Health Information Technology Advisory Committee

The Office of the National Coordinator for Health Information Technology

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) ANNUAL REPORT WORKGROUP MEETING

September 29, 2021, 1:30 p.m. – 3:00 p.m. ET

VIRTUAL

Speakers

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

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

Operator
All lines are now bridged.

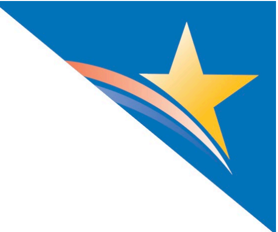
Michael Berry
Great, thank you very much, and hello, everyone, and welcome to the HITAC Annual Report Workgroup. I am Mike Berry with ONC, and I would like to welcome back our co-chairs, Aaron Miri and Carolyn Petersen, along with two new workgroup members, Steven Lane and Jim Jirjis, and I am hoping Brett Oliver, our other workgroup member, joins us shortly. Now, I would like to turn it over to our co-chairs, Carolyn and Aaron, for their opening remarks.

Opening Remarks and Welcoming of New Workgroup Members Meeting Schedules and Next Steps (00:00:28)

Aaron Miri
Yeah, absolutely. Go ahead, Carolyn.

Carolyn Petersen
I was going to say good afternoon, everyone. It is great to see you all and to continue to march forward with our annual report. We are really excited to keep moving on that this afternoon.

Aaron Miri



Absolutely. So, welcome to our newest members, Dr. Lane and Dr. Jirjis. Welcome, welcome, both fantastic, well-established, and esteemed members of our HITAC community and overall health IT, so we are so glad to have you and your experiences as part of this. We have had a lot of fun without you, but we are having even more fun now with you, so, welcome to the party, and I look forward to including you in all these good discussions.

Steven Lane

Aaron and Carolyn, just a comment on my behalf. Sorry, my camera is wigging out, so I cannot share. I think you guys have really done great work over the past couple years on the report, and I must say I have not previously found or made the time to participate, but as my other task force responsibilities have recently wound down, it seems like this is a great opportunity for us as HITAC members to deepen our engagement and to contribute to this. But, I am really interested in your perspectives as co-chairs regarding the value of the report. We have all been on HITAC for a while, and these reports have been filed each year. Do you get the sense that they are really being…? I know that they are called for in legislation, but do you get the sense that the juice is really worth the squeeze? You guys have put so much effort into this report year by year and put a whole lot of really insightful commentary, suggestions, and whatnot. Do you get the sense that ONC and others in HHS are really making use of all of that effort, or not?

Aaron Miri

I got a letter directly from the Secretary himself about the February timeframe directly thanking use for the report and how insightful he found it personally, and he signed it and sent it to me, and I think Carolyn and a bunch of others saw it as well, as a thank you, especially with him coming in as a new secretary at the time, the new administration, the whole nine yards. So, I do know it is being read, I do know it is being valued, I have heard from members and various offices on the Hill that referenced various aspects of it, I have seen our text, whether it comes from the HITAC Annual Report or various work efforts coming out of the HITAC in general, end up in various pieces of legislation. Steven, you have seen that as well.

So, I choose to think the glass is half full. Maybe I am just an optimist to my death, but that is the reality of it. I think it is very much worthwhile, and if nothing else, it chronologically states and gives some order of magnitude to some of the things that we are talking about because coincidentally, or perhaps not, a lot of the topics we were referencing before the pandemic ended up playing out during the pandemic, like a lack of a unique patient identifier and all of the things we have been talking about for some time, but it is kind of like “We told you so,” but without saying it that way, and that is the point of the HITAC: To give that early warning radar as to where we should be focusing our efforts. I think it is. Carolyn, what do you think?

Carolyn Petersen

I do too. I would say coming from a different perspective, I think the annual report is a document you can point people to, whether they are students just getting started in informatics, or patients, or other stakeholders who are not part of either health IT or the healthcare provider community, to lay out what the issues are in health IT that are primary right now, and also to illustrate what some of the consequences of those things are.

Certainly, in the industry, if you are a provider, you are intimately familiar with lots of these things, but if you are someone else who has a particular interest, or has a limited experience of impacts, or perhaps I should say an experience of impacts limited to some particular way related to your physician, it can be really hard

to figure out what the root problem is, what needs to change, how you need to advocate, or what it is that you can do that will actually help you to resolve the concern that you are experiencing. And, in that way, I think especially in patient advocacy and for caregiver advocacy, for other stakeholders who do not have as immersed a situation as industry and providers, it is very, very helpful in that sense because it is referenced and, by most people's perception, it is balanced and objective to the extent that a document can be objective.

Aaron Miri

And also, Steven, it also serves another purpose. It allows us to capture and respond to questions from the HITAC, which is what we are going through today on the crosswalk, which are great comments. Everybody that serves on the HITAC was specifically chosen for a skillset, a representation, a viewpoint, or some quality we bring to the table to bring a collective together, and I give a lot of credit to all the administrations and all the groups of folks that we have served over many years that take a lot of pride in putting together this team of people to synthesize an opinion that represents what is really going on in the healthcare industry, and so, it is another vehicle for us to make sure that all the voices at the table in the HITAC are heard, which you have heard me say all the time in our HITAC meetings, to make sure there is not a single voice that is inadvertently ignored or quelched or a question that goes unanswered.

And so, the annual report becomes a vehicle to help answer a lot of that, and Michelle Murray and the team do a phenomenal job of cataloging that, detailing that, and capturing the essence of the question, which is impressive as all get-out because I do not have that superpower, but she does and her teams do, so it allows us to also stay true to form, and the HITAC becomes this nonpartisan, very open, very collaborative group of folks, which is why we all talk all the time. So, that is a longwinded answer to say yes, Steven, it is valuable.

Steven Lane

I really appreciate both of your responses as co-chairs, and you said what I hoped you would say, and that is why I signed up to be here, and hopefully I helped inspire Jim to join as well. It just seemed like this was important work, and you guys deserve to have a little bit more support than you were getting so far.

Aaron Miri

I appreciate that. Well, I welcome you, and I welcome Jim, and I know Dr. Oliver is on the line now too, so we have three physicians now as part of our committee. That is fantastic.

Steven Lane

[Inaudible – crosstalk] [00:07:32]

Aaron Miri

No, it is great. We are going to have some good, meaty discussions on workflow and clinical impact, which is exactly where the rubber meets the road, so I am really appreciative of the three of you and how busy you are, especially as you all have day jobs. All right, should we get into it, Carolyn? What do you think?

Carolyn Petersen

Let's go for it.

Discussion of HITAC Member Comments on the Draft Crosswalk for the HITAC Annual Report for FY21 (00:07:52)

Aaron Miri

Let's go for it, all right. So, let's start off here. So, our agenda for this week… Obviously, we have our remarks, we will talk about meeting schedules, obviously, we really want to focus on the crosswalk here in a little bit, and Michelle has done a good job of detailing out the questions that have come back from the HITAC, so we can talk through those. That is where the substance is. Then, of course, we will have public comment, then adjourn for the day. Next slide.

All right, so, we are here. We are at September 29th, which is just amazing when I see that date. I cannot believe it is almost October. But, the September 29th meeting, we have another one in October, and then, really developing the draft as we go into the fall and winter months. Some history for you, Steven and Jim: When we first did this, we actually ran a little long because we were putting together the structure and format, so we actually ran into the holidays, and that became kind of troublesome, as we are trying to get feedback to Michelle on edits and whatever else, and it is Christmas break, and we are dealing with kids opening presents and things like that.

So, we learned to back into that, and so, we usually start a little earlier in the year now, really getting conversation going, so now, we have a really good format that makes sense. The introduction that we did last year of trying to use what I call plain English, putting all these meaty topics into a one-pager or a couple paragraphs that tell you what the experience could be from a patient perspective if we get all this right was very well received because it allowed folks who say, "Man, this is a lot of technical mumbo-jumbo, what does it mean?", to say, "Well, it means this." This is **[inaudible] [00:09:17]** in a care setting.

So, we will look to expand that this year with the stories. I will look forward, especially with the two of you and Brett being clinicians, to your giving us insight to nuances there that would really make the patient experience more meaningful, richer, and giving that care at the bedside not just great medicine, but exceptional medicine. I think that is a great opportunity for us to explain to the general public and the powers that be why this is so important, so that was a great addition last year. This year, you will see us spend a lot of time on getting into that story section, so just put that nugget in your mind. And then, we will get through it, and we will transmit sometime in the springtime, depending on dates and all the other activity that you can imagine is going on at any given point. So, sometime in the early spring, per statute, it is transmitted then to the Secretary, which then goes on to Congress. So, that is the schedule. Next slide.

All right. As for the full committee, we will be updating the HITAC on October 13th. I hope that is on a Friday. I do not know if it is or not, but anyway, October 13th, and then, again on November 10th, although the 13th is that special session that was called by Micky, if you recall, and then, of course, we will review the annual report in January. That is also an exciting time because we will probably also have new members of the committee coming online for the vacancies that will be on the HITAC. That is a really great way to indoctrinate and instantiate them on the topics and what is going on. And then, of course, again, approving it in February, with transmittal sometime thereafter, give or take. That is our schedule. Next slide.

All right. So, the next steps: Of course, we are going to talk about the crosswalk and then get ready for the presentation at upcoming HITAC meetings in October and November. I will remind you that if you recall last

year, although we were really focused on the pandemic for obvious reasons, and we still are, this is also a time where we start soliciting final comments, final questions for this year and this round, and we start trying to pull it out of the HITAC, so I will look for your help, especially behind the scenes, encouraging folks that have ideas or comments to please speak up. We capture every one of them. Even if we do not include them in this year's report due to timing or whatever else, we do capture that, and it does find its way into future iterations, again, not leaving one stoned unturned. No one's voice is unintentionally or inadvertently unheard, so we will look for your help in helping us to coax people to speak up and be vocal, as we know they are. All right, next slide.

All right, let's go into the crosswalk, please. I will blow that up. There we go. I will open it up on my screen too because the older I get, the more I have to squint. So, the way this works, for the new folks: If you look at that first line… Could you scroll to the right for a second, Excel team, just so I can show them? In blue text, Michelle does a great job of color coding for us to keep us on track so we do not reread every single line every time, what is in blue are the questions that have come back from the HITAC members, usually the name, what they have said, or if it is a long sentence, she will try to paraphrase it so the essence of the question will be in this, and then we talk through it. So, that is sort of the order of operations.

And then, if we just go item by item, sometimes there is a word edit, a copyright edit, a copysmith edit, or whatever you call it, where a word is misplaced or misstated, and that will be a different color, like red or other colors, just to note. But, every single word, sentence, structure, and intent is talked about by this group, so there are no words that are going into this report that do not come from the HITAC, but I do appreciate Michelle and Carolyn's amazing editing skills because I am not that person, so they oftentimes catch a word, a "whereas," a "be," or an "and" that should not be there, and that will be a different color.

But, in blue here will be the questions from the HITAC members, so again, if you have questions on order of operations or processes, please let us know. We have developed these over the years. Sometimes it may not make sense to you guys, but it may make sense to us, and that is just because we are in it every day, so I want to get you up to speed as fast as possible, so if this does not make sense, please speak up. Now is the time to talk about it. All right, so, with that, we are going to go into the areas. Carolyn, do you want to take public health and I will take the next section?

Carolyn Petersen
Sure, Aaron.

Steven Lane
This is a little awkward to see, keyholing around like this. Is this a document that we can pull up separately on a big monitor and look at while we are discussing it?

Jim Jirjis
It is on the calendar invite.

Steven Lane
It was not on mine. I just looked for it.

Aaron Miri

Is it in one of the downloads, Mike?

Steven Lane
I will go look for it. You guys go ahead. I am sure it is here somewhere.

Aaron Miri
I can also forward it to you, Steven, if you want.

Steven Lane
If it is easy, would you? I just do not have it.

Aaron Miri
Yeah, I have it right in front of me. Go ahead, Carolyn. Sorry.

Carolyn Petersen
So, I think we probably do need to scroll to the right here a bit to find the new pieces. So, we are looking at the proposed recommended HITAC activities. We are in the public health data systems priority area. That is an area that we added this year. We have here some comments from Jim Jirjis about proposed activities, first, that HITAC could recommend standards for an intermediary to collect data across public health data silos, and second, that HITAC could recommend that ONC develop a public health and lab testing entity certification program. Did you want to talk more about those in depth, Jim?

Jim Jirjis
Thank you. I think there was some recent news around some of our recommendations that the incentives…that perhaps HITAC could recommend standards and a way to use TEFCA, with its dedicated QHIN, for example, that one could address standards and how to operationalize them and how to address the implementation guide variation by leveraging TEFCA, and that having such an intermediary would create value in reducing a lot of the **[inaudible] [00:15:47]**, so I think that those were the main…that was the meat of the recommendation.

Steven Lane
It is interesting insofar as there are a number of different entities that could potentially serve in this intermediary role, and I think it seems like today, there are some states and regions where the regional HIE is playing a key role, there are some places where a lot of this is being managed through direct transmission and an interface has been set up, the potential role of care quality or TEFCA in the future… I do not know whether it is time yet for HITAC to recommend a single standard or one of a number of potential approaches. It is an area that confuses me.

Jim Jirjis
Steven, thank you, but the other piece of it is that the burden that falls on providers in multiple states to deal with all the variation could be settled if we were able to make recommendations to ONC because ONC has a convening role, even outside of its own direct standards requirement functionality, to coordinate across other entities, so that is why. Whether it be… To me, it seems like you would want to reuse existing national infrastructure, and the QHINs would address that, but there may be other ways to solve it.

The other thing on there was about the certification that from our perch, trying to report, even if you define the standards, what makes people adopt them in a consistent way? And, that is what led to the question about whether or not ONC should consider for both laboratory testing and public health whether there is some sort of standard so that people do not fail based on the technology. Otherwise, the fear is that people would use the money that is being given to create even more sophisticated silos with various interpretations.

Aaron Miri

What you could say is we are learning from the past. If you think back to early HIE days with Rio, then early iterations of HIEs, then HIEs that exist today, and now the TEFCA, what are the rules of the road? One thing that we thread a fine line here with our charge as the HITAC is telling ONC what to do, but what is interesting is we recommend a course of action, like learning. Let's find out and do a listening session or find out what the standards are that are out there, because I do know that as a matter of order, you see these meetings going on between ONC and the Sequoia Project trying to educate people on the RCE role and what is coming, and Marion Yeager is doing a great job of trying to educate the community to say, "This is coming, there is more coming, more information coming."

Steven, I know you chair the board there. There is a lot of work that is being done to try to educate, but I do not even know if all the HITAC is aware of all the different standards that exist, much less the history behind it. So, perhaps another recommended course of action could be to understand what that panacea view looks like. What are all the standards that are out there? I do not think I even know.

Jim Jirjis

For example, from my perch, we have 20 different HIE nouns and we are also connecting to Commonwell, so Steven, to your point, in the future, as TEFCA gets steam, most of these noun exchanges will likely be interacting as HINs, if not QHINs themselves, with the exchanges, so that is why I am just saying whatever answer for public health ought to align with that future.

Steven Lane

I think it is an important area for ONC to focus on, and I think our expression about what is going on is emblematic of that. It needs our focus.

Aaron Miri

Yeah, it does, and I think there could be a learning opportunity here, so, again, we try to recommend something that we all land on, and Carolyn and Brett, I am curious about your thoughts, but to me, I see this as an opportunity to put out there and instantiate that yes, it is a cluttered field, here is how it is cluttered, here is what we recommend we should do next, but Carolyn and Brett, what do you think?

Carolyn Petersen

I think connecting the dots is always good, and if we can do that in a way that points to something that would be more streamlined and potentially less costly and more effective for all deployers, that is a win.

Brett Oliver

I agree as well. I just feel like we have talked about this before, just maybe not in this particular public health data systems infrastructure topic, where we have talked over and over about the silos of public health data, the disintegration, and how it is… I think it matches to what we have talked about in other areas as well. I

think understanding it at a greater scale might be the first step, at least from my perspective. I know Jim and others understand it better at this point, but…I think **[inaudible – crosstalk] [00:21:11]**.

Jim Jirjis
Well, I think you are right. We saw a recent press release where they were…that ONC was looking just yesterday at QHINs and TEFCA for this very problem, and the only reason I think it is really candid for us to focus on whatever our appropriate constraints are is because it is a priority for Micky and for the Biden administration, public health and equity of care, and so, this seems like something that would be welcome for us to recommend as an area of focus in an annual report.

Aaron Miri
Yeah, that is a good point, and maybe you heard Michelle allude to it. It is another order of operations. What we do is once we get to a synthesis of recommendations and items like that, we try to prioritize them exactly like you are saying, based upon what we know of the current landscape, what we are hearing, and what we are being charged and engaged to do, how urgent this is, because you obviously cannot boil the ocean, but you can prioritize, so this could be a recommendation of a major priority, Priority 1, as something we really need to actively look at due to TEFCA turning on here very shortly, essentially, and those kinds of things. So, I think that is what you are alluding to, Jim. Is that correct?

Jim Jirjis
Absolutely.

Aaron Miri
Okay, perfect. So, Carolyn, I would look for your comments on this, but what I would propose is that we focus on your comments and then come back and prioritize after the fact. Or, should we do it in line? What do we feel is appropriate?

Carolyn Petersen
It might be easier to prioritize after we have gone through them all and refined each to what we think it should be.

Aaron Miri
All right, so we will do that. So then, for the outcome of this one, the proposed activity… Jim, I think we understand the intent of what you are saying and we are all in agreement that it is a convoluted landscape. We are saying for us to, No. 1, seek first to understand the landscape, so whether it is convening listening session, charging the Excel team and others to do some research for us and come back to us with what the landscape looks like, what is already being worked on, AKA what are the Sequoia Project and others putting out there as charged by ONC, and then, lastly, to develop a finalized recommendation, like pointing at some standard or standards as the recommended rules of the road. Am I hearing that correctly?

Jim Jirjis
Yeah.

Aaron Miri
Okay. Any debate or dissension to that? I want to make sure I capture that essence correctly.

Brett Oliver
No dissention. Would you want to add…? Maybe this is a second bullet of what you said, Aaron, but what is the national strategy? I understand looking at the web that has been woven over the years, but what is the national strategy? Is it TEFCA for public health? Maybe it is, and I just do not know. Asking ONC to comment on that would be helpful.

Aaron Miri
Great question. So, a follow-up would be pointing at something that would be, again, those recommended rules of the road. It is going to be interesting to see how TEFCA, as it rolls out state by state… Jim, I think you are spot on. There is going to be local variation. That is the beauty of our country. We have that ability to do that at the state and federal level. So, it will be interesting to see as it gets into practice and we work through that, but I think it is fair to say, "Look, here is a national framework that this will follow, and hopefully, State XYZ will follow it too," those sorts of things. Okay, next item. So, this one is public health data systems incentives. Carolyn?

Carolyn Petersen
So, sliding over to the right, here, we have some comments, some things that Arien brought up. "Tie to certification of EHRs with other certifications, of course, public health data systems, things like certified immunization registries that are getting data from certified EHRs, and then, intermediaries like labs, electronic lab reporting, tie particulars of funding opportunities across federal agencies to the ONC certification work, constrain optionality and certification programs as a national floor for interoperability, while preserving the ability of local actors like public health organizations to raise the ceiling to address local needs for data exchange." What I would note there is that those are comments, not proposed activities for HITAC. We need to think about what activities we can propose that the HITAC could actually do, since there is work here that potentially even ONC could not do on its own, never mind the HITAC.

Jim Jirjis
Just so I know, my understanding of ONC's role is that there is work that they can actually do, such as standards, but they also have that role coordinating across other agencies. So, the latter gives us license to actually recommend that they use that role to align incentives, for example, or… Am I misunderstanding? And therefore, HITAC could recommend that they address that.

Aaron Miri
Yeah. So, the way we have done that historically, Jim, is that we recommend inviting external agencies, like the CDC or the OCR, who have presented, to collaborate and learn together, so we do a learning session, a listening session, and work together.

Jim Jirjis
I see.

Aaron Miri
Michelle has the terminology specifically, but it is a way of showing that convening process without telling ONC, "Go do this," but if we want to work together with other agencies, if we want to be collaborative, which, of course, is always accepted, and work across, that is how you are seeing a lot of the other groups come

in and present with us or participate with us. To your point, that convening role is definitely something that ONC did a good job of, so as we point to that, it works out, if that is what you are asking.

Jim Jirjis

Perfect, thank you.

Aaron Miri

All right. Do you want to keep scrolling down, Accel team? I know there are more comments there.

Steven Lane

Before we go down, just going back up to the one before, did we settle on how we want to approach this notion of certification for public health systems and IT systems? This has come up so many times, and Arien's comments sort of presume that there is some certification here that applies, but I think we all know that the current certified health IT program is all about clinician EHRs, and it is not about the public health systems. We have been in a number of these meetings where we have said there should be this parallel certification program. In this report, do we feel that we should take a position on that one way or the other?

Jim Jirjis

I do not know how we would…how the U.S. is going to land in a place where there is enough definition to what "standard" means at each public health without some sort of certification-type program. Already, we have issues of whether they even want to participate, and most of the burden has come in at the different interpretations of how to implement. So, what are the other options if certification is not done?

Steven Lane

And, what drove certification on the provider side was all of the incentive programs, and now, there are all these incentive dollars available to support public health infrastructure, and it is clearly not up to HITAC whether ONC or anybody else takes this on, but I think if we, in fact, believe that a certification program by ONC or another entity, and ONC would certainly make sense for public health systems, presumably, there would need to be new legislation. There would need to be some way of saying to a public health agency in San Francisco, "You are not going to get your funding if you do not have certified health IT that does X, Y, and Z," but that just seems like such a key question as we are addressing, and then we can take Arien's comments and load them on top of that, tying these EHR certifications and the public health IT certification together.

Aaron Miri

Yeah. I will be honest: I am not even certain what exists for public health certification with today's standards. I know there have ben public health registries, I know there are student health registries out there, I know there are groups that meet and convene on that, I have heard anecdotally through another large trade group, that group that had developed the original standards for immunization registries and others, that it has not been updated in decades, so I do not even know what exists today in terms of a framework for public health. I do not know if you guys know; I do not know.

Steven Lane

I do not think there is much of one. Public health is such a bespoke cottage industry, down to the local level, but I think Arien's second bullet there, that funding opportunities for these public health agencies would be tied to certification of their health IT…

Jim Jirjis
From my perch, it is hard to address incentivizing public health agencies to do something without the something having sufficient definition that ensures that we solve the problem of interoperability.

Aaron Miri
It keeps coming back to… I wonder what is out there. Carolyn, you were speaking, sorry. Please.

Carolyn Petersen
When we talk about incentives, at least in the context of the Public Health Data Systems Task Force, we were talking about financials and other things that support the shift from whatever **[inaudible] [00:31:59]** public health entity is using now to the things that are determined to be the things people should be using going forward in the way that physicians, provider groups, and hospitals got various meaningful use dollars to try to do that. That is kind of…that was a significant part of the recommendations, and I think that there is still support for that from the Public Health Data Systems Task Force as well as from the HITAC.

Steven Lane
The obvious example is FHIR, right? How many public health systems have you talked to that said, "Oh yeah, we would love to do FHIR, but we cannot afford it, or it is not our priority. We are just trying to keep the lights on." And, if a prerequisite to them having the money to pay their electricity bill is that they have a FHIR server stood up and functioning to cover A, B, and C use cases, then that is a whole different world than the one we live in today.

Aaron Miri
Yeah. Well, you saw the ONC report that just came out last Monday or whatever that there is still a low uptick of adoption of FHIR, and it just… More people are getting their records, so it is a positive and patients are benefiting, but they are not benefiting as quickly because the adoption on the **[inaudible] [00:33:09]** is low, so to your point…

Jim Jirjis
Yeah, October 6 may change that for next year, right?

Aaron Miri
Yeah, that is very true. I, for one, hope it does. I am tired of debating the vendors on this topic. Okay, so, what I am hearing is a need to, again, better understand if there are certification criteria, are there existing criteria, and for us, then, to take that data, that synthesis, into what is then… How do we encourage adoption of XYZ standard if it is up to them? I am just making a guess here. If there is one that is there that is workable, that we all feel is positive, what would it take to then develop a carrot-and-stick strategy, for lack of a better term, for adoption? Is that what I am hearing?

Steven Lane
That makes sense.

Jim Jirjis
Yes.

Brett Oliver
Agree.

Aaron Miri
All right. Carolyn?

Carolyn Petersen
Yup.

Aaron Miri
All right, let's move on to the next section. No, not that one. Keep going. We just talked through all of that. Keep going. All right, NCVHS time. Go forward. I think we just talked about these funding silos. I am pretty sure we just walked through this again. It is the same thing, that… There is not a common infrastructure, there is not a pointing at what it is. Clem is spot on. How do we get data shared faster? As Carolyn was just saying, these are just comments that the HITAC made regarding this statement, so if there is something here that gives us feedback, let's pull it out, but to the degree of partnering with NCVHS and understanding what the barriers are, again, how do we get adoption of HIEs? Not everybody has a John Kansky running Indiana and doing a phenomenal job. I wish they did. The country would be in a lot better place. So, how do we do this? How do we get it in a way that encourages more adoption? That is the net of this one. Are there any specific things you guys can think of that we should focus on?

Jim Jirjis
I just have a quick question. So, when we say "focus on adoption," do you mean adoption of people participating with HIE nouns?

Aaron Miri
Yes, or standing up prospective local area-wide HIEs, like for a specific locale, maybe a rural territory, that kind of thing.

Jim Jirjis
That is what I was going to ask about. What we do not know is what the future of the noun HIEs are when the national exchanges become mature because the way I look at it, and I would love others' thoughts, a local noun HIE has two purposes, right? One is to be a convener of data so that people have a more longitudinal access to what is happening with the patient in the course of their care, right? There may be other value-added… But, that, the exchanges with USCDI increasingly should begin to replace with lower cost the HIE noun approach.

Aaron Miri
Lower cost and greater safety and security as well.

Jim Jirjis

Absolutely. And so, I do not know that I would be really excited about trying to increase adoption when that piece of it may be replaced by the national exchanges. Where I think the HIE nouns play is where they have…what are they going to do with that data? So, for those HIE nouns that are providing business value in their communities, then there should be less dependence over time on obtaining the data, preparing it, and mapping it to standards for use. Those costs should go down in a more secure way. For those HIEs that then have business interventions for value-based care in their communities, that business value should be what drives people to adopt it, not some generic sense that the local noun exchanges are valuable in the new world of national exchange of machine-understandable data.

Aaron Miri

That makes sense. And so, our recommendation here to partner with NCVHS had been to understand and identify barriers and potential opportunities for public health, and then, of course, the HITAC weighed in saying they wanted more frequent meetings with NCVHS and others to better understand and synthesize this. So, are we saying that we should add some of this language here, saying to partner with NCVHS and other federal advisory groups on coming up with a collective approach to adoption of health information exchange? Is that what we are saying?

Steven Lane

I think to Jim's point, the HIE noun, which is a term I love… More and more, people are talking about this notion of the health data utility that does not necessarily require a big, iron, central repository, a honeypot of health data from the region, so I think that perhaps we might want to even include that language. Instead of referring just to HIEs, we could say HIE/health data utility where available and affordable.

Aaron Miri

I like that, "health data utilities…" Michelle, you may have to investigate how that is used in the general language of folks. I do not know if folks will know that on the outside, but I like where Steven is going that, to try to make this really about just general adoption. Any dissension to this direction?

Steven Lane

And, this row is really all about funding.

Aaron Miri

No, it is funding, it is incentivizing, but to incentivize, to understand what to incentivize, you have to understand what the "what" is. Say that five times fast: What the "what" is.

Steven Lane

But then, also understanding more about what the dollar flows are that into public health, what are all their various sources, and for which of those it might be possible to link them to some requirement, whether it is using certified health IT or having certain services, et cetera.

Aaron Miri

That is right. Bingo. That is exactly right. I do not even know. There are so many pots of money now in different places. I do not even know. Okay, Brett or Carolyn, any comments or questions?

Carolyn Petersen

No, I am good with that.

Brett Oliver
Same here.

Aaron Miri
All right. Let's go to the next section, then, the fun one. Steven, this will be near and dear to your heart: ELR and ECR, and helping to expand adoption for electronic case reporting/electronic lab reporting, which goes back to your comments earlier about HL7, FHIR, and all the fun debates you and I have had with various vendors, Steven, trying to get this pushed through and these adoptions pushed through. In this one, really, it is how we identify the gaps of adoption of these types of standards or technology stacks that are out there and encourage adoption at a more rapid pace, whether that is incentive programs, whether that is whatever.

My comment during the HITAC was that ONC could partner with CMS and other agencies to basically incorporate data-sharing criteria into the lab certification process, with the goal of moving public health forward and away from fax machines. Essentially, you set up a CLIA-certified lab to be CLIA-certified, and therefore, for reimbursement, you have to meet some of these criteria and standards on the way you process samples and the whole nine yards. I am not a lab expert, but in a nutshell, there is a whole list of things you have to do to have the fidelity there of a lab result that you can trust. So, is there a possibility there within that to modify or add to that standard, or are there other similar standards that could be held onto? When you spin up a lab and you result something, you now must follow a certain criterion standard, including electronic lab reporting and ECR. So, that was my idea.

Jim Jirjis
Hey, Jim Jirjis here, being one of the huge pain points. I want to make sure I understand what we are saying here. So, when we were doing COVID reporting, which also applies to other public health case reporting, for most of the results we get from the laboratory systems, we are largely able to receive information with interfaces. They have the capability, but none of them are adhering to a standard interface, and out of 225 of them, zero report out with LOINC-based mappings. So, is that what we are addressing here, not only the interoperability transport standard, but the content terminology standard?

Brett Oliver
Hear, hear.

Aaron Miri
Correct on both sides. How do we automate this process so that this is a plug and play? It should be plug and play, yet you can google Austin, Texas in May of last year, who got into big trouble with fax machines that got jammed, so lab results got delayed and COVID results were not getting read for days because of fax machines. That is public health. That is public news. That is the reel. That is what happening with boots on the ground, as you know.

Jim Jirjis
Yeah, sure.

Steven Lane

So, there is a lot changing here, of course, with the latest CMS hospital rule, basically increasing the incentive for hospitals to participate in both ELR and ECR, and then, of course, there is changing technology at the same time. ECR was first built on Direct, and then, it went to eHealth Exchange, and now it is going to be able to go to FHIR, hopefully within the next year or so, and I think the same with ELR. It is all built on HL7 V.2 interfaces, but eventually, as we heard in our other task forces, we would like to see that moving to FHIR. So, I guess the question is as we put together guidelines or recommendations around this, as you say, we want to incentivize adoption, as CMS is doing. We want to throw the weight of ONC behind that, but we also want to encourage advancement of the technology from V.2 to FHIR, from Direct to FHIR, et cetera, and I think we want to capture all of that in this, in the adoption, the standards advancement, and the incentivization or requirement.

Brett Oliver

I agree with you, Steven. I do not want to limit it to just labs. It is very frustrating on Aaron's, Carolyn's, and my end, in our experience, to take your teams and work on an ECR for COVID, only to find out that your state infrastructure cannot support it. It goes back to the first topic we had in terms of public health infrastructure. CDC is not even… I would hope they would not mandate something without understanding the infrastructure that each of the states have, so, let's definitely look at it from a broader perspective, as you are suggesting.

Jim Jirjis

We had been working with Brittany Saylor with the White House, who convened us with Mike Wargo, and in the emergency infrastructure… I am trying to remember the name of the group. There is a group that convenes multiple different aspects of industry to actually identify what data sets and what structures need to occur during an emergency, and the reason I bring that up is someone just mentioned that we do not want to limit it to labs. We might make a recommendation to collaborate with that organization, with that government-sponsored group, to actually identify what subsets of information… For example, during COVID, PPE was a big deal, as were beds. There are so many different domains that are needed that I am wondering if a recommendation for collaboration across organizations would be to identify what beyond labs need to be included.

Aaron Miri

Yeah, we can do that. We can make a third bullet saying to collaborate with other convening groups across the federal government to find other gaps.

Jim Jirjis

I will give you the name of the group because they are the conveners.

Aaron Miri

That would be great, and the ONC team could investigate what the terminology and the vernacular look like. Again, we are just talking about collaborating and convening groups across the federal government. It makes total sense to learn. All right, any other comments or questions on this section, or should we go to the next one? All right, let's keep going. The next one, in blue, that we are talking about is still in public health. Really, this is about existing data health systems and the gaps. We have been alluding to this the whole time. How do we share even more information? This is really around the misnomer, which I am sure

you have all heard, that we cannot share COVID-19 data with you across health systems due to HIPAA and a bunch of other nonsense. HIPAA was widely misused, and it became the butt of many jokes on late-night TV for quite some time.

So, it is interesting. I think we should understand better how that happened. Again, there needs to be more education, especially with public health authorities. From talking to a lot of them, I know it drove them nuts that folks would not share or could not share case information. They would not even share anonymous case information. So, my comment on this to HITAC was to set minimum thresholds of exchange of code sets to increase the pace of adoption, basically saying that you do not have a choice. You have a volume threshold you have to share. If you have had a thousand people walk in that you are doing case reporting on, at least 80% of them must be transmitted electronically. Think of the VDT minimum standard that you had for view/download/transmit with Meaningful Use Stage 2. That is what I am thinking of in my head when I am saying that. How do we force the issue, regardless of what the misnomers maybe out there around HIPAA and others? Thoughts?

Steven Lane

We have been trying to peel this onion for some time, and when I worked with Marianne, we reached out to…I think it is OCR who owns this, and they have not been… They issued some guidance late last year, but it did not really get us very far. It did not really address the core question, which is that provider organizations, when exchanging data with public health for nontreatment purposes, are stymied by the minimum necessary requirement, and then, there are all kinds of hoops that people need to jump through, either at the local or state level, to verify that public health is requesting minimum necessary or exchanging minimum necessary. So, I am not quite sure what the next step is. I think it is fair that members of the public are concerned that the government, Big Government in the form of public health, is going to be getting too much health data beyond what is really needed to address the public health emergency. When you are a public health-er, it is like HIEs. “Just give me all the data, and I will figure out what I want to do with it later.”

So, this is a thorny area, so I think starting with a listening session to understand the barriers… It is not just applying the HIPAA minimum necessary standards. Maybe it is. Is that still the right standard? Have we had an experience these past two years that shows us that perhaps public health should have broader access to health data? I do not know. If we are going to continue to apply the HIPAA minimum necessary standard to nontreatment transactions… I am babbling a little bit, but I am trying to help think it through. What would be really helpful here? So, your comment, Aaron, that minimum thresholds for exchange of diagnosis code sets…

Aaron Miri

I was thinking of view/download/transmit and forcing the adoption of patient portals for Meaningful Use Stage 2, so in my head, I thought, “Is there some construct that we can put, especially on the covered entities and on public health data, to say you have to exchange so much of your case reporting data, lab set data, or anything regardless, electronically?” So, with any qualms you had about HIPAA and others that may be misguided, you have to do it.

Steven Lane

Is USCDI the coin of the realm here? Should we be driving towards telling providers that they can and/or must exchange USCDI as a data subset with public health for nontreatment purposes?

Aaron Miri
Maybe.

Jim Jirjis
One quick question. Just because it is USCDI does not mean it meets minimum necessary, though, right?

Steven Lane
No, exactly. Is minimum necessary the right standard? Is that the right way to go about constraining the data that goes from providers to public health for public health, which is to say nontreatment, purposes?

Aaron Miri
Good question. I think that is part of the… We need to understand more about what the barriers actually are. Obviously, we are aware of the ones that hit us in our respective parts of the country. We heard from the public and from other health agencies some of the misnomers like HIPAA and others that inhibited. I do not know. Carolyn, Brett, what do you think?

Brett Oliver
I do not have anything to add.

Carolyn Petersen
I am thinking.

Steven Lane
This has just come up in so many of our task force meetings, the Public Health Task Force, et cetera, and I have not seen a really clear path forward yet.

Aaron Miri
Steve, to me, the challenge is that it is easy to define a total set of data, like USCDI, from which minimum use elements could be selected. The problem with minimal use is it is so situation-dependent that it implies a set of tools for those who are requesting and fulfilling to either deliver only minimum necessary ad hoc or through some sort of predetermined subset definition, and I think that is what you are saying. If we had USCDI and if there was, for example, a TEFCA or an agreement as to the public health set that was a subset of USCDI, for example, then that could be defined and could be predetermined to be minimum necessary for public health, done, everyone has clarity, and they can execute on it.

Steven Lane
I think one of the challenges in all this has been that there have been all these bespoke data sets that have been developed. The EICR for case reporting does not always apply because it is the superset, but then, the APHL parses out a subset of that based on the reportable condition. For COVID, different public health entities define different data sets that they needed or that they demanded from providers, and we had to deal with that, such as each county wanting different data. It was incredibly frustrating.

And then, through care quality, we made the proposal that the CCD should be considered minimum necessary for purposes of epidemiologic investigation in the context of COVID. It seems to me that if we

can get public health over to FHIR, then this problem disappears because what we are dealing with is the need to stand up an interface, develop a document standard, or something else, or rely on the CCD, whereas if you have FHIR, you can basically say at this moment, for this problem, we want these data sets, kind of like what they did when they demanded that everybody put together a data file and send them, but you can do it as a FHIR query. They could just query us, or they could tell us to send them these data elements via API. So, I think that would need to be a part of this discussion, not only how we address this current minimum necessary requirement today, but how our ability to address it will evolve over time as the technology evolves.

Aaron Miri
Interesting. You are right. Carolyn or Brett, any comments?

Carolyn Petersen
No, I…

Brett Oliver
I agree with what Steven is saying. I am sorry, Carolyn.

Carolyn Petersen
It seems like it is always more complex. It looks like they could just… But, maybe the solution is to try to bring back Public Health Data Systems Task Force for a limited slate of meetings to talk about some of these specific issues. What are the challenges with trying to use FHIR? What are the specific technical issues there that would be seen in the field immediately if we went to that? And, to get a better sense of what are all the steps involved and what are the costs involved in trying to move to something in that way.

Aaron Miri
Okay. So then, if I am looking at action items, then, if I am understanding this right, we are still in agreement that we need to understand more about the barriers. It may not be the HIPAA minimum necessary threshold; it may be other things we talked about, but we still need to have HITAC be better informed of what those speed bumps are. Am I hearing that right?

Carolyn Petersen
That is part of it, and maybe it is also a way of enlarging the conversation to bring public health in, more specific conversations/discussion points, and try to look at broadening the view of landscape of opinions. What is really inbound as a potential solution to the problem? I think that there has been… In the meetings of the task force last summer, there were some really good discussions that were fairly broad, but there are clearly also some areas where individuals or stakeholders have a very strong preference for a particular position, and perhaps may not be so easily shifted from that position, so maybe there is more discussion, not just for the HITAC's understanding and clarification, but also for ONC's broader understanding of the tech issues and what the real pain points and barriers are.

Aaron Miri
That makes total sense. All right, so then, I just want to make sure I get the **[inaudible] [00:58:50]** right. We probably need to get an understanding of all the different other activities ONC is working on with this

because there may be other things that are in flight to update this item with. To your point, we need to bring public health more in, Carolyn, but I do not even know all the things going on.

Carolyn Petersen

So, maybe one of the proposed recommended HITAC activities is to conduct a survey of public health activities or systems to understand what all is going on out there as a prelude to understanding why it would be problematic or what would be needed to make a shift to FHIR or some other kind of system that would be perhaps more workable or preferable to clinicians, patients, and others.

Steven Lane

Yeah, I would agree.

Aaron Miri

And, Carolyn, your earlier comment about continuing to leverage the Public Health Data Systems Task Force to take on these kinds of problems as opposed to assuming that the full HITAC will tackle them makes a lot of sense, and I think that task force was very clear. They had a very short timeline, they were going to be selective in terms of which of their charges they tackled first, and I think one of the recommendations was that the band should be kept together so they could continue making music.

Carolyn Petersen

Yeah, and it is not like I am dying to set up a whole new slate of meetings on the calendar per se, and certainly, perhaps there is an opportunity for the HITAC members to attend any of those meetings because they are on the HITAC, but to try to get more specific about things, it felt like we kind of needed to be very broad, but not very deep because of our timeline, but it may be that in setting up some more detailed discussions, we get to the details that contain the devil.

Aaron Miri

Okay. So, assuming no objections here, then we will move on to the next section. Are we all good with this? Maybe I am still a little lost. I think we are good.

Carolyn Petersen

I think so.

Aaron Miri

Okay, next section, please. All right, we are at the Terry O'Malley comment. So, "The exchange of data for transitions of care, the gap being that poor exchange of information during transitions of care increases likelihood of a poor outcome, and the challenge that a uniform process is needed for standardized exchange of essential information to transfer from one side of care to the other, again, going from inpatient to hospice, LTAC, or something like that. The opportunity is the exchange of data for both transitions of care between care **[inaudible] [01:02:00]** to transitions or transfers of levels of care, going from med/surg to ICU or whatever and back, that kind of thing, between floors, needs stronger standards. Investigate the requirements for improving the exchange of data during transitions or transfers of levels of care, particularly around standards, and please consider including this topic area for a transitions-of-care proposal. So, when it comes to…"

Jim Jirjis
He probably meant "from a transitions-of-care perspective."

Aaron Miri
Yeah, that sounds probably more like what Terry said, but yeah, or he misspoke. But, the question I have… Interoperability… Given that we have three physicians, I like this. So, I am curious. We all know that handoff is incredibly important between levels of care and sites of care. Are there standards? Are there best practices? What does that look like? Is that an interoperability bugaboo?

Steven Lane
Well, it is definitely interoperability. This was…MU2, the requirement to send a CDA document at the time of transition of care, but it was years ago that that was defined. It was all about the use of documents as opposed to FHIR, and as we all know, if you have seen one CCD, you have seen one CCD, so I think there is really an opportunity to look at these standards. That is the existing standard, that you send transitions-of-care to the A document for specific transitions, but how do we make that more effective? I think what he is saying is yeah, we are doing that, but it is not really good enough.

Should we be looking at evolving the standard of just which information is sent, making it somehow more dynamic so it is not like every…the referral from a PCP to a dermatologist is not treated the same as a transition from a hospital to a long-term care facility? So, I think that is what he is getting at: What are the standards for the content, what are the standards for the format, what are the standards for the transport, building on what was developed by MU2? Is it a decade now? It has been a long time since that standard was established, and I think everyone got comfortable with it, but I think what he is saying is that it is not doing the job as well as we could be doing the job.

Aaron Miri
Got it.

Brett Oliver
This is Brett. I would agree 100% with that. I would also expand that to ask what is the compliance with transition-of-care standards as they exist now? It is a black hole. I do not even get CCDs most of the time. It is a crapshoot of what you will get, if anything, and it is a tremendously important… It is one thing for a transition of care from a 24-hour hospital to back home and seeing me in the office a couple of days later. If you go to an LTAC or some kind of long-term facility and then they show up in your office or in the ED with no information… I think it is tremendous opportunity, whether to evaluate the standard, expand the standard, investigate the compliance with the standard, which, quite frankly, I think is poor, at least in my region.

Steven Lane
The other thing is that the CMS EDT requirement has been layered on top of that, and I know that for us, we are really struggling with how to make sure the right data is going at the right time because a transition is an admission, it is a discharge or a transfer, and those transfers, as you mentioned, Aaron, could be between units within a hospital or between levels of care. I think we made a good start on this with MU2. I think the CMS rule is another iteration, but then, how to bring all of that together and coordinate these

various rules so that we are really getting closer to the mark of getting the right data to the right users and the right format at the right time?

Aaron Miri
Jim or Carolyn?

Jim Jirjis
I concur.

Aaron Miri
Carolyn, what do you think?

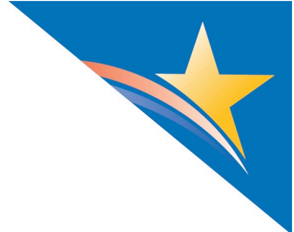
Carolyn Petersen
Yup.

Aaron Miri
So then, what we are…so, obviously, investigate… And, I would also say is there any measurement on adoption? What I am hearing is there is a variation, obviously, between Kentucky, California, here in Florida, and where I was in Texas prior to this. It is the same kind of "your mileage will vary" thing depending on who we are exchanging data with, if they even have electronic systems. What I am learning here is that some of the ancillary sites, especially in the very rural parts of Florida, are still on paper, so it is very interesting. I know there is also an ONC effort going on to measure success criteria. We heard about it in the HITAC two meetings ago. Michelle, I am not sure if that is something we can investigate. Is there a success ratio on this specific issue being measured or approached? There could be an opportunity here to incorporate that effort into that success measurement. I forget the name of the program that is going on.

Steven Lane
Well, it certainly overlaps with the EHR reporting program that we just had a chance to review and comment on at the HITAC. I do not remember this coming up specifically for reporting on transitions of care. It was probably in there, but I am just not remembering. But, to be able to have the EHRs themselves report on how often they are doing this, what they are sending, et cetera…

Aaron Miri
Okay. So, what we can do is do a little investigation on this one comment and see what is part of the EHR reporting program, what is part of the other efforts that are going on, and then come back to this group. Michelle, is it possible for us to collaborate via email on this once we have a little more visibility on other measurement efforts going on?

Michelle Murray
Yes, we can look into that further for you. I just want to point out, too, that I was paraphrasing for Terry. He sent a multipage proposal for certain HITAC members to look at. It was not too clear to me exactly who he wrote this for. Maybe it was a general proposal. So, there was a proposal, and you received it, so it would help to look at that to make sure we are capturing his intent. This is my interpretation of his introductory text. I think you guys all reflected back what I was hearing from his proposal.



Jim Jirjis
Can I make a quick comment?

Aaron Miri
Yeah, go for it.

Jim Jirjis
On the row where it talks about improving exchange data, in this case, it is transitions and transfers of care, but even more broadly, the CCDs… When Steven said if you have seen one CCD, you have seen one, boy, we experience that. One difference we saw between Commonwell and eHealth Exchange was how much energy was put into doing quality assessments of how people are interpreting the standard. The implementations were so varied in how people interpreted that led to a lot of it. And so, it may be worthwhile to actually have…I am blanking on her name, the person who is in charge of eHealth Exchange quality assessment…

Aaron Miri
Didi Davis.

Jim Jirjis
Yes. That may be useful because we may get insights on where the money is based on what they are seeing that is driving most of the variation from standards, and much of it is implementation interpretation, not necessarily that the standards are not right.

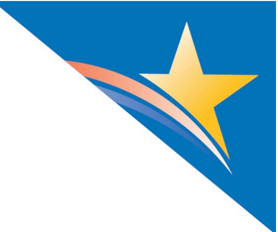
Aaron Miri
Okay. I completely understand that comment. So, what I would propose is let's let Michelle get back to us with what they find, and then we can interweave that into that point as well, so it is not just transmission, but did you actually interpret it right, and is the quality or veracity of the data there to make that interpretation?

Jim Jirjis
I may have misunderstood. This is just about getting people to actually send it electronically. That is one thing. If by "particularly around the standards" we also mean how they are interpreting it so we can actually use it, then my comments are valid. If not, then I am off the mark.

Aaron Miri
You just cannot say the words "meaningful use." You are just banned from that. Deal?

Jim Jirjis
"Helpful use"?

Aaron Miri
There you go, "helpful." "Most helpful use." We will qualify them like that. All right, let's go to the next section, please. I believe we have one more blue. All right, this is "Increase health equity across populations." That is so important. And, regarding the barriers to delivery of relevant public health-related information through APIs, so again, we are trying to figure out what those common barriers are across all regions, all walks of



life, and why those exist. So, Denise basically stated supporting enabling rights uniformly across states. Abby recommended considering a consumer protection process for electronic data storage with easy-to-understand terms and identification of bad actors. Carolyn commented to consider education **[inaudible] [01:12:06]** plain English, updates to ONC patient tool kit, which you recall a couple years ago, when they first launched, was excellent and really guided people through how to get your own data and how to go do these things with pictures and everything. It was really well done by ONC. But, build upon that previous consumer education and really beef that up.

And then, Sheryl Turney: "It could be addressed **[inaudible]** of third-party apps and defining educating about terms of analytics and statistics." Those are all fair comments. So, again, our recommendation had been to explore barriers in delivery of relevant public health-related information through APIs, patient portals, et cetera, but if you look at all these comments… Again, this is me talking out loud, so I am looking for your feedback as well. It sounds to me that what we are looking for is a comprehensive, easy-to-understand playbook, again, kind of what the ONC had created earlier a couple years ago, but really beefing that up on how we decrease the amount of health inequity right now in the country. Thoughts, questions, suggestions?

Steven Lane
Well, a lot of work is obviously going on in the world of patient-directed apps to access data from providers, like the whole CARIN Alliance world. I think part of this is the question of patient apps and, potentially, provider apps to access data from public health. Whether public health entities will be publishing APIs so that patients and providers and, potentially, payers or other researchers could access that data… There is a mention here of patient portals or apps that presumably would leverage APIs and other tools. I think this is important, and again, it has come up in the Public Health Task Force that that public health data has to be treated much more similarly to data that is generated by clinical organizations and providers and made available for query, download, and use. I like where this is going. I think Abby's comment is interesting. A consumer protection process…

Here, again, a lot of focus has been put onto informing and educating individuals when they use an app to access their clinical data from providers or labs as a subset of providers. Presumably, that would be similar if a patient enabled an app to access their data directly from public health, where they had collected that data either through their own means, such as case investigation, public health nurses, et cetera, or they had received that data from others, such as other providers and labs. There is a lot here.

Aaron Miri
There is a lot of here. So, we look at specific action items. What do we, as HITAC, recommend doing? Obviously, I am hearing there is urgency around this, but what are the tasks we need to do? Obviously, we need to learn, and then double down on the existing effort or something because, to your point, Steven, there is a lot of work going on. What do others think? Jim, Brett, Carolyn?

Jim Jirjis
I do not have my head around this one enough to comment.

Aaron Miri
Okay, that is totally fine.

Brett Oliver

Parallel to that, I would like to understand the current efforts under way and where those are before I would ask to double down. I do not know that I know enough to ask that question.

Jim Jirjis

If you look at the All of Us initiative and if you look at national infrastructure, it sort of implies that there will be an m-health component to this right, where there is a group of people thinking about how we collect information from patients and how they interact with their record. Is there a governmental group that actually looks at that? Because it starts to smell like that here, right? I know that with all of us, the "Framingham on steroids" part of the component is actually asking patients questions and how we capture that. This feels like it is getting into that space, and I wonder if there is a collaboration with other groups who are thinking about this.

Aaron Miri

Great question. So, maybe it is a catalog of all the existing efforts that are going on right now across federal agencies and, again, learning and collaborating with those efforts. It could be that as a step one, but to throw all our weight behind it… I do not know either, Jim. That is a great question. If there are, I would love to see the data. That would be very helpful.

Jim Jirjis

These third-party apps… Forget public health for a minute. You guys saw the news on Health Gorilla with the VA, right? Did you guys catch that?

Aaron Miri

What is that?

Jim Jirjis

The VA just announced a public/private partnership with Health Gorilla, which is one of these third-party apps to collect **[inaudible] [01:17:41]** the record. Health Gorilla just had another news article come out, and that is that they are interacting directly with eHealth Exchange, so you see this as becoming a reality as smart third-party app developers are positioning themselves. And, the reason I say that is because getting access to the data from the EMRs… The other thing was you saw where Apple now also has six different EMRs that they are interoperating with.

The reason I say all that is if I am one of these One Record or Health Gorilla, the first step is to aggregate the data in a machine-understandable fashion. The second step is to figure out what else I am going to do with it, and one of the things they are going to do with it is probably begin to capture data from patients directly. And so, that gets into the m-health component. I think public health fits in that. How do you address the patient's interaction now, whether it is through third-party apps or portals with this? Anyway… Josh Denny is a good friend of mine. He is in charge of that All of Us initiative. I wonder if he might be a good place to start to see if there are m-health groups because that is an important piece of the All of Us initiative, collecting additional information from the patient.

Aaron Miri

Okay. What I am hearing from an action item here… I just want to make sure I am hearing right, and I agree with all of those. Maybe we need to marinate about this offline and figure out what the right next steps are. Obviously, we have to explore the barriers and figure out those comments, but are there other pieces here, and cataloging those pieces and getting them together, but I think the task force is asking for a little more time to think about this. Is this right?

Jim Jirjis
Yeah.

Carolyn Petersen
I would go with that, yeah.

Aaron Miri
Okay. So, Michelle, if it is okay with you, we would like to work on this one, collaborate via email, and maybe even talk about it in the next meeting if we need to. I guess it is across the line because this is a very meaty one. So, obviously, I am going to hypothesize it will be a major priority for us, but we want to get it right with our recommendation.

Jim Jirjis
Hear, hear.

Aaron Miri
We have a minute before we go to public comment. Carolyn, I am going to propose this: Given how close we are on time, do you think we should hold the prioritization discussion to the next meeting or just slow chat about it in email and make it official in the next meeting?

Carolyn Petersen
Yeah, that sounds good. We are too close to public comment now to do that.

Aaron Miri
Yeah, I want to make sure we save time. We have about a minute before public comment. Any other comments you guys have about the blue text that we have talked about today? Anything else you want to say that we can talk or think about in the last minute here? I will say that these are very deep topics, and public health is not easy, as we have all learned, excruciatingly so over the past year, and it is an area of tremendous focus, which I am really glad to see. So, Steven, to go back to your earlier question at the very beginning of how relevant this data is going to be and this report is going to be, I think particularly this year, we will give focus a clear roadmap as to where we are thinking things should head. It has to be critical. So, Accel, if you would pull up the public comment slide, Mike, I think we can move to public comment.

Public Comment (01:21:41)

Michael Berry
All right, great. Thank you, Aaron. Can we open up the line for public comments?

Operator

Yes. If you would like to make a comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 if you would like to remove your line from the queue, and for participants using speaker equipment, it may be necessary to pick up your handset before pressing *. One moment while we poll for comments. There are no comments at this time.

Michael Berry
Thank you. Aaron, Carolyn?

Aaron Miri
Carolyn, do you want to start?

Carolyn Petersen
Great meeting. We got a lot done today and had some good discussions. I think we are in a good place. Thanks, everyone.

Aaron Miri
Absolutely. I saw Jim had to just jump off, but thanks, Steven, for hopping on, and Jim, if you are still there, thank you for joining us. I know both of you are very busy. Glad to have you on the task force. This is a fun discussion.

Jim Jirjis
Thanks for letting us crash the party.

Aaron Miri
No, that is what it is all about.

Steven Lane
Yeah, hopefully we will add more light than heat.

Aaron Miri
You are all MDs, so there is a joke there somewhere, so I will leave that alone.

Jim Jirjis
Well, I will end with this. I started out with how many doctors does it take to screw in a lightbulb? Do you know the answer?

Aaron Miri
Go ahead.

Jim Jirjis
One. We just hold the bulb and the whole world revolves around us.

Aaron Miri
Very good.

Jim Jirjis
Thanks, guys.

Aaron Miri
Take care. And, if the AMA is listening, that was a physician saying that joke. Anyway, all right, thanks, everyone. Have a good one.

Brett Oliver
Thanks, everybody. Take care.

Adjourn (01:23:26)