
Great point, great point, thank you. That's a great point.

Carolyn Peterson - Individual - Co-Chair
The next issue, patient electronic address information. This was coming along with the exchange of imaging report and images, things brought forward by Clem McDonald.

Aaron Miri - The University of Texas at Austin - Co-Chair
I would also add-on digitization of new types of images. I will give you an example, which is digital pathology. This year, finally the FDA certified the very first modality to be able to digitize slides, and we're looking at it now. And only to realize the space for standards and the space for doing that is so early days, I literally think back to when radiological images were first digitized off of the light boxes. Folks are like, how do we do this? It's the same questions all over again, I feel like I'm living in a paradox. There is a degree of how do we help further adoption of that? How do we continue to help get things digitized like slideware, which if you think about every day is millions of slides couriered between facilities at a tremendous cost and a tremendous lack of access to that information? So, to the degree of it, I think that's a good point to think about. How do we do that?

Carolyn Peterson - Individual - Co-Chair
Highlight VA data cost initiatives.

Aaron Miri - The University of Texas at Austin - Co-Chair
Highlight VA data quality initiatives. Okay.

Carolyn Peterson - Individual - Co-Chair
No, no. We realized a lot about what the VA is doing. So, it's probably a good time to look at that, because they have the largest patient group around.

Aaron Miri - The University of Texas at Austin - Co-Chair
I would say that, or the DoD, right? I know the DoD has been putting out good stuff recently about things they are learning, things they have realized so maybe do both.

Brett Oliver - Baptist Health - Member
Particularly as they go through their implementation over the next however long. You learn about your systems when you do that. It may be an appropriate time to ask.

Aaron Miri - The University of Texas at Austin - Co-Chair
I think that's a great point.

Carolyn Peterson - Individual - Co-Chair
Challenges with incorporating and reconciling data received from various external sources. That is a good tie into the PD HD step we have looked at this year and will probably continue to look at going forward.

Aaron Miri - The University of Texas at Austin - Co-Chair
And maybe payment around that, as well. Again, I don't know if that is directly our charge or just more of a recommendation that we should help to maybe transmit that to CMS to say, can there be clarity

around some of this? I will give a specific example. When looking at things like patient outcomes it's very murky to understand, are these reimbursable items, however they translate directly to decision-making and clinical decision-support for admission. Case in point, if somebody is reporting they may feel severely depressed, and might have a tendency for thoughts of suicide, psychiatric help can be readily available immediately before the person presents based on reporting back based on certain types of questions. However, we look at that a look at it from FEMA funding perspective, it's very unclear what mechanisms that that may go. So, not only with PD HD, but are their ways CMS can help audience clarify, or open up a phone a friend because when I looked at this specifically, I said, who do I ask, there's nobody to ask. It's like, how do we deal with that?

Carolyn Peterson - Individual - Co-Chair
And that ties and also to the next one, the cross-date data exchange and privacy considerations. Where is it going? What are the roles that relate to it there, where is it coming from? What do we have to worry about?

Brett Oliver - Baptist Health - Member
Not just the rules about, you are exactly right. But if I'm getting information that I didn't ask for with all this exchange, what is my liability and all of the documents for the end user, because that is something, I hear from my colleagues all the time. I got this stuff and I have to click done. What does that mean? What is legally done? That's what the button says. Does that mean I reviewed it? Does that mean I'm now responsible for it? I cannot clear it out of my in-basket unless – I don't want to push that button. Because if there's a hidden something in those 100 pages I just got and something happens, it's like, you reviewed that, why didn't you notice that? There is that is a growing problem as we continue to – and that's a little bit what I think Steven was talking about challenges in incorporating all this reconciled data because you are reconciling multiple times. I've got CVS data and the same medication list. I've got to go through and do it twice now.

Aaron Miri - The University of Texas at Austin - Co-Chair
That's a great point, and also how does that play into recent sort of change guidelines about residency and documentation about the documentation of medical records and sign off on that, right. We're waiting for that right now looking at that because we obviously have a medical school component as part of our academic medical center. And so, it's to what degree that things have to be reviewed and signed off, and to what specificity, and what does it actually mean? Each word, rather than types into the note or the chart the attending, should they look at every single word, and say done to each word, or done to a paragraph? I mean, it's very interesting, the considerations to your point that has to be there. So, what is the limit, so you don't go overboard?

Carolyn Peterson - Individual - Co-Chair
And it ties back to PD HD issues also. And as we start to bring PROs into clinical care, not just clinical trials, organizations need clarity around the liability issue. Maybe that's a conversation we should try to get into with the next person since it seems nobody else is doing it.

Aaron Miri - The University of Texas at Austin - Co-Chair
I think it's –

Carolyn Peterson - Individual - Co-Chair
People have been asking about it for many years, you know, as –

Aaron Miri - The University of Texas at Austin - Co-Chair
You are absolutely right. I queried about two dozen CIOs across the country asking what you are doing with PRO. The answers were very interesting, and a lot of folks all had the same theme as to, we really don't know who to ask or how to bring this together and start looking at but it's such an important element of care. And the other aspect of it back to the topic we are speaking about is if you provide a PRO back to a patient and you provide them a clinical summary attached to that, how do you help them interpret that? Today, cases – what we are providing is street lab back to the patient because we believe in full transparency to see it. And the amount of questions we get back from our patients is very interesting. Depending on what type of PRO, and what they answered and how it is scored and that the care that was given when they first presented is interesting. All of that is very emerging space. I think it is going to become even more important as we're collecting more data, to your point.

Carolyn Peterson - Individual - Co-Chair
So that gets us through topic suggested by other members of the HITAC. Coming to the list of things that we brought forward there were digiceuticals.

Aaron Miri - The University of Texas at Austin - Co-Chair
No, no it's not, actually. It is a term that's been used in very many papers. I would if I could go back in time, absolutely.

Carolyn Peterson - Individual - Co-Chair
Implications of the California consumer privacy act of 2018 and the European Union, general data protection, regulation, and privacy issue, I think Washington State is also looking at doing something.

Aaron Miri - The University of Texas at Austin - Co-Chair
Yes, I saw that. Yes.

Carolyn Peterson - Individual - Co-Chair
Right now, in other states and for some reason I'm thinking Pennsylvania, but that might not be right. It's something they are deciding to look at more because space is wide open and continues--.

Brett Oliver - Baptist Health - Member
You've got vendors like Epic, for instance, creating de-identified amalgamations of data. That's going to affect their efforts if they're like okay, we can do it all from Washington and California. Or if you've got European Epic data, now we can't – that kind of, again if we don't get federal guidance then the states will kind of over the next decade, we'll have 50 different ways of doing it, which makes data exchange clearly much harder.

Aaron Miri - The University of Texas at Austin - Co-Chair
You're exactly right, again, that goes back to your earlier comment about learning about what the DoD and others are learning from as they exchange it because obviously, they're nationwide. What are

some of the gotchas they've had to overcome? Even though they're a federal agency, maybe have other things to consider there are still lessons learned, so I think it's a good point.

Carolyn Peterson - Individual - Co-Chair
Which brings us to the 42 CFR Part two and FERPA, sharing student records, data segmentation, we're going to be building a little bit of data segmentation in the health IT care continuum in **[inaudible] [00:32:32]**.

Aaron Miri - The University of Texas at Austin - Co-Chair
Yes, we are.

Carolyn Peterson - Individual - Co-Chair
Maybe that will give us a little bit of a direction.

Aaron Miri - The University of Texas at Austin - Co-Chair
That's a good point. We did go into this during that and really to what degree is the intersection point therebetween FERPA, HIPAA, and others. And then, of course, 42 CFR and then also SAMHSA and other substance abuse type of information. I look forward to that discussion. I think this is another area where I have seen, and I have heard a lot of folks from a very wide range of the spectrum here. I honestly think it needs to be clearer.

Carolyn Peterson - Individual - Co-Chair
Yes. Good point. **[Inaudible] [00:33:09]**.

Aaron Miri - The University of Texas at Austin - Co-Chair
Yes. Go for it, Brett. We had a big discussion last time. So, go ahead.

Brett Oliver - Baptist Health - Member
It's just as more data is made available, the comfort level for the end-user clinician is we'll pull it in and then it makes things more difficult to find. Each vendor has certain ways around it, Epic shops. You got your reason for the visit, and then your encounter, and the encounter will have anything done to the patient during that visit, including the physician's note. We are not used to that. We are used to the physician's note standing alone. That's the way we were taught. If it goes to court, everything that happened has to be in your note, and that's really not the legal standard anymore, but then changing behavior again is very, very difficult. If you look at the U.S. and the regulations that we have for coding and billing, primarily, and the legal atmosphere versus European, Epic, this is the first time I looked at it.

Now Epic has European shops. The notes are 40% of the length in Europe than they are here. When it's been analyzed at least at an Epic level they are saying it's got all of these links that are just pulling in data. Are there any changes to this, any changes to that, so as the data becomes available? The notes that we rely on is what we go to with what happened with Carolyn's last dose, what happened with Aaron's last dose? I don't want to see stuff brought in, yet there is movement with changes that started this year, but that continued education, if that's all it takes. If there is no more federal guidance

that needs to happen, we can use the federal resource or education and say, no, no, no, that's fine. You don't need that in your note, don't need that, don't need that. Change behavior, but it's a real problem in delivering care that interoperability potentially could make worse.

Aaron Miri - The University of Texas at Austin - Co-Chair
That's a good point. After our lab discussion about this, I actually went back to my organization and searched, we searched in a few ways to help this because I started looking at the notes and our notes got longer, more bloated, which is good and bad. Particularly because we also have a medical school, so when I look at certain patients, I'm like boy. Scrolling, scrolling. So, looking into tools like natural language processing and others to try to upfront standardize, automate and fill in as much note as possible so that way you're coming back more of reading, approved, approved, approve versus having to type it in and it's streamlining what needs to be in there.

It's almost creating templates, based upon appointment type, visit type, those situations. It gets difficult in more acute and trauma base but at least in the ambulatory setting there, we are half the way there. To the degree of primary care and others, is that a consideration point? Should we look at NLP and as that ties into AI and others downstream, you know. Are there technologies there? Where is that intersection point with health IT? I don't know, I'm just throwing it out there as are these consideration points.

Brett Oliver - Baptist Health - Member
But I mean, you're right, it's coming. I hope sooner rather than later, I'm just burnt out and to be fair, it's not just federal regulation and interoperability that leads to that problem. Maybe worth looking at to see what we can identify. I think fixing it is probably piecemeal and not necessarily our – with the right regulations. But it's a major problem. And if there can be, just imagine, it's comforting to a clinician. If we can improve usability of EHRs, which is part of what we're talking about here, I think, traditionally, some of my older colleagues will use their note as their chart, so instead of, I'm not ready to deal with my EHR, or it's not set up the way I like it so I'm going to put everything about this patient in my note so I have one point of reference, that's the reality of where we are where these things are rolled out without a lot of end-user thought to it.

We are finding a lot of pieces with that. I get that. I don't know where else to go, but if I go to my note, I know it's in there. Oh my gosh, I cannot have the seventeen pages note every time. I get them and as primary care physicians, I was like, what happened this time? That's all I want to know. I know I had strep throat in fourth-grade. What now? That's the clinical impact that happens because you end up missing things that are important. Not to mention just the time and troublesome **[inaudible] [00:37:39]**.

Carolyn Peterson - Individual - Co-Chair
All right. Consumer access to immunization data.

Aaron Miri - The University of Texas at Austin - Co-Chair
We talked about this too in our pediatric workgroup, so this is – I learned a tremendous amount with the variety and the states and different template types across state lines. I wonder how many people

actually know that. There is such good information coming out of that workgroup I cannot wait to be presented today because I had no idea. I started looking at this and it's amazing just the school forms, of what makes an immunization type, and how states like New York have a form that the vendors are saying you cannot digitize this because it's all free tax, it's all non-conformable shapes. It's just this weird thing that was ratified in state law, essentially. To the degree of it, are these components to bring up and piece out and say, we need to consider how to get through this because that's going to be a big barrier.

Brett Oliver - Baptist Health - Member
Have they talked at all about some of the human resources laws that really interfere with some of that? When I'm referencing for instance in our organization, if I get a flu shot through HR, which I am required to do, that does not flow to my chart, because it has to be two separate charges in human resources. We talked about putting up an electronic barrier but that's what we ended up doing, is just two separate databases. My clinicians are coming to me and they're going, it's not just I want to know the brand of this flu shot, it's also Brett's getting reminders that he doesn't have his flu shot from our automated system, but I did. I had it. It's your place. What are you talking about? It's frustrating. So, now we're looking to interface this product that stores our HR state information stuff with our State information exchange. And then, once we're bidirectional with them, it's silly but all predicated on these HR rules. Oh, no, your HR chart has to be different data segmentation, maybe it gives their – anyway, it was not 100%.

Aaron Miri - The University of Texas at Austin - Co-Chair
No, it's a good point.

Brett Oliver - Baptist Health - Member
A corollary to that. Again, we've got all of these rules about who can share what, and the more data that's shared, are we going to make more rules and more segmentation? I think that's going to make it worse. We talked about it before where psychiatric and substance abuse records have to be kept separate, and why? I'm a clinician, I need to see everything about you to make the best, wisest recommendations and decisions. I don't know, understand socially why that is but we've got laws that protect that data through HIPAA, and I'm still liable for not letting that out, so I don't know why they need all these separate rules for a student or with HR.

Aaron Miri - The University of Texas at Austin - Co-Chair
Yeah, and everything else, yeah. That's a good point. Carolyn, I'm sorry. Christina, I know you are in the car. Curious any thoughts there?

Christina Caraballo - Audacious Inquiry - Member
I think this is – yeah, I'm coming off. I think this is a great topic. I am fully supportive of it. I think it's important for patients too. I think about just access to immunization records and as a mom. It's the one thing I want easily every time I need school forms or camp forms, and it's a hassle right now to get them. And then I think of one of my best friends actually recently told me that she wanted this problem solved. She is getting ready to go to Peru and has lived in multiple states, and she's going for two-year teaching. It's been a nightmare trying to figure out where her records are, what she has and

doesn't have, and just being able to get them from the different states, and figuring out what exists where took her a lot more time that she realized, and was like, why isn't this easy? I think that from a consumer access and patient perspective, it's something we should just really address, and I think there is a need.

Aaron Miri - The University of Texas at Austin - Co-Chair
Got it, okay.

Carolyn Peterson - Individual - Co-Chair
I think there's a related issue in that if we have not already will soon identify the public health need in terms of getting a better understanding of where unvaccinated people are and where those concentrations occur so we can start planning for epidemics and outbreaks. I know last night in the New York Times there was an article about an outbreak of measles in Brooklyn, and certainly, that is something we have been seeing in Oregon and Vancouver on the Oregon/Washington state line. Even if we have laws that require parents to vaccinate tomorrow, we still have an unknown population of children who haven't been for many years who will be susceptible, and that will have consequences, potentially, for the next ten to 20 years. It will be good to start getting a handle on where the populations are and to be able to do predictive analytics and some planning around it.

Brett Oliver - Baptist Health - Member
Does CDC do anything like that? Asking, assuming that like **[inaudible] [00:43:04]** state exchange has to report that data to CDC. **[Inaudible].**

Aaron Miri - The University of Texas at Austin - Co-Chair
Good question, I don't know.

Carolyn Peterson - Individual - Co-Chair
I don't know.

Christina Caraballo - Audacious Inquiry - Member
Brett, I couldn't hear you. What was the question?

Brett Oliver - Baptist Health - Member
I was just asking if CDC was already doing some of that, and if they were, my thought was can we leverage that to help your friend's issue? I don't mean specifically but where you are trying to find, okay, if the CDC is tracking this, and I have to believe they are not flying by the seat of their pants when we have these outbreaks they have some idea of where immunization rates have dropped and I've seen maps like that from them. Maybe not to a community level, I don't know. But if they've got that, how are they accessing that data, and can that be merged somehow when a patient needs to go, I if they've got that, how is accessing that data, and can that be merged somehow when a patient needs to go, listen I don't care where I got done in the country. If it's recorded in CDC, can I access that?

Aaron Miri - The University of Texas at Austin - Co-Chair
I don't know. Yeah, good question, I don't know. Maybe they are extrapolating something else. I don't know. Great question. Okay.

Lauren Richie - Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Public comment? Yeah, why don't we do that? Operator doesn't look like we have many public comments. Can you open the public lines?

Operator
Yes, thank you. If you'd like to make a public comment, please press star one on your telephone keypad and a confirmation tone will indicate your line is in the queue. You may press star two if you would 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.

Lauren Richie - Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Do we have anyone in the queue?

Operator
Not at this time.

Aaron Miri - The University of Texas at Austin - Co-Chair
They are all getting coffee.

Lauren Richie - Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay, so maybe, I know we still have half to go, should we just maybe wrap-up with PDMP and then we can revisit the other at a later date?

Aaron Miri - The University of Texas at Austin - Co-Chair
Yes, that's perfect.

Carolyn Peterson - Individual - Co-Chair
PDMP integration with the HR, Aaron?

Aaron Miri - The University of Texas at Austin - Co-Chair
To the degree of it, there is, this is a, I think a known, not only is it problematic and burden for physicians to go and check multiple sources of data being integrated into EMR. As a state issue in various state mandates this and what not, I did. It's very, very, very, very, to the degree of it, right now in Texas case in point the Texas Senate just passed last night a Bill that will finally mandate this within Texas, and so, hopefully, called the House signs off. And at least Texas gets on board with this. That's great for me but what about the rest of the country? To your point the chart that was sent out. I know at the last meeting top. That's great for me but what about the rest of the country? To your pointing

the chart sent out. I know at the last meeting I think this was a topic Dr. Rucker's spoke up about and said there was a lot of work going on out there to the point of that chart and others, and it is a very tricky and nuanced situation, so –

Brett Oliver - Baptist Health - Member
ONC and CDC are working together on a project that we happen to be involved in as an organization. There are other things they are doing, too, but just a practical perspective it's going to move slow.

Aaron Miri - The University of Texas at Austin - Co-Chair
It is.

Brett Oliver - Baptist Health - Member
And it's difficult.

Aaron Miri - The University of Texas at Austin - Co-Chair
Maybe there are ways to take that work and sum it up and put it into the report, and recommendations to help the efforts to say, hey, how can we bring some of this together and bring to, and maybe just bring a conversation to the powers that be and say, we could use help with XYZ, as we do standards and all of the work going on. And also, it's a way to give credit and highlight to taskwork going up like I was unaware of like that chart.

Brett Oliver - Baptist Health - Member
I think you make a good point, and even though there are 50 different state regulations on this, if the Federal Government said, it's okay to store a patients PDMP record in a legal medical record, or it's not, one way or the other. You still have State regulation but at least it would give cover if someone wanted to change it or felt as an organization, well, I've got the federal, it's a little like marijuana legislation now. No one, there's federal level and there's state-level I guess, it would be first but, anyway.

Aaron Miri - The University of Texas at Austin - Co-Chair
It's good guidance that leads to it right? That's a great point, a great point. All right, I guess we'll pick up the rest of the topics on the next call and gives us more chance to go back and marinate and finish up some of these Task Forces we're currently on to see what comes out of them. Any comments from the table before –

Lauren Richie - Office of the National Coordinator for Health Information Technology - Designated Federal Officer
I'll just check in. Michelle, anything else you want to cover that we missed before we wrap-up.

Michelle Murray- Office of the National Coordinator for Health Information Technology – Staff Lead
No, I was just wondering if you could group the last three together pretty quickly and then we would have to clean up that one section.

Aaron Miri - The University of Texas at Austin - Co-Chair
The recordings, and the photographs?

Michelle Murray- Office of the National Coordinator for Health Information Technology – Staff Lead
Yes.

Aaron Miri - The University of Texas at Austin - Co-Chair
Yes, so these three ones I brought out, just to really expand the modality types. We did talk about actual language. Good. And to the degree of it, how do we make sure that it's not just data, the datatypes, again, recordings, video, photograph, sort of the discussion earlier about again, recordings, video, photograph, sort of the discussion earlier about how to do we not only take things like slides and digitize them, and transmit them, and share them, but also how do we expand electronic medical record so it's not just discrete data, but it's everything. Everything necessary for you as a clinician, Brett, to make a recommendation.

Brett Oliver - Baptist Health - Member
I think they are all kind of lumped together. I mean, I'm sure technically they're not close to being lumped together, but for practical purposes –

Aaron Miri - The University of Texas at Austin - Co-Chair
Well, and it's nuances too, to each of those, right, so, maybe types of consent that's needed for audio because they can think up privacy laws that specifically call out audio and recording within different states and needing two-party, one party authorization. I think with video something similar, very nuanced. Photographs are nuanced as well. It gets into a whole slew of privacy and other components. But maybe a way. I like your idea. At a high level, we can make a recommendation so we can advance it versus folks going out, too difficult, we can't solve it, but we can do this instead. Okay. So, we will pick up the other items, there's a few lefts on here at the next report workgroup, and then, gives us time again to go back and marinate on any other topics, and Michelle, anything else for us?

Michelle Murray- Office of the National Coordinator for Health Information Technology – Staff Lead
No, this was very helpful. Thank you.

Aaron Miri - The University of Texas at Austin - Co-Chair
Thank you.

Carolyn Peterson - Individual - Co-Chair
Should we do a brief verbal poll about what schedules our like in early June to start thinking about when we might want to schedule the next call? I know we all want to get past the NPRM stuff and probably past the holiday, at least before we pick up.

Aaron Miri - The University of Texas at Austin - Co-Chair
I would say so. That would be helpful for me.

Carolyn Peterson - Individual - Co-Chair

You don't have time for more meetings, Aaron?

Aaron Miri - The University of Texas at Austin - Co-Chair
I mean, you know.

Lauren Richie - Office of the National Coordinator for Health Information Technology - Designated Federal Officer
I can do a Doodle Poll or something.

Aaron Miri - The University of Texas at Austin - Co-Chair
Yes, that would be helpful. Yeah, there we go. Okay. We will get a Doodle Poll out and get some things on the books ASAP.

Carolyn Peterson - Individual - Co-Chair
Awesome

Brett Oliver - Baptist Health - Member
Beautiful.

Aaron Miri - The University of Texas at Austin - Co-Chair
Thank you all, appreciate it. Goodbye.