



# Transcript

## HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) MEETING

November 10, 2021, 10:00 a.m. – 12:45 p.m. ET

VIRTUAL



# Speakers

Name	Organization	Role
<b>Aaron Miri</b>	<b>Baptist Health</b>	<b>Co-Chair</b>
<b>Denise Webb</b>	<b>Indiana Hemophilia and Thrombosis Center</b>	<b>Co-Chair</b>
Michael Adcock	Magnolia Health	Member
Cynthia Fisher	PatientRightsAdvocate.org	Member
Lisa Frey	St. Elizabeth Healthcare	Member
Valerie Grey	New York eHealth Collaborative	Member
Steven Hester	Norton Healthcare	Member
Jim Jirjis	HCA Healthcare	Member
John Kansky	Indiana Health Information Exchange	Member
Kensaku Kawamoto	University of Utah Health	Member
Steven Lane	Sutter Health	Member
Leslie Lenert	Medical University of South Carolina	Member
Arien Malec	Change Healthcare	Member
Clem McDonald	National Library of Medicine	Member
Brett Oliver	Baptist Health	Member
Terrence O'Malley	Individual	Member
James Pantelas	Individual	Member
Carolyn Petersen	Individual	Member
Raj Ratwani	MedStar Health	Member
Abby Sears	OCHIN	Member
Alexis Snyder	Individual	Member
Sasha TerMaat	Epic	Member
Andrew Truscott	Accenture	Member
Sheryl Turney	Anthem, Inc.	Member
Robert Wah	Individual	Member
James Ellzy	Defense Health Agency, Department of Defense	Federal Representative
Adi V. Gundlapalli	Centers for Disease Control and Prevention	Federal Representative
Ram Iyer	Food and Drug Administration	Federal Representative
Jonathan Nebeker	Department of Veterans Health Affairs	Federal Representative





Michelle Schreiber	Centers for Medicare and Medicaid Services	Federal Representative
Ram Sriram	National Institute of Standards and Technology	Federal Representative
Micky Tripathi	Office of the National Coordinator for Health Information Technology	National Coordinator
Steve Posnack	Office of the National Coordinator for Health Information Technology	Deputy National Coordinator
Elise Sweeney Anthony	Office of the National Coordinator for Health Information Technology	Executive Director, Office of Policy
Avinash Shanbhag	Office of the National Coordinator for Health Information Technology	Executive Director, Office of Technology
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Vaishali Patel	Office of the National Coordinator for Health Information Technology	Presenter
Norman E. Stone III	Federal Electronic Health Record Modernization Office	Presenter
Yvonne Cole	Federal Electronic Health Record Modernization Office	Presenter





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

### **Operator**

Thank you, all lines are now bridged.

### **Mike Berry**

All right. Hello, everyone, and thank you for joining the November HITAC meeting. I am Mike Berry, I am with ONC, and we are very pleased that you could join us today. As a reminder, your feedback is welcomed, which can be typed in the chat feature throughout the meeting or made verbally during the public comment period scheduled at about 12:30 this afternoon. So, let us get started with our meeting. First, I would like to welcome ONC's Executive Leadership Team to the meeting. And with us today will be our National Coordinator, Micky Tripathi; Steve Posnack, our Deputy National Coordinator; Elise Sweeney Anthony, the Executive Director of the Office of Policy; Avinash Shanbhag, the Executive Director of the Office of Technology. I will now call the meeting to order and begin the roll call of the HITAC members and the federal agency representatives of the HITAC. When I call your name, please indicate that you are present. I will start with our co-chairs. Aaron Miri.

### **Aaron Miri**

Good morning.

### **Mike Berry**

Denise Webb.

### **Denise Webb**

Good morning.

### **Mike Berry**

Michael Adcock. James Ellzy. Cynthia Fisher. Lisa Frey. Valerie Grey.

### **Valerie Grey**

I am here.

### **Mike Berry**

Adi Gundlapalli. Steven Hester. Ram Iyer. Jim Jirjis.

### **Jim Jirjis**

Here.

### **Mike Berry**

John Kansky.

### **John Kansky**

Good morning.

### **Mike Berry**

Ken Kawamoto.

### **Ken Kawamoto**

Morning.

### **Mike Berry**

Steven Lane.

### **Steven Lane**





Good morning.

**Mike Berry**

Leslie Lenert. Arien Malec.

**Arien Malec**

Good morning.

**Mike Berry**

Clem McDonald. Jonathan Nebeker.

**Jonathan Nebeker**

Good morning.

**Mike Berry**

Brett Oliver.

**Brett Oliver**

Good morning.

**Mike Berry**

Terry O'Malley.

**Terry O'Malley**

Good morning.

**Mike Berry**

James Pantelas.

**James Pantelas**

Good morning.

**Mike Berry**

Carolyn Petersen.

**Carolyn Peterson**

Good morning.

**Mike Berry**

Raj Ratwani.

**Raj Ratwani**

Good morning.

**Mike Berry**

Michelle Schreiber.

**Michelle Schreiber**

Good morning.

**Mike Berry**

Abby Sears. Alexis Snyder.

**Alexis Snyder**





Good morning.

**Mike Berry**

Ram Sriram.

**Ram Sriram**

Good morning.

**Mike Berry**

Sasha TerMaat.

**Sasha TerMaat**

Good morning.

**Mike Berry**

Andrew Truscott.

**Andrew Truscott**

Good morning.

**Mike Berry**

Sheryl Turney.

**Sheryl Turney**

Good morning.

**Mike Berry**

And Robert Wah.

**Robert Wah**

Present. Good morning, everyone.

**Mike Berry**

Good morning, everybody, and thank you very much. I am now going to turn it over to Aaron and Denise to kick us off this morning. Aaron, Denise?

## **Remarks, Review of Agenda and Approval of October 13, 2021 Meeting Minutes**

**(00:03:39)**

**Aaron Miri**

Absolutely. Good morning, everybody. Thank you very much for joining us for the November HITAC session. We have a really good meeting today. I will ask for your flexibility as we juggle a couple of things in sessions that are going and start times. But we will try to keep the time for when public comment will be. And the always important break that is in here. Some important topics for the month to go through, and I look forward to going into detail. Denise?

**Denise Webb**

Yes, good morning. Just so everybody knows, Micky is running a little bit late, so we are going to have comments from him probably before we start ONC's presentation. So, we are going to have an interesting morning today and we are going to hear some good presentations. I am looking forward to the discussion and the input from our committee. Aaron, I think we should go ahead. Let us go ahead and do a motion to adopt the meeting minutes of October. If I could get a motion.





**Andrew Truscott**

Truscott moves.

**Female Speaker**

Second.

**Denise Webb**

And all those in favor, say aye.

**All in Unison**

Aye.

**Denise Webb**

And anyone who disapproves? No? Any objections? All right, so, I am going to let Aaron go ahead and go over the agenda and give some talking points on where we are with the Annual Report Workgroup and our Annual Report.

**Aaron Miri**

Absolutely. Thanks, Denise. So, today we have got Micky's comments at some point, probably here in a few minutes or so. And we are going to go through obviously remarks and the approval here, which we are just doing now. The ONC objectives, benchmarks, and measurements will be led by Elise and the team at somewhere around 10:25. Again, give us a little grace as we maneuver to allow Micky to do his comments. Then we have got interoperability monetization strategy. Then we always have an important break. And then, of course, we will look at the calendar year '22 HITAC work plan. Then we will go for public comment about 12:30 with final remarks around 12:45 at which we will adjourn. So, it should be a quick meeting today, but it should be impactful and a good discussion here.

So, with that, let me give you a quick update on where we are with the report workgroup. First, I want to thank the ONC team. Michelle, everybody else, my co-chair, Carolyn Peterson; always a wonderful partner in crime as we have worked through this over the past several years. But really, what we are looking at here is we are talking through the gaps, and challenges, and opportunities really that we recommend for the activities for inclusion of our Annual Report for FY21. Much like we talked about at the last HITAC meeting, really going through some of those discussion points. Again, I encourage you to please feed us back your comments and so forth. The draft report will be brought, obviously, back to the full committee early in the winter of 2022. And then we will go through that in detail with you with a fine-tooth comb. But right now, we are still taking your suggestions, we are still taking your inputs, particularly around the important domains around public health, interoperability, privacy and security, and whatnot that are the HITAC charges.

Also, it is important to note that we adopted last year what I call the story section of each of those charges. What does this mean in plain English for patient care delivery or clinical care delivery? And so, I ask you to look at those stories from last year. And as we articulate the new narrative for each of those sections, if we were to get all these things right, what would it look like from a health care delivery perspective? Think about that. What would that mean in your locale, your respective health system, your respective company as we advance care delivery across the country? So, with that, Denise, if I am reading it right, it looks like Micky is on audio. No, he is not on audio yet. Nope. So, I think Denise, should we transition then over to going right into the objectives?

**Denise Webb**

I think that is a good plan, so we can stay on track. And then we can have Micky speak to us after Elise and the team are finished.

**Aaron Miri**

Perfect. All right. So, Elise and Seth, we turn it over to you.





## ONC Objectives, Benchmarks, and Measurements (00:07:26)

### **Elise Sweeney Anthony**

All right, that sounds good. So, let us see, hopefully, you all can see me here. All right. Hi, everyone. My name is Elise Sweeney Anthony, I am the Executive Director of the Office of Policy here at ONC. Today we have the pleasure of sharing with you some objectives and benchmarks, as well as a discussion of some recent work that we have been doing around patient access as well. The stars of the show today will be Seth and Vaishali, so Seth Pazinski is the Director of Strategic Planning and Coordination Division here in the Office of Policy at ONC. And Vaishali Patel is the Branch Chief of the Data and Analysis Branch in the Office of Technology. So today, we are going to be talking about, as I said, objectives and benchmarks. We will also be talking about some research findings in the space of patient access. And also, as always, we welcome your input. So, we are looking forward to the conversation about everything we present today and looking forward to your feedback. So, we will go to the next slide.

All right, so this slide highlights the 21<sup>st</sup>-Century Cures Act requirement. I always like to bring this up when we are talking about objectives and benchmarks. As you can see here, that the OMT is charged with establishing and updating objectives and benchmarks for measuring progress. And this is something that the HITAC has seen before. We've shared with you what our objectives are as well as the benchmarks, and you provided your feedback about that. So, we are looking forward to the same here. And these are helpful when we think about the HITAC Annual Report development. In terms of understanding what OMC is looking at, what we are aiming towards, and also how they relate to the priority target areas which are: patient access, interoperability, thinking about tech as it supports public health, and privacy and security.

So, we will also talk later as well, not just about some of the work that ONC is doing, but we are excited to have our colleagues from FEHRM with the Federal EHR Modernization Program to share with you some of the thinking that they are doing around interoperability measurement. So, Seth is going to kick us off, and then we are going to talk a little bit after that about some of the work that Vaishali and her team have been doing. I also want folks to keep in mind, that it is that perfect opportunity, as I always like to talk about the importance of the strategic plan. So, the Federal Health IT Strategic Plan 2020 to 2025 looks at what the federal government is focused on as it relates to health IT. So, as we are thinking about objectives and benchmarks, as we are thinking about our work at ONC, we are also thinking about that larger federal health IT framework that is included in the strategic plan. So, just another note to keep in mind, continue to check that out, and stay tuned in for that. With that, let me turn it over to Seth.

### **Aaron Miri**

Seth, you may be muted, my friend.

### **Seth Pazinski**

Thank you. We go to the next slide, thankfully. Thanks, Aaron. As Elise said, Seth Pazinski, Director of Strategic Planning and Coordination at ONC. So, last year at this time, we presented these two objectives and some activities for benchmarking progress through the fiscal year 2022. So, that would take us through October of next year. And then we communicated these same objectives in the strategic plan that Elise mentioned, the 2020 to 2025 Federal Health IT Strategic Plan. So, ONC's two objectives that we are focused on are advancing the development and use of health IT capabilities, as well as establishing expectations for data sharing. And those two objectives lead to a goal from the Federal Health IT Strategic Plan about connecting health care with health data.

So next, I am going to highlight a couple of key focus areas for ONC as we are pursuing this goal. We can go to the next slide. So, our efforts are focused on these four areas right now: the impact that we are aiming to have, establishing equity by design as a core principle for the development and use of health IT, working on modernizing public health data systems to integrate public health and clinical care systems to effectively respond to public health emergencies, standardize health information sharing by supporting health IT users with various standards. In particular FHIR and the USCDI standards implementation and







then creating simplified nationwide connectivity for various health IT stakeholders across the care continuum. That includes our work on the Trusted Exchange Framework and Common Agreement. We can go to the next slide, and I am going to go over some of the activities that we use to make that happen.

So, we are focused really on three primary areas. On standard certification, the ONC certification program, and different activities that support the exchange of electronic health information. And then, of course, all of these we are in a cross-cutting way focused on coordination with various partners. So, for these three areas of standard certification exchange, I am going to take a quick look back at the past year, talk about progress made, and then a look ahead at the work coming up for 2022. And that will also inform some of the work plan and conversations that we will have for a committee later in the meeting. So, I will start with standards progress over the past year. We can go to the next slide.

So, this is focused on the US Core Data for Interoperability Standard, which we published Version Two. HITAC has a key role to play in our annual cycles and iterations related to the USCDI standard. So, with Version Two, we establish three new data classes around diagnostic imaging in clinical tests, as well as 22 new data elements. Included in those were the elements that support social determinants of health, as well as data elements for sexual orientation and gender identity. We can go to the next slide, which stays on the standards areas. I talked about Public Health Data Systems and standardizing information sharing. A lot of the work here focused on those areas. Various projects and activities related to the FHIR standard and supporting that maturity and implementation, as well as some of the standards efforts we focused on to support public health needs, including the COVID-19 response. And in addition to that, we completed the inaugural or first cycle of the standards version advancement process which is going to continue as an annual cycle moving forward. We can go to the next slide.

So, shifting focus to certification, really the emphasis on this over the past year and heading into next year will continue to be on the implementation of the ONC Cures Act Final Rule. So, you see we published various resources to support the implementation of the certification requirements. Also just highlighting that a number of the compliance requirements for conditions of certification went into effect, including things for information blocking with the focus on USCDI data, and things like assurances and communications. We can go to the next slide. A lot of the work in the past year has been around accelerating information sharing, so ONC was particularly focused on information blocking and supporting that aspect to share information around that. So, publish a variety of information blocking Q&As as well as fact sheets and holding some public webinars. The TEFCA we talked about at our last HITAC meeting last month. So, moving forward to have everything in place to open up for business in early 2022. So, just highlighting some of the engagement, including the HITAC engagement that took place over the past year.

So, now we can go to the next slide, and we will just pivot to looking at the year ahead, starting in the standard space. Later in the meeting, we will talk through some of the HITAC anticipated schedule for USCDI and that continuum annual cycle. And also, on the FHIR standard, continuing work there and supporting that maturity and implementation. So, looking forward to the release of HL7 FHIR R5 as well as updating the FHIR Core Implementation Guide to support the USCDI standard. We can go to the next slide. So, staying in the standard space, this is the focus area that we have had related to public health standards and advancing those. These are all projects that we kicked off over the past year, including work with Standards Development Organizations, and work with supporting lab standards and developing lab standards, and then finally on building out health information exchange services that can benefit support public health agencies. We can go on to the next slide.

Certification, as I mentioned, is just the continued focus on implementing the ONC Cures Act Final Rule. So, these are two deadlines that will be coming up related to the rule in 2022 around real-world testing and then initial attestations requirement coming due as well. Next slide. So, on our efforts to support the exchange of and encourage information sharing, these also stem from the ONC Cures Act Final Rule in October. The definition for information blocking and the scope that is covered under that will no longer be





limited to the data elements in USCDI. So, that will expand out to be EHI, where it is electronically protected health information. To the extent that that EPHI would be included in a designated record set as the terms are defined in HIPAA, with one exception there noted on the slide. We can go to the next slide.

So, continuing with activities in the exchange is focused on the TEFCA implementation. So, the goal there and the target to go live and open for participation in early 2022. So, just note some of the key steps involved there, which include completing the common agreement Version One and the related materials to support that, and then beginning with selecting onboarding and starting to share information through that through the TEFCA network. We can go to the next slide. So last piece, just looking forward at the year ahead in 2022. This focuses on ONC's activities related to this STAR HIV program, which is a grant program. Supporting the advancement of health information exchange services that benefit public health agencies, including services available to support communities disproportionately impacted by COVID-19. Next slide, please. So, this is really where we connect the objectives and the different progress and plans ahead to the work of the HITAC. In particular, how the HITAC Annual Report can communicate progress related to these areas that are on the screen here. These are the target areas that are defined in the Cures Act, which includes the use of technologies to support public health, interoperability, privacy Security, and patient access. So that all ties into the HITAC Annual Report that you heard Aaron mention earlier in the call.

So, welcome any feedback that you have today on the different areas that we talked about, and I am going to turn it over to the Vaishali Patel, who is going to dive into one of these areas. In particular, the patient access area, to share some of ONC's recent findings there. But I will turn it back to the chairs. I don't know if you want to pause here for questions.

#### **Aaron Miri**

Exactly. I appreciate that. Great question, Seth. So really quick, sort of a football audible right here, a little bit of a change-up. So, right now, what I want to do is give a second for the HITAC committee to be able to ask questions of Elise and Seth. And then we will go into Vaishali's presentation. Then we will do the same thing there with questions. And then we are going to pause for a moment and give Dr. Tripathi several minutes to do his remarks right after that. So, just in terms of order of operations. The first step will be any questions for Seth and Elise from the HITAC. Please raise your hand by using Adobe Connect. I see Dr. Lane with his hand up.

#### **Steve Lane**

Good morning. Thanks, Seth, and Elise. Great presentation. I had a question, and I should have asked this in some prior setting, but it just struck me now in light of other discussions that we have been having. Back on Slide 13, in the discussion of the scope of the information sharing rules. And the language that says EHI means electronic PHI to the extent that that would be included in a designated record set. And it is striking to me that it says, "would be included" as opposed to saying, "is included." And this has come up in our discussions with Athena and others that Sasha has been helping to lead in terms of helping us all define our DRS and how we are going to be sharing information. This may be way more than is appropriate for you guys to address here. But I think those words, "would be included in a designated record set" as opposed to, "is included in the designated record set" of the data holder seems very pertinent and helps me to understand some of the recommendations that are coming out of the task force that is working on that. But can you say anything, is that a real difference? "Would be included" versus "is included"? And if that is too much for right now, that is fine.

#### **Elise Sweeney Anthony**

We are having a couple of sessions that are specific to the information-sharing provisions in the rule. One is on November 17<sup>th</sup>. We will have a clinician-focused session, but there is also going to be an Ask ONC that Mike Lipinski, who leads our regulatory team, will be holding. And that is coming up I believe in December. But I will be announcing the date exactly soon. That would be a good place to go deeper into the questions around EHI. But there is some preamble on this that we included in the rule. What we can





plan to do is use the Ask ONC session as an opportunity to dig deeper into this, just in the nature of time here.

**Steve Lane**

Thanks. That is fine.

**Aaron Miri**

Good deal. All right. Next in queue, we see Abby Sears.

**Abby Sears**

Hi, can you hear me okay?

**Aaron Miri**

Yes, ma'am.

**Abby Sears**

You can. Okay, great. My question is more of a general thought that I am trying to think through as you put this forward. There are a couple of areas that as we thought about the USCDI and we are moving upstream around the social determinants of health and the mental health data, which is going to be foundational to the public health modernization that has to happen. I couldn't tell by what you presented how that is going to fit into those priorities, and I think they are foundational. Have you had conversations about that?

**Elise Sweeney Anthony**

This is Elise. When it comes to mental health and behavioral health overall, we are working very closely with our partners at HHS to understand and identify what are the health IT opportunities that exist to support that particular landscape. So, that is something that has been a commitment of ONC over time. So, we will continue to work with our partners on that. But as you can imagine, it is a much larger component to that beyond just ONC.

**Abby Sears**

Yeah, I guess if I could just add. From an equity standpoint, a lot of what is happening in the country, we have to have a focus on equity. Could you help me see how the plan you put together is going to drive a more equitable sharing of data and a more equitable infrastructure?

**Elise Sweeney Anthony**

Yeah, sure, I can start, and then others at ONC might jump in as well. So, when we are looking at data, and the USCDI is a great example, in the USCDI Version Two that we recently released, we are thinking about equity and building that into our work overall. Dr. Tripathi, who is on the line, talked a lot about equity by design, and that is a core concept of our work at ONC. So, with USCDI for example, the latest version includes things like sexual orientation and gender identity, and that is part of our inclusive approach to standards and inclusive approach to thinking about health IT. There are also other activities that we are doing at ONC. A lot of our work around social determinants of health is also thinking about the equity opportunities that exist there and the opportunities for data to SDOH data to support and address and identify health disparities. We held a workshop this summer that looked at SDOH and equity as well. And those are just examples of some of the things that we are doing in this space that are supportive of the equity landscape. But let me see if others at ONC have other things to add as well.

**Seth Pazinski**

Hi Elise, this is Seth again. So, one of the things when we get into the work plan for the HITAC next year, this is an area that was brought up in the draft Annual Report that the HITAC has underway in an area where we do want to get HITAC feedback. So, we are looking at how we can leverage the HITAC to provide insights and information on how we can move forward with plans that advance equity.





**Aaron Miri**

That is the other question, which is what Abby is saying. Would it be helpful on the plan? Can there be a note when the USCDI Version Two goes from voluntary to required? Is there any type of timelines to better define some of those data elements? Really around SDOH as again, going from voluntary to flipping the switch. Is that worthwhile, do you think?

**Elise Sweeney Anthony**

Well, I think Avinash is on this as well, and he might have some thoughts on that.

**Aaron Miri**

Perfect, perfect.

**Avinash Shanbhag**

Good morning, Aaron. Hopefully, you guys can hear me. I was having the same thought, Aaron, as you had. That the USCDI upgrades depend a lot on stakeholder input and submission. So, I think that this will be an area of getting the details of what is in the scope of value data elements in this very important field. That is all I wanted to mention. I was not quick enough to lower my hand since you had already captured what I wanted to mention. Thank you.

**Aaron Miri**

You are welcome. Good. I guess the culmination to sum that up; maybe that small tweak could help answer this question on the roadmap directionally for folks thinking like Abby is thinking. Abby, I see you re-raised your hand. I do not know if you to follow up with a quick comment on that answer.

**Abby Sears**

Just a quick comment because I do not want to belabor this point. On the USCDI, and Dr. Lane can report this better than myself, but when I was on the USCDI Task Force, one of the challenges we had on the Task Force was that unless the fields are completely developed, there is a feeling that there is difficulty to add it to the USCDI. And to wait for the fields to get fully developed by the outside entities, we just do not have that level of time if we are truly committed to changing equity in this country. So, there is a chicken versus an egg comment that I am trying to make, around how can ONC's roadmap look at streamlining the process so that we are expediting the need for some of this work as quickly as possible? I guess that would be my request for you to think about.

**Aaron Miri**

Good comments, good comments. How do you convey urgency and go down something tricky and complicated? You are right. That is a good point, Abby. Dr. Lane, I do see you raised your hand, so I guess you want to jump in here with USCDI comments or whatnot on this topic. Go ahead, sir.

**Steve Lane**

Yeah, I think just to the point of urgency, which is certainly one of the recommendations that the Task Force did push back to ONC is having a process for identifying priorities even within the maturity levels. The other comment that I wanted to say is it would be very helpful, as I put in the chat if ONC could provide some detail regarding the plan, scope, and timing for the recently announced USCDI Plus effort for data sharing amongst and between the federal agencies, CMS, CDC, et cetera. I think that that effort, once we can shine some light on it will help us to understand the directionality of the USCDI work.

**Aaron Miri**

Good deal. All right. So, if no more hands there. Just one more time for HITAC members, anymore? No? All right. Then next we will go to Vaishali.

**Vaishali Patel**

Hi, thanks, everybody. I just want to do a quick time check. I do not know, Michael Berry, if you are on. Do I still have 25 minutes? I just want to be respectful of everyone's time. I don't know.





**Mike Berry**

I think you are good, Vaishali. Go ahead.

**Vaishali Patel**

Okay, great. All right. I can skip slides if needed. So, today I am providing a data update on looking at API measurement and the current state of patients' access to their electronic health information. Next slide, please. And so, ONC's measurement efforts around this area touch on some key points that we think are critical to the ultimate goal, which is individuals being able to use an app, smartphone, whatever device they want to access and use their electronic health information. So, the key touchpoints are looking at the availability of FHIR-based APIs within health IT products, looking at the implementation and adoption of FHIR-based API. Because just because they are available doesn't mean they are turned on and made available to patients. So that is an important measuring point that we have come to realize. And then, also looking at providers giving patients access to their electronic health information as well as looking at on the supply side. So that is the demand side, on the supply side are there apps available that leverage FHIR-based APIs for patients to access their electronic health information? And then ultimately looking at the usage of smartphone health apps and other means to access and use electronic health information. Next slide, please.

So, we leverage several different data sources to measure these touchpoints. I am not going to go line by line on this, but suffice it to say, we leverage national survey data. I will be touching on the hospital side today that we partner with the American Hospital Association. We leverage programmatic data from ONC's Certified Health IT Program, the Certified Health IT product list data. We leverage national survey data that we do in partnership with the National Cancer Institute, a representative survey of individuals looking at their use of electronic health information. And then we also actually scraped public app galleries that are published by EHR developers to try to glean information on the app ecosystem. The next slide, please.

So, the first touching point I will be talking about is just looking at the availability of FHIR-based APIs. Next slide. And to measure that, we take a look at the certified health IT product list that I was mentioning earlier. And based on that, as well as linking that to CMS program data, what we find is about eight in 10 hospitals as of 2019 have adopted certified health IT technology, meaning the 2015 edition that has FHIR-based APIs incorporated within there, that capability in place. And on the clinician side, it is about six in 10 clinicians have adopted the 2015 edition. You can also see there is an additional around seven percent or so of hospitals, letting us round up to 91% of hospitals, which have adopted or could adopt the 2015 edition. What that means is that they currently have an EHR that has the 2015 edition available, but they just haven't adopted that yet. This is that data as of 2019. So that is something that we will be tracking, and we have been tracking over time. And similarly, on the clinician side, about seven in 10 clinicians have the potential. So, they've either adopted or could adopt a 2015 edition because their HER developer has a 2015 edition product available. Next slide, please.

So, moving on to not just looking at availability, but actually whether those capabilities are turned on. Next slide. What we found is, based on hospital survey data that hospitals enabling patient access to their electronic health information using a FHIR-based API has nearly doubled just within two years. Between 2017 and 2019, you could see from 38% to 70%. And one thing to note is on the prior slide, I noted that in 2019, about eight in 10 hospitals had a 2015 edition with the FHIR-based API capability, and you can see that about seven in 10 roughly, different data sources, have turned that on. So, that is why it is important to measure both the capabilities, as well as whether those capabilities have been turned on, implemented, and made available to patients. Next slide, please.

So, I will now be reporting on the supply side, looking at the availability of apps that leverage FHIR-based APIs. Next slide, please. I think as I mentioned earlier in terms of data sources, we take a look at what is publicly available in in-app galleries. In this case, this analysis focuses on five different app galleries from these vendors, as well as Smart Gallery. And there have been significant increases over time between





2019 and 2020 in the number of apps that were listed. Again, this likely represents a subset of apps that are available because not everything is made public. So, ONC is limited in our analyses to what is made available in public. There are about 734 unique apps in 2020, and in 2019 there were 600. One other thing of note that I will say here, is this doesn't show the volatility and dynamic nature of the app ecosystem, because when we looked at apps in 2019 and compared them to 2020, there are several apps that also just disappeared and dropped off, as well as new apps that came on. Next slide, please.

Overall, what we found amongst the 734 unique apps is that one in five support FHIR. Not surprisingly, this varies by functional category and the use case of the app. Administrative apps, a smaller proportion of those apps support FHIR as compared to the more clinical-oriented apps. Whether that is research, care management, and patient engagement. Within the patient engagement category, about 13 apps are apps that provide patients with direct access to electronic health information. So those 13 apps of the 734, obviously it is still a relatively small number overall. And that is something that we will be tracking over time. Next slide, please. And now I will be talking on the demand side. So, looking at patients' access to their electronic health information. Next slide, please. So, this is based on our national survey that I mentioned that we do in conjunction with the National Cancer Institute, where we have been tracking for several years, you can see since 2014. Looking at the proportion of individuals that have been offered a patient portal by their health care provider insurer and then looking at the proportion of individuals who then access the patient portal. So nationally, we can see here that in 2020, six in 10 individuals nationwide were offered access to a patient portal. And this has grown since 2014 where about four in 10 were offered access. The proportion of individuals who have accessed their portal, which has grown less so, from 25% to 38%. So, that is something on the demand side that we probably need to work on overtime. And as more apps become available, the supply-side increases in its enhancements. We will be tracking this over time to see how this evolves. Next slide, please.

And now, looking at smartphone health app use to access and use electronic health information. So, next slide, please. So, this slide shows the method by which portal users access their health. And you can see here about four in 10. So, both the 22% and the 17% together portal users accessed their electronic health information using a smartphone health app in 2020. And about six in 10 used a computer only. We do not have measurement into the use of third-party apps to access one's electronic health information. Partly because it is really difficult to craft a survey question that distinguishes between the portal app and the third-party app. But that is something that we are working on in the next round of the survey. We are going to try to measure that and see how it works. But right now, what we can measure is the use of an app that is provided by a health care provider, an electronic health record developer, to access one's portal. And so, that is what we can share today. Next slide, please.

In terms of future measurement, I wanted to talk about some of the gaps in measurement and what we are trying to do to address those gaps. Next slide, please. So, I think I mentioned to you, there is the availability of FHIR-based APIs and certified health IT products, and then there is whether those APIs have been implemented. We have some survey data that provides us with some insights into this. But what we have also tried to do is develop a tool that leverages data that HER developers will be reporting on. So, the service-based URLs or endpoints for the health IT modules and by pinging the tool pings the endpoints and provides results back that indicate whether that endpoint is active or not. And also, other kinds of information that relate to that endpoint, which will allow ONC to monitor the implementation of FHIR-based APIs in a much more refined way. As opposed to what we are reliant on now is very limited information from just hospitals only as to whether those capabilities are enabled or not. So, we are excited about this project, and I think it'll provide some great insight into what capabilities are actually available and up and running. And looking at the locations of those capabilities as well so we better understand what types of providers have those capabilities up and running versus those who do not. Next slide, please.

As I mentioned, we are limited in our insights and what we can provide on the usage of third-party apps that access electronic health information and the availability and the characteristics of those apps. We are limited to what is publicly available, which I mentioned is only a subset of what is out there. And so, as





you all are aware, the HITAC proposed some measures that can provide insights into patient access and use of electronic health information. Specifically, the measures that were proposed are looking at the methods by which individual patients access their electronic health information and the availability of apps using certified API technology. So that way, we have a better sense of the actual supply side, as well as the demand side on third-party app access, the availability of third-party apps, and usage of those apps. Next slide, please.

All right, well, I am open to any questions and discussion. One thing I do want to say, which I had wanted to discuss today, but we are still in the process of analyzing, is looking at disparities related to patients being offered access and then their subsequently accessing data. We are in the process of analyzing that data and maybe at a future date, I can come back and share that information. But I did want to mention that that is of importance, and we are measuring those kinds of gaps and we hope to have that information to share with the public.

**Aaron Miri**

Great job. Vaishali, thank you very much. You spurred a lot of great conversation in the text convo.

**Vaishali Patel**

I am sorry. I have not been looking.

**Aaron Miri**

No, no, no, it is great. I am going to point the HITAC members to it is time to raise our hands and use the Adobe Connect feature for questions that you want to ask. Even those that have been passionately typing away at various components here. And I appreciate the feedback also written here. But Vaishali, hats off to you and the ONC team on some of this research here. It is very telling, very eye-opening, and I will take prerogative for a second as chair. It is amazing how many third-party apps intersect with our EHR here in Florida and what some of those hills you have to climb to make those talk and connect are. And so, I think you are beginning to shine a light on potential opportunities in the future to accelerate velocity here. So really, thank you for doing that. All right. So first up, let us see. Any hands? Let us see any hands here. If there are any hands from the HITAC members, please raise them in the Adobe Connect function. I see Abby Sears. Go for it.

**Abby Sears**

I am back. I would just like to ask, and this data is amazing, and I think what I am going to ask is going to be hard. So, I understand that. But it would be fascinating to know from an equity standpoint around what patients are accessing their data. Do we know anything about those patients? Are they more commercially covered? Are they Medicaid? Are they uninsured? What's the race? The ethnicity? Is English a second language? Do we have anything that we need to pay attention to related to policy so that we are creating an equitable process for access?

**Vaishali Patel**

Thanks, Abby. That is what I was mentioning at the end, that we are analyzing. If we go back to those rates, there was that line graph with the rates of patients accessing their data as well as being offered access. And have analyses in progress that are looking at the disparities around that. So, looking exactly, Abby, at what you mentioned. So, looking at any disparities as it relates to race-ethnicity, we are looking at socioeconomic-related factors, education, income, looking at individuals with chronic health conditions. The survey data is fairly rich. Of course, it is self-reported. And the drawbacks to that. We do not have data specifically on, as I mentioned, who is using third-party apps. That it is a black box for us. But to the extent that we can measure the portal based on the survey, that is what we are trying to get a handle around. And as you all know, access to the portal is the key to not just the portal, but to the third-party app itself. Because you need that login, you need the login to give to the app developer. It is the same login. So, it is important to measure because it has implications for third-party app access, too. So, we are on it, Abby.





**Aaron Miri**

Yeah, and I think it is interesting, also there could be opportunities for future USCDI classes as we get more into the details of what we may need to start tracking, right? So, I think this is a great discussion. Next in this line is Dr. Lane.

**Steve Lane**

Thank you. I just really want to shout out to Vaishali and the team that has been working on this. I have had the opportunity to talk with them several times, and they are digging deep in terms of trying to figure out how we can meaningfully measure this over time given the data that is available from the vendors. So, thank you for that. I also just wanted to highlight some of the comments that I put into the chat. Specifically at our organization, over the last year, we have seen a nearly 90% increase in the use of APIs. I am sorry, not 90, nine times increase, I should say, in the data accessed by API patient queries, primarily by way of Apple Health. And I would love to see it happening more with common health, where we are hoping to see that eventually. But there is increased access going on, and it has been heartening to see that. And as far as I know, and others may know differently, those apps are still not routinely querying for the patient notes, the clinical notes that have been made available as part of information sharing. I think we are still waiting to see that burst. And I think when that capability comes online with some of the larger apps, I know some of the smaller apps do have that, but when that comes online, I think we may see even more uptake of this type of access.

**Aaron Miri**

Dr. Lane, you are exactly correct. We had to do a workaround to provide the notes to certain apps by putting them in a data warehouse and importing an API to that for the guys to retrieve the data. You are exactly right. A lot of those interfaces are not written for the full gambit of data elements. So, spot on. All right, Sheryl Turney, you are next.

**Sheryl Turney**

Sorry, trying to get off mute.

**Aaron Miri**

There you are.

**Sheryl Turney**

Can you hear me now?

**Aaron Miri**

Yes, ma'am.

**Sheryl Turney**

Okay, great. Great presentation. I think this is very valuable for us to look at. I was curious, though, as you are trying to expand to look more at third-party apps in terms of how you envision collecting the data, number one. And number two, one of the things that we have all looked at and various venues have all stated is that patients are looking for their data to be in one place. And without having the means to gather that data together and have it in one place, it can be a little bit disjointed. And it is difficult from a patient's perspective. One of the things we found is that you might have a physician that is connected to a hospital, but he is not connected to the EMR system, so you cannot get your notes for that particular provider. So, what are the things that we are looking at to capture some of that type of data as you move forward with collecting these types of information points?

**Vaishali Patel**

Okay. I think, as I mentioned, with regards to the third-party app usage and access, which is something that one avenue is through the EHR Reporting Program. As I mentioned, just having EHR developers who may have access to these data to be able to report back on patients using that. As I mentioned, it is hard to measure it through survey data, so we are trying to scrape what is publicly available in terms of







availability. But the usage piece is something that the data largely resides with health care providers and developers. And so, that is ultimately the data source that we need to tap into. And we are open to suggestions if you all have any on that front. From a policy side, what we have been trying to tackle is we have been trying to do it through surveys and other means. But as I said, there are limitations around that.

So, in terms of the gaps or the issue around measuring with data coming from different health care providers and having it integrated within one, I think that is going to be a measurement challenge that we are going to have to grapple with. Particularly as the usage of apps increases over time. And, hopefully, the third-party apps can enable patients to integrate data from various sources into one place. But that is something that we are going to have to try to measure and develop measurement around. Right now, we do have some measurement as it relates to gaps in interoperability as experienced by patients. We didn't present it today, but we do have data on the proportion of individuals from the same survey that report that they've had to bring their lab test results to another health care provider because the data didn't come over. So, it kind of addresses your point I think more indirectly. To what extent are patients having to be those intermediaries and having to do it in a paper-based way? As opposed to having the electronic means to go to their provider and show the test results if it didn't come over via electronic exchange. So anyway, suffice it to say, I think it is a challenge what you raised. A measurement challenge in addition to the technical challenges of actually making that a reality. So that is something that we will be working on. Thanks.

**Aaron Miri**

Good deal. Les Lenert, you are next.

**Leslie Lenert**

What I wanted to ask was whether we could get some more details about the Lantern Project and how it works. Because that sounds like the future of how we are going to measure API usage and performance. So, I saw a few rough technical, a sentence or two, but I would like to have a little bit deeper understanding if you can share that.

**Vaishali Patel**

I think we can share. There is a website where we have the tool. There are two developers so far that have published their endpoints, and Lantern has consumed them and then done analyses around them. And we have a dashboard up that you could take a look at, and I would be happy to share. Anyway, I could put it in the chat after I am done presenting here answering your question. I could put that in the chat, and you can take a look at that. And we are planning to host a webinar on Lantern shortly. I do not want to promise a date yet because we still have to figure that out. But it is going to be a public webinar and we are going to be talking about Lantern and some of the issues that we are trying to address with it. And everyone is welcome to join. We are just beginning to socialize Lantern. Because of the publication of the endpoints, the requirement, as you guys all know, is until December 2022. So, this is just sort of leading up to it. But we will be happy to provide more detailed information and talk to anyone interested. We are super enthusiastic about it, too. Thanks, Avinash. He put the link to Lantern in the chat.

**Leslie Lenert**

It is also in your slides, so I am already on the site.

**Vaishali Patel**

Oh, okay. Okay, cool.

**Leslie Lenert**

You have the URL actually in the pdf.

**Vaishali Patel**





Yeah, and I am happy to follow up offline. You can email me, and we can set up a time to talk, too. If everyone is interested, I am happy to come back. We can have the team come back and present it at a future meeting. I am happy to do that.

**Leslie Lenert**

I think in contrast to survey methods, this is probably a much better and more reliable way to get data.

**Vaishali**

That is the future. The survey methods are useful for getting the end-users perspective. Whether that is clinicians, hospitals, individuals. But to measure some of the things that we want to measure, yes, tools like Lantern, the EHR Reporting Program where the data is coming directly from developers; depending on what we are trying to measure, going to the source is better than trying to get it through self-report or attestation.

**Aaron Miri**

Yeah. And it is a technical discussion, right? And it is deidentified. There is no PHI. It is truly about usability, equitability, and the “how,” right? And the “where.” So, I think it is phenomenal. And for those of us that have development jobs as I do, and others, there may be an opportunity to partner with some devices to kind of get a landscape of various regions of the country. I see the map here. I am looking at the Lantern website, it is fantastic. But just as key partners say, what can we learn together? I would be happy to volunteer my health system and my development team to partner and better draw up metrics and whatever else. I think it is important. Exactly what Abby and others have been saying to give a more equitable health care environment. So, I think you find a very willing number of CIOs and clinicians across the country willing to partner with that have market arms.

**Vaishali Patel**

Great, thanks.

**Aaron Miri**

Wonderful. All right, any other questions? All right, those were a couple of great presentations there. So, no other questions. Dr. Tripathi if you are still on the line, sir, you are next in the queue.

**Micky Tripathi**

I am here. Can you hear me?

**Aaron Miri**

Yes, sir.

**Micky Tripathi**

And can you see me?

**Aaron Miri**

Yes, we do.

**Welcome Remarks (01:02:19)**

**Micky Tripathi**

Okay, great. Well, thank you and thanks to everyone for your flexibility on the schedule. The real misfortune of that is that I had to follow Vaishali. And that is a really tough act to follow, as well as Seth. So, I will do my best here. This is our last HITAC meeting for 2021. First off, I want to thank all the HITAC members and the invited presenters for sharing your expertise and insights over the past year. Let me just make a small adjustment here. Together, we have accomplished quite a bit in 2021. Our nine committee meetings, one public health hearing, we had five subcommittees to include, the Annual Report Workgroup, the EHR Reporting Program Task Force, the Interoperability Standards Priorities Task Force,





the Public Health Data Systems Task Force, and the USCDI Task Force, which generated a ton of valuable advice and feedback to us. I also want to thank all of the HITAC members and public SMEs that contributed to these subcommittees. You provided a variety of perspectives that helped shape the HITAC's recommendations, which were invaluable tools.

In addition to the recommendations outlined in the Annual Report, the HITAC submitted 148 recommendations to ONC this year, and we consider all the recommendations in the course of our work. Rest assured, we look at every one of those and consider them very carefully. You also completed and submitted the FY20 HITAC report to congress and are working towards completing the FY21 report. I think as many of you may know, in addition to all of us at ONC, Congress also reviews the task force recommendations reports in the Annual Report. So, your efforts are seen by many. I am also excited to invite each of you to our next ONC annual meeting, which is coming up here very soon. We recently announced the dates for the annual meeting, which will be held virtually on February 2nd and February 3rd next year. So please mark your calendars and join us. We will be sharing more details about the agenda soon on HealthIT.gov. For your awareness, we have an important webinar planned next week and hope you can join. I think Elise already mentioned this but let me restate it. This is the second in a series of clinician-focused webinars on information sharing and the information blocking regulation. And that is going to be held on November 17th from 1:30 to 2:30 p.m. My team will explain how information sharing leads to more affordable and equitable care and improved care quality. This is the second, as I said, in a series of clinician-focused webinars. We had our first one a little while ago and we got tremendous attendance. Over a thousand people joined and we got tremendous feedback as well. And so, we hope to continue that level of engagement in the next set and very much look forward to everyone's participation in that. You can register for the webinar by searching for upcoming events on the HealthIT.gov website. And the recording for this webinar will be made available after the event if you are not able to attend the live webinar. And of course, the recording from the previous one is already available.

So, now I turn to what is the bittersweet portion of my remarks. This is the last committee meeting for six HITAC members whose term expires at the end of the year, and I want to take the opportunity now to express my deep appreciation to each of you for your commitment and hard work over the past four years. The first person I want to mention is Michael Adcock. Michael has served as a HITAC member since January 2018 and was also the co-chair of the Information Blocking Task Force. Next, I would like to thank Terry O'Malley. In addition to serving as a committee member, Terry was the co-chair of the USCDI Task Force and a member of the Interoperability Standards Priorities Task Force. Next, I want to thank Sasha TerMaat. Sasha served on the committee and has been a member of multiple task forces to include TEFCA, the Interoperability Standards Priorities, Conditions and Maintenance of Certification Requirements, Information Blocking, USCDI, ICAD, and the EHR Reporting Program Task Forces.

Next, Andrew Truscott, Andy. In addition to his role as a committee member, Andy has also served on several task forces to include TEFCA, Interoperability Standards Priorities, Information Blocking, ICAD, and the USCDI Task Forces. Next off is Carolyn Peterson. Carolyn served as the first co-chair of the HITAC from 2018 until 2020, along with several other important roles, including co-chair of the HITAC Annual Report Workgroup and Public Health Data Systems Task Force. And she served as a member of the TEFCA, Health IT for Care Continuum, and Conditions and Maintenance of Certification Requirements Task Forces. And finally, I want to thank Robert Wah. Robert has been an instrumental member of the HITAC, having served as the first co-chair of the HITAC from 2018 until 2020. So, please join me in thanking each of these HITAC members for their significant contributions over the past four years. I am going to give them a little applause here. We are expecting the Controller General of the United States, who heads the GAO, to announce five new HITAC appointments by the end of the year. A secretary of HHS will also appoint a new member soon. These six new members are anticipated to start their three-year term on the HITAC in January of next year.

So that wraps up my remarks. I just want to extend my best wishes to all the HITAC members for a happy holiday season. I know it feels like we are just coming out of summer, so maybe it feels premature. But as





we know that this is the last meeting of the year. So, I certainly do not want to miss the opportunity to wish all of you a happy holiday season, and we will meet again in January. So, please be on the lookout for the 2022 calendar invites very soon, and I am going to turn it back to Aaron and Denise for the rest of the meeting. Thank you.

**Aaron Miri**

Thank you, Micky, appreciate those comments. And I want to just quickly say thank you to all the HITAC members, especially those who are rolling off. You all are family and you always be family. And I know we are not going to stop collaborating. So, thank you. I want to echo that. Denise?

**Denise Webb**

Yes, I want to add my thanks to Michael, Carolyn, Terry, Sasha, Andy, and Robert. I enjoyed working with all of you and wish you well, and appreciate all you did for HITAC and for the communities that you live in. All right. So, I think we are ready to start our next presentation. We have Lieutenant Colonel Norman Stone presenting from the US Air Force. My favorite branch of service since I also served in the Air Force. And we also have Yvonne Cole. They are going to talk to us about the DoD and VA interoperability modernization strategy. So, I will turn it over to you, Colonel Stone.

**Interoperability Modernization Strategy (01:09:31)**

**Norman E. Stone III**

Hi, good morning. Can I do a quick little microphone check? Can you hear me okay?

**Denise Webb**

Yes, sir.

**Norman E. Stone III**

Yes? Okay. I would first like to introduce Ms. Yvonne Cole. She is the Director of Metrics and Analysis at the FEHRM, the Federal EHR Modernization Office that was initially created in 2008 by NDAA and wholly rechartered last year, frankly, to be formally known as the IPO and is now the Federal EHR Modernization Office. But Miss Cole is the Director of Metrics and Analysis of the office. So, I would like to turn to her, if she doesn't mind, and she will get us started. Ms. Cole, are you online?

**Yvonne Cole**

I am, thank you. Can you hear me okay?

**Norman E. Stone III**

Yes, ma'am. Loud and clear. I will go on you for a while.

**Yvonne Cole**

Awesome. Wonderful. Well, why do you not take a moment and introduce yourself before you go on mute?

**Norman E. Stone III**

Okay. Name is Norman Stone. By training, engineer, and orthopedic surgeon, but my experience the past six or seven years in the DoD VA space trying to improve health data exchange. Not just between the two departments, but also their partners and generally speaking, try to make things more enjoyable in the practice space for clinicians in those in those areas. I think I know a lot of the names on the HITAC here from prior interactions. But for those, I haven't met, good to meet you. And you are always welcome to join in some of the productions that we are leading now. We certainly do not propose to have all the answers, but as ONC frankly does, I think. We are still pushing the frontier back as best as we can with eyes on the longer-range over the horizon goals that we know might not be accomplished today or tomorrow, but we are greatly hopeful that five years, 10 years, 15 years, 20 years with that continuous gradual pressure, we will move things moving forward. Ms. Cole? Back to you.





**Yvonne Cole**

Awesome. Thank you so much. So, good morning, everyone. So, let us go ahead and go to the next slide, please. So, here is our agenda. I am going to provide a brief overview of the interoperability modernization strategy. And Dr. Stone will follow up with a discussion on the candidate performance measures, the performance measurement plan, and the down-select process. So, next slide. And let us go ahead and get started. Next slide. So, as you can see here, our driving force is the NDAA 2020, which directed the firm to deliver a comprehensive interoperability strategy concerning electronic health records jointly developed by the Secretary of Defense and Secretary of Veterans Affairs. In response to this mandate, the firm established an advisory group to oversee, and support, and approve the strategy and the supporting documentation. The Integrated Product Team was also established to identify department goals and objectives, supporting initiatives, and candidate performance measures. As you can see on this slide, the effort was broken into three phases. The strategy, which was delivered to Congress in October 2020, identified department goals and objectives and is directly aligned to the Federal Health IT Strategic Plan. The supporting plan, a document that is internal to the departments and was approved by the Executive Committee in March of this year, and which defined the initiatives mapped to the goals and objectives identified during phase one. And lastly, the PMP, or the Performance Measurement Plan, is currently underway. Next slide, please.

During Phase One, the departments adopted verbatim the goals identified in the Federal Health Strategic IT Plan. They are to promote health and wellness, enhance the delivery and experience of care, build a secure, data-driven ecosystem, accelerate research and innovation, and connect health care and health data. They also identified several objectives within each goal, as shown here. Please feel free to look these over in your leisure and provide any comments you might have. Next slide, please. During Phase Two, 27 initiatives were documented in the supporting plan. Six of those are considered to be foundational, which is to say that they are broadly pervasive, enable a wide spectrum of interoperability, and support most of all the objectives identified in the strategy. Are there any questions so far?

**Denise Webb**

It doesn't look like we have any presently.

**Yvonne Cole**

Great, we will go to the next slide. These next few slides show an alignment between the goals and objectives identified in Phase One and the initiatives identified in Phase Two. Please look these over at your leisure and reach out with any questions or comments you may have. And next slide, please. Dr. Stone or Dr. Elzy, you have been integral to the process. Would you care to share anything at this time?

**Norman E. Stone III**

I am listening and I am reflecting on how to make this talk that we are starting now most germane to the HITAC members and attendees here. And I think the germane aspect is related to Vaishali Patel's talk a moment ago, and that is this challenge of measuring progress. Either broadly with health IT, broadly with the implementation of national standards and initiatives, or more narrowly with interoperability between VA, DoD, and partners. So, I think when I speak for a few minutes, I am going to try to pull that thread. This is our best effort so far to measure interoperability. We are presenting to you the process we followed with first establishing goals and 17 objectives and then doing an inventory of DoD and VA enterprises to see if we can find already active initiatives that are supporting those goals and objectives. And that is what Ms. Cole, of course, is displaying right here. And then the next step is going to be that Phase Three where we start to turn to, well, it is difficult to improve things if you cannot measure them. So how can we start to measure them? And we will get to that Phase Three in a moment. But I think what is germane to the HITAC here is the process we are taking and eventually be our best effort at performance measurement. Dr. Elzy, or perhaps even Dr. Nebeker, do you have any comments there?

**Jonathan Nebeker**

Can you hear me? This is Jonathan.





**Norman E. Stone III**

Yes, yes, I can.

**Jonathan Nebeker**

So, what I would like to call out is the HITAC, we saw the ONC's version of the Federal Health IT Plan. And this is, I think, a very good example and maybe the only example, I am not sure what the other agencies are doing, of a government agency taking that strategic plan, creating general categories of goals. That is the 1A to 2D, 2A through 2H, and then mapping specific initiatives to those goals. And under development are specific accomplishments within those goals that we are trying to realize. And so, this certainly isn't perfect. I congratulate the team and everybody's involvement to put this together. It may look very simple, but it was a very big effort for two agencies to come together to do this. And I think maybe the challenge might be back to ONC with assistance to the HITAC. We have strategic plans; how do we operationalize those? How do we measure progress? And here is an example and look forward to improving it with you.

**Norman E. Stone III**

Thanks, Dr. Nebeker. And we have all appreciated your guidance and insight along the way over the past year-plus through this. And it certainly isn't perfect. And yeah. Are there other thoughts or comments before we proceed? Okay. All right. Ms. Cole, can I ask us to go back to the goals and objectives slide for a moment? Could the slide controller please go back two or three slides? Yeah, there you go. That is the slide. If you take a glance at these here, people might have in mind some other ideas on goals and objectives broadly in the corporate world or even within the health care world. You think of Kaplan and balanced scorecard strategy maps, Donabedian, Shewhart. There are a lot of theoretical aspects of performance measurement, which hopefully you'll see a little bit confused there. But one of the challenges is writing objective statements, and I suspect most of the people on this call have had some exposure to writing goals and objectives like this. If you look at our objectives that are listed here, I will not hold them up as the absolute what you should do, but you can pull out some things. You can see a recurrence of stakeholder groups here. Beneficiaries, which is the elastic term to mean anyone who is the recipient of care at our facilities. Health care teams, benefits care teams, leadership, IT staff. So, we have the key stakeholders mentioned there. They are not independently demarcated someplace, but they are there.

And then a lot of these objective statements are often read as vision statements. And where the boundary is between a vision statement and an objective statement, I think can be difficult to pinpoint. But if you read through these, it almost sometimes feels that there should be another layer underneath them with more specific objectives that show the march to progress towards the vision-sounding statement there. But I think frankly, I think out of the box, you try to go for the best product you can. But frankly, I think through iteration, if there is interest in this, we can iterate and tone this down to something a bit more specific. I appreciate Dr. Nebeker's acknowledgment there that this is a challenge to get to a consensus with such a large number of voices in the choir if you will. Any comments or thoughts on the goals and objectives list here?

**Sheryl Turney**

I do not think you can see my hand is raised, but this is Sheryl. I did want to ask a question and also make a comment. It is definitely, I agree with you, difficult when you are talking about goals and objectives because they typically need to be something that, as you already said, can be measurable. And the difficulty, I think, is how do you measure these goals and objectives? Because they are fairly lofty. And I do not think that the plan is written in a way that we have said by X date this is what we are looking to deliver that can be measured this way. So, the measurement piece of it seems to always come after and is a little bit of a struggle. And this year I did participate with a group that is looking at quality measures, and there was a lot of discussion about what can be captured within our digital environment to make it less burdensome to create some measures. And I do not think before this effort I realized how specific we maybe need to become to ensure that we are A) measuring the right things, and B) the goals are being translated to achieve the appropriate results. Because as we are moving forward, obviously, the





goal is our access to data, so the data can be where you need it when you need it and have it be digitally delivered without a lot of work on the part of the patient.

So, how do we then frame that in our overall goals and objectives to make sure that that is what we put in place and not a lot of work that doesn't move us forward to that goal? And, you have broken it down to a very large set of measures, or not measures but objectives, that you are trying to implement through this mechanism. Which I am sure was no easy feat. Looking at this, how do you collect information that tells you whether or not health and benefit team members can provide care wherever the beneficiary is located? If the beneficiary has to go to an ER and they are not connected to your system, then how are they going to get the data that they need? And I do not know if they've solved that problem, but I know for my sister who is in the military, the systems are not always connected, so they cannot see what is going on when they go to a VA doctor versus a regular doctor. How does that work?

**Norman E. Stone III**

Thank you. Yeah, thank you for those comments.

**Sherly Turney**

Some of those patients are still broken.

**Norman E. Stone III**

I think I think that was sort of a "ditto," a plus one to the comments that you make forays into this territory, and you go into uncharted areas. And a lot of people are standing around and willing to shoot arrows at everybody and you try your best to withstand them. And hopefully, we push back the frontier so that we can uncover more issues to be addressed and methodically work towards them. Yes, ma'am. I think I can move us along. Oh, go ahead.

**Denise Webb**

We have one more hand up if we could. Arien Malec.

**Norman E. Stone III**

Sure.

**Arien Malec**

Thank you. And thank you, Colonel Stone. I appreciate this outcome-based approach to interoperability. I think I have the same comments, number one, concerning the variety of places that service members and veterans receive care in the community as an objective. I see that there is a referral objective incorporated in the outcome statement. But increasingly with TRICARE as a part of veterans' daily lives. Much care is delivered in the community as well as in military treatment centers, facilities, and VA facilities. Number two, sort of same comment on love the outcome statement. And then part of the art here is what are the inputs to the outcomes? And then what are the quarterly results that tie back or demonstrate measurable progress to the outcomes? So again, this is all lovely and applauding the outcome basis. And then, wondering what the what are the inputs are and wondering what the key results are the tie back to the inputs.

But I think mostly what I am interested in is in areas where the Interoperability Program is doing work. For example, referral services are doing work that is maybe in advance of the priority areas that ONC has identified for interoperability. If there are ways where we can build learning loops between the work that the Interoperability Program is doing and national priorities. I think we have been working on referrals for a long time. I think we recognize that 360 referrals would bring a ton of benefit to the civilian sector. So really interested in learning from the DoD and VA experience. And again, there is a good, natural tie particularly with fee-based services in the veteran community, as well as with TRICARE referrals to civilian settings of care, where we can build natural linkages between the military health service, VA, and the civilian sector and build out 360 referrals. And I guess maybe the last comment as an objective that I wonder might be here is on value-based care and in providing better care given units of taxpayer





expenditure. And how we can better align this interoperability program with the value-based care program, which that EHR program in many ways is intended to underscore from a team perspective in the civilian community.

I am sorry, this is too many thrown at you, but just interested in learning and in having this team provide the assignments back to us. Are there areas, and I am sure that there are, where the standards on the ground, as implemented in the EHRs that are being deployed across the VA and DoD are insufficient to achieve the outcomes that you have articulated. And areas where I know from experience, the VA and DoD try ridiculously hard to follow the standards as implemented, and are often sort of in a morass where the standards do not address the outcomes. Are there areas where the learning that you are doing should be fed back into the standards and interoperability development that we are doing so that the VA and DoD community can achieve the mission better? So, I am sorry, that was a lot of stuff to be thrown out. I love this work. I have been a partner for some of this work for decades now and just really interested in advancing the mission and also taking some of the learning on the ground and injecting it back into the work that we do. So, thank you very much.

**Norman E. Stone III**

Yes, sir. I will say there is a lot packed into that group of comments right there. I do not think I can effectively respond to each one. I did take some notes here. I am sure Ms. Cole did as well. But I will keep them in mind for reflection on things like value-based care, the consults 360, referrals 360, maybe feeding back, and if there are clear standards impediments to obtaining data as well as sort of feedback loops, perhaps with ONC and other people and to refine performance measures. So, I hope that I captured a few of the nuggets there. We can talk again. Go ahead.

**Jonathan Nebeker**

I think that your participation would be welcome, and I think there is a need. I think it would be beneficial between certain members of the HITAC and the excellent team from ONC who worked on the Federal Health IT Strategic Plan to huddle. To think about how this informs the next iteration of the Federal Health IT Strategic Plan. And then also, how does this become maybe a pilot that ONC can use to prove out some concepts and HITAC can use to prove out some concepts for a more powerful strategic plan in the next iteration that is directly linked to outcomes. Behind this gold table norm reference, there is a whole matrix that automatically generates user stories based on different outcomes and target user groups. And I think that there could be some potential benefit here. So, there is a willingness for that. You know how to contact, that's Dr. Norman Stone. I would be very interested in collaboration.

**Norman E. Stone III**

Thanks, Dr. Nebeker. I appreciate that.

**Denise Webb**

All right. That was our last hand up, and I will turn it back over to you.

**Norman E. Stone III**

All right. We will pause a few other times for comments as we go through. Was there another comment?

**Seth Pazinski**

Yeah. It has something to do with ONC's work on the Federal Health IT Strategic Plan across the various federal partners. We did bring that to the HITAC for feedback. So, I think the opportunity here is we do have alignment at the goal level across the Federal Health IT Strategic Plan and the DoD modernization strategy. So, we can connect certainly with our partners at the firm, and VA, and DoD, and look at ways to maybe come back with some specific targeted questions for the HITAC. But from a HITAC perspective, we do just need to make sure we are having those engagements all happening in the public space. And then we can think up and then come back with targeted topics for discussion related to the objectives and measurement.







**Norman E. Stone III**

Thank you. Thank you, Mr. Pazinski, and double thank you for providing us with the goals that formed the baseline for this effort as part of the 2020 to 2025 Federal Health IT Strategic Plan. Thanks for laying those out for us. Ms. Cole, do you think we should continue back down there? I think two or three slides ahead?

**Yvonne Cole**

I do. I think we should go ahead and jump into the performance measurement plan because a number of the questions will be addressed in this area as well. And I do look forward to future collaboration. We do have ONC partners at the table IPT meetings for many years to come. And we do, just one point of reference, we do have another division in the firm that is deeply integrated into the standards. And as you talked about, that feedback loop is there and exists today. So, we have built a lot of relationships, but there is always room for more folks and opportunities to excel. So, thank you, and I am going to turn it over to Dr. Stone.

**Norman E. Stone III**

Okay, great. Next slide, please. So as Ms. Cole mentioned, in Phase One, we elaborated the four goals and 17 objectives, and those were delivered to Congress in October of last year. After that delivery, Phase Two kicked off, which the central activity there was the inventory of currently active programs, projects, efforts, initiatives live within DoD and VA. And then taking those initiatives and aligning them notionally to the goals and objectives identified in the strategy itself. And once that was done, we transitioned into this Phase Three. And Phase Three, we have it labeled as Performance Measurement. It should be called the Performance Measurement Plan because we are not measuring anything during Phase Three. The purpose is to develop candidate performance measures, roughing them out, framing them out.

Think about building a house, but only the walls, only the studs in the walls, two by fours. That is it. Give it the rough shape, the conceptual idea of what the performance measure might be. We are not trying to put the sheetrock on, run the electrical wire, no plumbing, no faucets, no paintings on the walls. We are trying to rough outline some concepts, and we constantly had to bring the group back to that superficial layer because there is a tendency when you are dealing with intelligent, knowledgeable, ambitious adults that we often, as you guys probably know, want to follow that line deeper, deeper, deeper, deeper, deeper down. And that needs to be done before you go live. But the purpose of this effort was to frame out some concept, and we had often put bumpers on the bowling lane and wall and bumped the conversation back to the center. But the goal was to kind of frame out some ideas.

So, here you see the purpose process and deliverable slide. And the purpose, I think, we are trying to frame out those candidate performance measures to enable tracking of progress toward the objectives in the strategy. Now I already told you that the objectives are sort of phrased as vision statements in some respects, and we have already talked a little bit about some of the challenges related to measuring against those objectives. The process or the approach that we took was to divide the 20 initiatives into five workgroups roughly aligned to the anticipated subject matter expertise for those clusters of initiatives. Then we led an initiative-by-initiative review of those 20 initiatives and tried to spur or turn on the conversation to get people thinking. People who are from the programmatic side, but also the user side of the initiatives to get them thinking about interoperability facets of the initiative. And how would you theoretically with your rose-colored glasses on, how would you measure performance and progress there?

Then we took those performance measures and with the group aligned them to the objectives. And the goal is ultimately to get a very succinct set of highly valuable performance measures that show progress for each objective. The deliverable is intended to be a document that shows this parsimonious set of high-value performance measures, and we hope to have that delivered. Well, frankly, I hoped to have a delivered last month. But as things go, we are still rolling through. Let us go to the next slide, please. It shows them this way. So, at this point, we have reviewed 19 of the 20 initiatives, and on the slide here





you see the five workgroups, benefits related initiatives, standards-related initiatives, population health-related, more clinical related and of course, drawing the boundary between these groups, you can imagine it is not a clear boundary. And then Workgroup No. 5, which was previously titled the Technical Work Group. But we found that caused consternation from some people because they felt that the word technical could mean so many things to so many people. So, we rebranded that one just Workgroup No. 5 to hopefully relieve some of that stress. So, as I said, as of yesterday, we have reviewed 19 of the 20 initiatives and we have a whole group now of candidate performance measures. So next slide, please.

During the discussion, we outlined three categories of performance measures that we were going to talk about. This was principally to inspire the conversation if it was running flat, to get people thinking, to grease the skids. The three categories are transactional, programmatic, and outcome. I think we can split hairs; I shouldn't say split hairs. I think we could discuss categories like this in a lot of different ways based on some of the theoretical underpinnings from Kaplan, Donabedian, from other folks like that who preceded us. We certainly could talk about process measures. We could talk about leading versus lagging indicators and a variety of other ones. Organizational level, financial, customer perspective, to bring in some of the Kaplan terms. We felt that for leading these groups that we were leading, we stuck to these categories here and we could be faulted for that. I agree it is open for criticism there. But we felt that we were not dealing with nuanced, thoughtful folks who live in the performance measurement world. And I have seen people's eyes glaze over pretty quickly when you start trying to explain the difference between leading and lagging indicators and health care, as well as some of the more abstract ideas of Kaplan. However, we try to keep those in the background, and we have those ideas present. And if we needed to sort of re-morph this, I think we could talk about process measures, organization levers, financial levers, measures, and such.

But for our discussions, we try to guide people by saying, okay, think about transactional metrics, and what we mean by that are things that are easy to count. Think the number of logins, number of downloads, number of documents sent back and forth. Just simple one, two, three, four, five integers of counting. For more DoD, VA spin you can think over in the examples column there are blue button record downloads. That is downloading the quote whole health record of an individual through one of our portals. Or, for example, the number of prescriptions sent electronically to a pharmacy either with VA, within DoD, or to a civilian partner. Those are the transactional category. The second category we talked about was programmatic. And think here, what are the programmatic milestones for a government program? So, you think about big things like IOC start, IOC completion, full operating capacity, full deployment decision, those are the big ones. But you could also think about things like the number of hospitals deployed to, percentage of the intended users deployed to. Likewise, here is the example percentage of hospitals that are alive with a new electronic prescribing system. Now when I say that, a lot of us here who have worked in the performance measurement space realize that almost every single word in that example there needs further refinement and definition. And I agree. But again, we are trying to keep it at the frame-out level. Let us keep the conversation at the concept.

### **Denise Webb**

Dr. Stone, I apologize for interrupting you, but I just wanted to give you a time check. We have about 10 minutes.

### **Dr. Norman Stone**

Oh, okay. I apologize, I thought we had a bit more than that. We will accelerate here, guys. And if we just put the brakes on, just shout. Outcome metrics, this is where we are trying to get to. But I didn't want people to feel like we had to jump straight there. A lot of times, I think if you prime the pump of causation and let people put out transactional and programmatic measures that in the back of your head, you are going, "not there, not there, not there." But eventually, I think you see the light start to turn on and we can get to outcome measures. Things like, can we measure a lagging thing? Like improvement in cholesterol level in patients who had electronic prescriptions sent and filled vice paper, or reduced time required by pharmacists to fill the electronic prescription vice paper? So, these outcome measures do not have to be





just clinical, like the cholesterol level. They can be financial, efficiency, satisfaction. I would like to show you an example of what I think is a great satisfaction and time savings one next. Next slide, please.

Here is something. Here is one of our initiatives. It is called the Chart Search API. This is a VA initiative that should be celebrated, I think. Because it hits a lot, a lot of veterans or will be, I think. The key thing here is at present when a veteran submits a claim; I'm using broad brush strokes here, please allow that. When a veteran submits a claim for a disability benefit or similar, there is a very structured process that gets kicked off. Part of that process is searching the health records and other records, personnel records, administrative records, for evidence that supports or refutes the claim. Right now, as I understand, it is a fairly manual process. Not just paper, but there are electronic systems that have to query each separate system and figure out how to download, and PDF, and paste into an electronic folder. And apparently, there are 60 days allocated to that segment of the process at present. So, this Chart Search API, the intent is to convert all of those, search once, and have the Chart Search API go out and query all of the electronic systems that are now being queried individually and manually. So that is the first thing. Make one query stop.

The second thing is to have the Chart Search API have an electronic tagging and saving and storing function that builds what is called the electronic folder, the eFolder, that supports or refutes the claim. So that is a quick little background on this file. They hope to get the time down from the roughly 60 days allocated down to one day. And frankly, in the future, to have a bot, frankly, go out and crawl based on keywords in the claim, so that the claims examiner has offered data as they arrive in the system. They are offered some potential sources of evidence as they arrive. So, putting that brief little description aside, the group turned up four candidate performance measures from this work. I have them marked preliminary because of course, we have not finished this Phase Three activity, so please allow us flexibility here. These may or may not survive the down select. The first one is a simple, pretty programmatic active performance measure. Number one, there. Delivery of the Chart Search API software iteration, number one. So clearly, that is sort of an IOC milestone, initial operating capacity. All right. The second one, again transactional. Count of the monthly active users of the Chart Search API. Again, very transactional. How many users are actively using this once per month? And the third one there is the number of searches performed within the Chart Search API in the past month or quarter or something like that.

Now I tend to discount these transactional measures pretty quickly, but I would like to submit for your consideration one aspect of transactional metrics. They might not be useful by themselves, but they can point you into areas that might uncover an outcome measure. What I mean by that is, if you take your number of monthly active users and you find, for example, your five percent highest volume users, okay? You can approach them with perhaps a targeted survey or phone calls and say, "Why are you using this so much? What value is it delivering to you?" And during those interactions and conversations, you can get to outcome measures. They might say things like, "It saves me 20 minutes per day. It saves me 40 minutes per claim that I examine." So, I would ask us to keep in mind that transactional measures, even though we do not like them in general, they can be the key to unlocking the door and getting you to an outcome down the road.

So, the fourth performance measure here that we are showing is one that I like. It is I believe an outcome measure, could be considered a process measure. It is the time in queue for the evidence-gathering phase of the claim review. And so, this is that segment of the overall claim response process that is allocated to evidence review. Right now, it is 60 days, we can get that less. And I think this Chart Search API is going to do it. They track this time already. And so, we are hoping to show a chart of declining time as the months go on for that time in queue as it goes down lower and lower and lower. And the benefit? Veterans are having to wait less time to receive a decision on their claim status. Now, can I pause for a moment there? Over the last two slides, the categories as well as this example, does this spark any initial thought?

**Denise Webb**





We have one question from Dr. Wah, and then one other, Jim Pantelas. And we do only have about four minutes. So, Dr. Wah, if you could go ahead.

**Robert Wah**

Thank you, can you hear me?

**Norman E. Stone III**

Yes, sir.

**Robert Wah**

I just want to thank the DoD and the VA for bringing this to the HITAC. We do not get to see this often at the HITAC and I think there is some great work that has been done. I am biased, having served in the military for a long time and as the associate CIO for Military Health, I would just remind everyone that we have made huge progress in both DoD and VA. And the two data points I just wanted to share with the HITAC is, I haven't prescribed on paper in a military facility for nearly 30 years. And that, compared to where we are in the civilian world, I think is a remarkable achievement. And also, back in 2005, we reported that we transferred over three million records from departing service members who are leaving active-duty service over to the VA. That was nearly 20 years ago we transferred that kind of volume of records from the DoD over to the VA. But my real question in this area of performance measurement for Colonel Stone is that there is a reference to the COVID-19. I believe it is called COVID-19 registry and workgroup three for the public health IT work. And I just had a question about what the status of that is. As the committee knows, I have done a lot of work on smart health cards, and most of those are coming from state immunization registries. But members of the DoD and the VA do not report to the state registries when they get immunized. And so, there is a dependency for those members in the DoD or the VA that want to get their health information about their vaccination status reported out digitally. And I am hoping something in that COVID-19 workgroup is going to provide that.

**Norman E. Stone III**

Sir, it sounds like you have a question related specifically to the COVID-19 registry effort.

**Robert Wah**

Yes.

**Norman E. Stone III**

That wasn't an intended part of this discussion today. This discussion is on the interoperability performance measures. But I can connect you to the people who are working on the COVID-19 registry, for sure. And they can discuss what sounds like a more detailed question that I have the background to it to answer thoroughly today.

**Robert Wah**

That would be great, but I just want to highlight the fact that the VA and the DoD folks aren't in the state-based immunization registries. We need to make sure there is a way for them to be able to get digital information about their vaccine status and their COVID status.

**Norman E. Stone III**

Sir, if you want to send me an email, I can get you connected.

**Robert Wah**

I will do it. Thanks.

**Denise Webb**

All right. Thank you, Dr. Wah. And we have a question from Jim Pantelas. And then, Colonel Stone, I think what we are going to need to do so we can stay on schedule is to have the HITAC review your





remaining slides and we can certainly invite you all back next year to come to talk to us again. If that would be okay with you.

**Norman E. Stone III**

No trouble, no trouble at all. Hopefully, we will not be working on this next year, but yes.

**Denise Webb**

All right, Jim Pantelas.

**Female Speaker**

Now we will be working on the next step.

**Norman E. Stone III**

Yes, that is right.

**Denise Webb**

I agree. Hopefully, we are going to have a lot of this done. Go ahead, Jim.

**James Pantelas**

Yeah, my name is Jim Pantelas, I am ex-Navy, the real Air Force. And I receive my care at the VA based on a full-service related disability. And I am excited by what you are saying about the delivery of Chart Search APIs, but you are addressing them from a claim review evidence response perspective. And I am wondering whether or not they are being developed with the end-user, including the veteran. One of the hardest things that the veteran has to deal with is gaining access to supportive documentation when they are filing for any kind of claim. And if you could make those APIs available to the veterans as opposed to, or in addition to the claims reviewer, we can probably do the searches for them and cite the available evidence.

**Norman E. Stone III**

Yes, sir. I like the way you are thinking about that. I will tell you I am not from the program office that is writing and running the Chart Search API. I am holding it up as an example of what is a good one of our 20 initiatives that I think shows a clear dependency on interoperability between systems as well as organizations. And also came up with four illustrative performance measures that help talk us through what we have been doing. So, I regret I do not have deep knowledge of it. But again, I can connect you to the Chart Search API Program Office for follow-up discussion, if you'd like.

**James Pantelas**

That would be great. Thank you.

**Norman E. Stone III**

Sure.

**Denise Webb**

Thank you, Jim.

**Norman E. Stone III**

Should we conclude there, Miss Webb?

**Denise Webb**

Yes, please. And I want to thank you and Yvonne for your presentation today. We appreciate it, and it looks like you have a lot of work to do in terms of executing your plan. And we wish you the best.

**Norman E. Stone III**

Very good. Thanks for having us today.





**Denise Webb**

Thank you. All right. Okay, we are going to have a break for five minutes. And so right now, it is 10:57, so let us all be back at two after the hour. Excuse me, it is 11:57, I am on central time.

**Break (01:54:44)**

**CY22 HITAC Work Plan (01:54:45)**

**Operator**

All lines are now bridged.

**Mike Berry**

All right. Welcome back, everybody, to the HITAC November meeting, and we are going to kick off our next portion of the presentation. I will turn it back to Aaron and Denise to provide their opening remarks.

**Aaron Miri**

Yeah, welcome back. That was a really interesting view into the VA and what is going on there, so thank you for that. All right. Well, let us get into the next item here, which is the calendar year '22 HITAC work plan. Denise, unless you have any objections, I can bring you right back over to Mike.

**Denise Webb**

That sounds good. Ready to go, Mike.

**Aaron Miri**

All right. Mike, it is all yours.

**Mike Berry**

All right, thank you both. I appreciate it. And I am back. Again, I am Mike Berry. I am the Designated Federal Officer of the HITAC. But I, and of course, all of us at ONC have been working to develop the work plan for next year, and we are at the point now where we need all the HITAC members' input to finalize the work plan. So, if we could go to the next slide? All right. Our HITAC work plan considers the four target areas that Seth went over earlier, and I am sure that each of you is very familiar with them. We have privacy and security, patient access, interoperability, and the use of technologies that support public health. So, we factored all these target areas as we developed the work plan. Next slide. Next slide, please. There you go. So, today I would like to review the list of topics for the HITAC work plan and the timing for those topics, along with identifying any other topics that you would like for us to consider. Next slide.

All right. So, I just wanted to provide the process used to develop the work plan, which included reviewing the transcripts and the meeting notes from prior HITAC discussions. We did quite an extensive analysis of the HITAC recommendations, including all the HITAC Annual Reports. We considered our legislative requirements and work plans in our emerging issues. And we met with the co-chairs last week to get their input as well. Next slide. So, as Micky mentioned later, we were quite busy, or you all were quite busy this past year. We had five HITAC subcommittees and produced the FY20 HITAC Annual Report and of course, are currently working on the FY21 Annual Report and we held the public health data systems hearing. What is left to complete early next year will be the FY21 HITAC Annual Report. Next slide.

Now we are getting into the good stuff. This is a grid that you are probably familiar with that shows our work plan so far. So, I will start with the HITAC committee meetings. We are considering having a HITAC meeting schedule for the first 11 months of next year. And the Federal Register notice will go out probably in early December that has the official dates of those meetings. All the meetings will be virtual. That is what we are planning for. If something changes, we will give the HITAC members plenty of notice if we





can resume in-person meetings. If we find that we do not have enough material we could, we might cancel the meeting. But we wanted to get ahead and plan those meetings out for the whole year. We also have our usual administrative meeting for the HITAC members, and that is just an opportunity to go through the work plan and talk about the SOPs and that sort of thing. We will have, as Micky mentioned, six new HITAC members, and we want to make sure that they are comfortable with how the HITAC operates and the next steps.

The FY21 HITAC Annual Report Workgroup will wrap up by February. That is the usual cadence for the HITAC to vote on the FY21 work plan. And then in June of next year, we will start the next cycle for the FY22 work plan. The other big news on here is a new line, what we are calling interoperability standards workgroup. And in case you are wondering what that is, it is the merger of the USCDI and Interoperability Standards Priorities Task Force. And this was a HITAC recommendation last year that we took under strong consideration for this year because these are recurring task forces, but we wanted to characterize them as a workgroup. And many of the same HITAC members are on both taskforces anyway. And then we wanted to align resources more efficiently. And so, if you are interested in joining this new workgroup, please let me know because we are going to hit the ground running in January, as you can see. And if anyone is interested in volunteering for a co-chair role, please indicate that as well.

So, what the plan is here based on this schedule is to discuss the level two data elements that would be included and USCDI Version Three. And so that would be from January to say, around mid-April. And then start the ISA discussion from mid-April to June. And the reason why we have the TBD portion on here is to allow us to talk again about the USCDI process if we feel the need to continue that discussion. So, that is why that is on there. So, just wanted to point that out to you that that is our plan for the Interoperability Standards Workgroup. The next element is the health equity by design hearing, which we would like to kick off sometime early in 2022. So, what we are contemplating is holding a listening session. Kind of an ONC-hosted listening session to help us formulate the plans and the agenda for the hearing. And of course, we will provide those to the HITAC as well. So, the listening session would be to the hearing. But as noted multiple times throughout today, health equity by design is a focus area and a priority for ONC, and so we want to make sure we have a hearing on that subject.

And then finally on the list is the Public Health Task Force and/or feedback sessions. We are interested in your feedback here. There are so many things to talk about with public health. If we could dig deeper into some of the recommendations from the Public Health Data System Task Force. We could provide updates to you on the Executive Order Workgroup activities that you have heard about before. So, interested in getting your feedback on that. I will go to the next slide, and we will open up for discussion shortly. So, if you can move to the next slide. Okay, thank you. So, these are the other topics we identified for the HITAC discussion for next year. All these top topics again came from HITAC recommendations. So, this could be a focus discussion during a HITAC meeting that could lead to a task force, a listening session. We need your feedback on what things we could focus on because this is a pretty extensive list, as you can see. So, I am not sure we will get to everything, but we would like to prioritize these and decide what the timing is for each topic and also what the charge focuses on if it turned into a task force. Or do we just have a listening session to invite speakers to talk through at a HITAC meeting? So not necessarily going into a full task force, but at least, you know, continuing the conversation.

There are a lot of recommendations from the HITAC about holding listening sessions, and we think this is a good opportunity to do so under this additional topic session. So, if we can go to the next slide. So, I want to open up for discussion here and really what we would like to know, are there any additional topics that should be considered that you haven't seen on the list? And I mentioned what should we consider as we are developing the charge? What could be a task force, which should be a hearing committee discussion? And how do we prioritize those things? And we can toggle back to those previous two slides to help the discussion. So, I will turn it back to Aaron and Denise to open up the discussion.

**Aaron Miri**





Sounds good. So, if any HITAC members have questions, please use the Adobe Connect function to raise your hand. I see Dr. Lane with his hand raised.

**Steve Lane**

First, a comment, Mike, and the team. I think the decision to combine the ISP TF and the USCDI task forces into a single body is a good one. Having served on and led both of those groups, I think it does make sense to bring them together to coordinate their efforts. The other comment that I had was on slide seven, where we talked about the potential topics for discussion, and we included the first bullet point on improving the interoperability of lab data. And I would just point out that lab data includes both the orders and the results. And I think that it is important that we also consider lab order data and its interoperability in addition to the results. This has been discussed within the ISP Task Force and in other settings. The tremendous benefits it would derive to patients and potential providers if orders for labs and other tests were interoperable, such that if there were placed within one organization, that that order would be available to be picked up by any provider of those services so that the patient has the opportunity to shop based on cost, quality, convenience, et cetera, and then have those results go back to the ordering provider. So, I want to highlight the opportunity to look at both orders and results under the category of lab data. But also, when we are talking about imaging and other sorts of testing.

**Aaron Miri**

Sounds good. All right. Next up, Alexis Snyder.

**Alexis Snyder**

Hi. About the electronic health records and the patient safety on the list, which is great to see, I think I have mentioned this a couple of meetings in a row at different times. I think it is a great opportunity to discuss how EHRs and patient safety can be greatly affected by inaccurate information in the chart. And as we move forward and push and strive to move forward and advance interoperability between health care systems, we need to make sure that there is a way to get information that is inaccurate and therefore affecting patient safety in several ways corrected. And also corrected starting from the patient's end when the patient or caregiver is the one finding these grave errors in the chart. And so, I highly push for more processes that will help fix this conundrum in the health care system. And seeing this on the list is terrific, and I think it would be great to have a working group or a task force in this area.

**Aaron Miri**

Good comments. All right. Next up is Terry O'Malley.

**Terrence O'Malley**

Hi. So, on the waves to advance the care continuum with health IT, I am hoping that includes care plans and transitions of care, which I do not see called out anywhere else. So, that would be my one hope for your continued great work. So, thank you.

**Aaron Miri**

Sounds good, Terry. Abby Sears.

**Abby Sears**

Thanks. One of the things I wanted to call out was the social determinants of health data. I think just needing a sense of urgency around finding some way to make sure that the data can be moved quickly. We aren't going to be able to do a good job on the continuum of care and care transitions if the data that we need is not defined enough and movable so that the complete record. And that goes also to the data around behavioral health, mental health, and substance abuse. Those laws have just only recently changed, and there is still a lot of concern around that. And I think working through how to make sure that people understand how to move that data and the importance of moving that data will all lead to patient access, privacy and security, care continuum. We cannot do that if we do not have complete knowledge of that patient. So, I just want to put my plugin for that.







**Aaron Miri**

That is a good point. And even maybe better defining what social determinants of health data is, right? I mean, it could be something as simple as patient-reported outcomes, all the way to food information, allergy information, and getting into the meat of it. Great point. Great, great point.

**Abby Sears**

Exactly.

**Aaron Miri**

All right, Jim Pantelas.

**James Pantelas**

This would be under the intersection of research and health information. I am wondering whether or not anybody is considering or working on the creation of centralized health information capabilities for research on expired patients. If my understanding is correct at an institutional level, a lot of the HIPAA restrictions are removed upon death, but there doesn't seem to be any central repository for that kind of information cross institutional. And I wonder if we should look at that.

**Aaron Miri**

Good suggestion. Mike, I do not know if there is anything you want to add to that.

**Mike Berry**

I am sure if anyone on the ONC has any comments about that. Otherwise, we can take note, Jim.

**Aaron Miri**

Come back to it.

**James Pantelas**

Okay. Thank you.

**Aaron Miri**

Any other hands raised? I do not see, although I could have sworn there was somebody else. Dr. Lane, you are back up?

**Steve Lane**

Yeah, sorry, Aaron. I just wanted to put a voice to the comments that are going in the public comment about the opportunity afforded by the Congressional repeal of the Section 510 provisions and the potential benefits of pulling together a group to look at patient identity with the now option of at least discussing the idea of a universal patient identifier. We have got years of pent-up thinking about that, and it would be nice to bring it into the public eye and decide if, when, whether it is appropriate to do work in that space.

**Aaron Miri**

Great point, great point. In the Annual Report workgroup, we bundled that topic under privacy and security and patient access, and Michelle and the ONC team have done a good job of extrapolating out. But you are right. Now with a focus, perhaps you could focus on double click on that. Be respectful of whatever regulation there is there. But in the repeal of that, it would be great. So, I wholeheartedly endorse that. Any other comments?

**Denise Webb**

I have just one comment, and I apologize if somebody already mentioned this. But speaking of patients and patient access, the focus has been very much on getting patients their data. But then also patients have data they want to share electronically from their devices and things back to their electronic health record. So, I think that is something that we have talked about exploring or discussing and what that





might look like and how that might affect certification and falls under privacy and security as well, how we would address that in terms of those devices connecting.

**Aaron Miri**

What is great, I will give credit to Carolyn Peterson, a really good focus on patient-generated health data over the past couple of reports. You are exactly right, Denise. It is something that needs to be better defined and better understood, and also the clinical viability, right? So, Dr. Oliver and others have weighed in on what is relevant, what is not, how to determine relevancy from a clinical perspective. That whole realm needs to be further articulated. So, great points. Great points.

**Denise Webb**

Right.

**Aaron Miri**

Dr. Lane, you are back up?

**Steve Lane**

Just a follow on to Denise's comment that your patient-generated health data doesn't necessarily have to all be pushed back into the EHR as a copy of that data. There is some data where that is just going to be impractical from a volume and the signal-to-noise perspective. But the ability to access, exchange, and use patient-generated health data is a desirable direction that we all want to go in. I do want to put a voice to a comment I put in the chat during one of the earlier presentations. We are just now starting to see EHRs being able to accept FHIR write access to their database and starting to see some apps being able to push data into the EHR. This is something that we have been talking about for several years, and it has been a long time coming so far. With our vendors, they are only allowing that with apps that are in their App Store. And actually, there may be only one so far, but I am working with a couple of other vendors to try to get that turned on for more apps. I think that is a real breakthrough and certainly when we are thinking about patient-generated health data and the ability to make that data available, looking at FHIR write access to the EHR or view access from the EHR out to another app and leveraging the APIs is all going to be part of that solution set.

**Aaron Miri**

Yeah, great points. And another dimension of that exact topic has always been what are the legal ramifications of pushing that back PGHG back to the medical records? The medical record is a legal document. And better articulating that. The tendency in health care is to pause if we do not know. If it is not well defined and articulated. So, how do we get through some of those understandings, right? So, I think it is a great point, Dr. Lane.

**Denise Webb**

Well, maybe we could have a certification program that those app developers and product developers could apply to.

**Aaron Miri**

Yes.

**Denise Webb**

So that they could get a certification through the Health IT Certification Program.

**Aaron Miri**

Good point.

**Denise Webb**

It is more usable for us on the provider side in terms of what we would be getting from those apps. Or being able to view them.





**Aaron Miri**

I would agree. I see a comment here in the chat about the care continuum, which I advocate for long-term care, and LTACHs, and rehabs, and SNFs, and et cetera. And if we can start doing this, perhaps this gives them the ability to see a true picture, pan to see what is happening in and out of an acute care setting, right? So, it could help a lot of things. You are spot-on, Denise. Any other comments from HITAC members? Questions? Good stuff.

**Mike Berry**

All right. I will ask our logistics team to move ahead on the slides a couple. Really good discussion and really good ideas, and now you see why we have meetings carved out for 11 months out of next year. So, you'll be very busy next year as you have been this year. So, we appreciate your input. So, as far as the next steps go, we are going to consider everyone's comments today, and we will also look through the chat as well to make sure we capture other comments from the public in addition to our HITAC members. And we will finalize the work plan in January. That will be part of our January meeting to go through the final work plan and we will work from that. And so, we will have a busy 2022. I appreciate everyone's input. And again, if you think of anything after the meeting today you could email me directly, speaking to the HITAC members, to let me know. And we will add that to the list. And also, just a reminder for those interested in the Interoperability Standards Workgroup. Let me know who you are and let me know if you are interested in serving in a co-chair capacity, and we will be able to kick off that meeting immediately after the January HITAC meeting. So, we want to hit the ground running. If you can keep that in mind and send an email to me, that would be great. And so, that concludes my presentation. Thanks so much for your time, and I will turn it back to Aaron and Denise.

**Aaron Miri**

Yeah. Denise, we are about six minutes ahead here, but I would move that we go ahead and move to public comment and see if there is a comment there. Seems like there is a lot of chatter in the text box, so maybe giving some more airtime to folks to be able to speak in. What do you think?

**Denise Webb**

Well, I have a question for Mike because I know what the [inaudible] [02:17:31]. You provided tentative dates for meetings, and you said we are going to have 11 meetings next year? Is that what I heard you say?

**Mike Berry**

We are planning for 11 at this time. Right. January through November.

**Denise Webb**

Okay. And it may have just been my computer, but it showed up with six meetings and the others were blacked out. It could just be my programming. I will go back and look at it. I only saw six meetings. I thought, oh wow!

**Mike Berry**

No, six is too short to have a list.

**Denise Webb**

I didn't think that was right. I will go back and [inaudible] [02:18:03].

**Mike Berry**

And I can resend that to Denise. Again, the special meeting dates will be listed in the Federal Register notice. That is our process. And they will all, again, be listed as virtual at this time. Any other questions, Aaron, Denise?

**Aaron Miri**





No, the queue looks good.

**Mike Berry**

All right.

**Denise Webb**

Looks like we can go to public comment.

**Public Comment (02:18:24)**

**Mike Berry**

All right. Operator, can we open up the line for public comment?

**Operator**

Yes. If you would like to comment, please press star one on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press star two 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 the star keys. Our first question is from Shelly Sprio with Pharmacy HIT Collaborative. Please proceed.

**Shelly Spiro**

Good morning. My name is Shelly Spiro. I am the Executive Director of the Pharmacy HIT Collaborative, representing over 250,000 members of the majority national pharmacy associations, including pharmacy education accreditation and 11 associate members. Pharmacists play an important role in transitions of care and from a health IT provider standpoint, we value the most from receiving and exchanging medication-related data during transitions of care. According to the 2014 HHS National Action Plan for Adverse Drug Event Prevention, we find patients being transitioned between care settings are the most vulnerable for hospital readmissions due to adverse drug events. The likelihood of ADEs occurring may also increase during transitions of care. For example, discharge from a hospital to a nursing home or a patient's move from one health care provider or setting to another. When information may not be adequately transferred between health care providers, our patients may not completely understand how to manage their medications. The pharmacy profession stepped up, and over the last six years have adopted a FHIR-enabled pharmacists electronic care plan validated at NCPDP and HL7. This eCare Plan is highly adopted by 21 system vendors and is being taught in 93 colleges of pharmacy. In another initiative through a joint effort with NCPDP and HL7, we are working on a FHIR resource for a standardized medication profile to help exchange medication-related data during transitions of care. Thank you very much for allowing me to make these comments.

**Denise Webb**

Thank you for your comment.

**Operator**

There are no more comments at this time.

**Mike Berry**

All right, thank you, operator. Aaron, Denise, do you want to provide your final remarks for our November HITAC meeting?

**Final Remarks (02:21:09)**

**Aaron Miri**

Sure. Denise, would you like to start?





**Denise Webb**

Sure. Well, I want to thank everybody for a great year. We got a lot of work done this year and I appreciate everybody's efforts and the time they spent to get us further ahead. Looking forward to next year, I wish everybody a very happy holiday season as we enter into Thanksgiving and then the Christmas holidays and take care. Stay well.

**Aaron Miri**

And I would say quickly, the holiday time is always a moment to give thanks and to give grace and to be appreciative. It has been a very, very tough year, particularly for our clinical care providers and the patients that we serve. And so, for all of you, be safe. Thank you for a wonderful, wonderful year and a collaborative year. Again, for the folks leaving us, you are always family. You are always welcome, and you know how to get a hold of us. We are always talking. But the work never stops, and we have always got more mountains to climb. So, thank you for that. And please stay engaged no matter what. We look forward to working with you, and you are family. So have a happy holiday. Be safe, be well, and we will see you soon.

**Adjourn (02:22:19)**

