



# Transcript

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

August 30, 2022, 11:00 a.m. – 12:30 p.m. ET

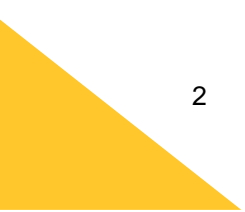
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# Speakers

Name	Organization	Role
<b>Medell Briggs-Malonson</b>	<b>UCLA Health</b>	<b>Co-Chair</b>
<b>Aaron Miri</b>	<b>Baptist Health</b>	<b>Co-Chair</b>
Jim Jirjis	HCA Healthcare	Member
Steven Lane	Sutter Health	Member
Eliel Oliveira	Dell Medical School, University of Texas at Austin	Member
Brett Oliver	Baptist Health	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Michelle Murray	Office of the National Coordinator for Health Information Technology	Staff Lead





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

### **Michael Berry**

And good morning, everyone, and thank you for joining the HITAC Annual Report Workgroup. I am pleased to welcome our cochair Medell Briggs-Malonson, along with our workgroup members Steven Lane and Eliel Oliveira, who are all with us today. Brett Oliver is not able to be with us today, but Jim Jirjis and Aaron Miri are planning to join us a little later in the call. Public comments are always welcomed, which can be typed in the chat feature of Zoom or can be made verbally during the public comment period later in our meeting. Now, I would like to turn it over to Medell, who will kick us off. Medell?

## Opening Remarks, Meeting Schedules, and Next Steps (00:00:39)

### **Medell Briggs-Malonson**

Thank you so much, Mike. I really appreciate it, and good morning to all, to our monthly workgroup meeting, and as Mike mentioned, we are going to be very fluid today, primarily due to the fact that some of our members will be joining us at another time and that some of our other members may have to leave. So, we are just going to go over some of our various different meeting agenda items. And so, first, what we are going to do is we are going to walk through some of the discussion of the topics that we previously discussed in last month's meeting as well as during our larger HITAC meeting, and there are some additional topics as well that were introduced at our most recent committee as a whole from HITAC that we are also going to discuss. And then, again, as Mike mentioned, we will open up for public comment at the end. Next slide.

So, before we jump too far into the meeting schedule, I just do want to remind all of the various different committee members that if you do have any chat or any comments, please make sure to chat directly to everyone. In addition to that, we have emojis if we want to emphasize anything as well, and please also use the raise-hand function if you do want to add a comment as well.

So, this here is actually showing our meeting schedule for the rest of the year for our Annual Report Workgroup, and of course, we already are into the month of August, and then, our next meeting after today's meeting will be on September 7th, where we will continue to go through the crosswalk of the various different topics, and we will also continue that through October, and then, in November and December, we will really focus on developing the draft of the annual report while also incorporating all the various different feedback that we have had, and that will again go directly back to the HITAC committee in order to ensure that we have it as comprehensive as what it needs to be, and then we will update that additional draft in order for HITAC approval and even for eventual submission as well. Next slide.

Now, this is also, once again, for the entire full committee, when we are going to directly send this back to all of HITAC, and you will see all of the various different dates, September, October, November, January, February. The only month that we are dark is going to be December, so we will have a very packed, filled time. And, I saw that, Steven. Seems like emojis are not enabled, so if they are not enabled this time, so we will make sure to see if we can explore that for our next meeting. Next slide.

### **Steven Lane**

Actually, Medell, I am not so sure we need emojis because I do not think they can be captured for the public record the way that the chat can, so we might be better off just going without, as fun as they are.



**Medell Briggs-Malonson**

As fun as they are to emphasize. Thank you, that sounds wonderful. So, just to provide a little bit more of a high-level view of what we are doing and our primary objectives, once again, this workgroup was created, and currently, what we are doing is walking through the crosswalk of the various different topics with some key principles that we want to center, really making sure that we are identifying those gaps and the opportunities as well as what our recommendations are, which will go back to the HITAC full committee in order to then receive more feedback to incorporate into our overall report.

In addition to that, what we are going to do is make sure, on September 14th, that we are going to present all that we are discussing today directly to that HITAC meeting. And then, last but not least, the workgroup will then continue on throughout the fall, as previously mentioned, in order to finalize some of our crosswalk, really what we are thinking about for the elements of the report, and then continue to provide all of the brief updates as needed to the HITAC committee. Next slide.

**Steven Lane**

Just a comment. I think we should be prepared to get some meaty feedback from HITAC when we present the draft. Just like Eliel, when he was reading through it, came up with "What about this? What about that?", I hope we get that from other members as well.

**Discussion of Draft Crosswalk of Topics for the HITAC Annual Report for FY22 (00:04:48)****Medell Briggs-Malonson**

And I think we will, and especially because we went over at least some of the topics, and so, people know what we are all envisioning, so I agree. I hope that we have a lot of great input when we take this back in September. So, the next piece of discussion of the crosswalk, and once again, we are going to pull up the crosswalk in just a moment, but this is just the draft, so we really appreciate all of your thoughts and comments so that we can make sure we are incorporating all of the various different topics that were recommended into this crosswalk, and then, also really want to thank the ONC team for helping to start to build out that crosswalk, and so, this is going to be our opportunity to really reflect on that and make sure that there is nothing else that we want to add.

So, once again, considering all those gaps, challenges, and opportunities, and also thinking about what we as HITAC can actually do, there are some additional target areas, and we can have some fun discussions today about naming of some of those different target areas, and really, those two target areas focusing on health equity as well as public health. I am looking at all the emojis that are popping up in the middle there. And then also, looking at the primary target areas of interoperability, privacy, and security, as well as patient access to information. Next slide. Great. So, before we jump into the crosswalk, any questions, any points of clarification as well that we need to provide for all of us as a workgroup? Okay. All right, great.

Well, if we can bring up the crosswalk now, and what we can also do, if we can scroll down to the bottom first, so there were three topics, and actually, Eliel, you mentioned even some additional topics that I think we should discuss as well, and I just want to first pause, take a look, and discuss the additional topics that did come up during our previous HITAC committee for us to then ponder saying yes, do we want to include this in this year's annual report, or are there any revisions or modifications we would like to make, and then, Eliel, we know that there were some other topics that were recommended by you as well.





So, some of the additional topics to consider that came up: There was one area that was labeled underneath our health equity target area of the use of telehealth, and the discussion, at least from what I recall, and I would love to flesh this out with you all, was the importance of the use of telehealth in order to expand access, and especially to really advance health equity. And so, when we are discussing, of course, the various different aspects of the digital divide, whether it is access to the various different types of forms of internet, whether it is broadband or wifi, or even access to various different devices, and the literacy around digital use as well, is this something that we want to include into our annual workgroup? So, I want to just bring this up and see what the workgroup thinks. Is this an important priority that we need to include in this year's report?

### **Steven Lane**

Medell, I think it is important, though I tend to think everything is important, but I do think this is important, and not only as it relates to equity. Clearly, that is a critical topic, and access for those who are not otherwise able to access traditional face-to-face services, but it also raises other challenges, the unintended consequences of the discontinuity of care, the fact that so much telehealth is being offered by independent organizations that are not necessarily connected to the sites where a patient may receive their ongoing primary care, and I think the interoperability challenge is both assuring that the provider of the telehealth service is fully informed about the patient's health status and has access to their health information, but also that the documentation of their care be captured and then made available and transmitted to other members of the care team broadly.

So, I think that there is a lot to telehealth. I do not think we have spent a lot of time thinking about it in the HITAC context, and I think we should. It has been sort of like it did not exist, and then it did exist, and then it was like, "Who is going to pay for it and are they going to keep paying for it?" That has really been the focus, as well as fraud and abuse, and those are all relevant questions that need to be addressed, but I think from a health IT perspective, both the issues, as you said, of broadening access, lowering the barrier to access, thinking about those issues, but also assuring that that care is truly integrated into the whole-person care that needs to go on longitudinally.

### **Medell Briggs-Malonson**

Absolutely. I completely agree with that in every way. I think there were also some discussions about making sure that we keep this really focused because, of course, there is all of the technical infrastructure of telehealth, but I think what we are all referring to when it comes to telehealth is making sure that, as you mentioned, the interoperability, that it is fully accessible and supporting the care needs of all of our various different populations in the appropriate way, and we are not leading to more silos and fragmented care, which we know can adversely impact patients' care and overall outcomes, and so, really designing those use cases and ensuring that we do not have barriers to forward that continuity. I completely agree with that.

### **Steven Lane**

I had not thought about this before, but I would also argue that all the concerns that are raised about fraud and abuse could be addressed by baking in the necessary interoperability. CMS, for example, could say, "We will pay for telehealth if and only if it is performed by somebody who has access to the patient's health information at the outset and who is connected and makes that information available through the network's framework subsequent to the care," the idea that standalone telehealth may not be reimbursed at all,





reimbursed at the same rate, or whatnot, again, designing for interoperability since we know it is so critical to safety and continuity of care.

**Medell Briggs-Malonson**

Absolutely.

**Eliel Oliveira**

I totally agree, and I think your comments, Medell, are excellent in terms of us building a technology that serves the most affluent and ones that are savvy enough to be able to manage technology, but in our work here in the medical school, we do notice evidence of individuals that are underserved and are not utilizing technology as well as others, so we could be widening the gap further, and standards could pave the way, like Steve is saying, where we could enforce some things. I am just thinking of a lot of cases here of individuals that need help, but also have challenges with a different language because they may have immigrated from Ukraine right now. So, what do they do if their appointment is electronic? How do you get a translator involved? We do not have processes for that. Like Steve said, we just landed on these solutions because we had a major problem that needed telehealth, but we have not worked through the technology requirements to do this the right way.

**Steven Lane**

An interesting question. Certainly, some telehealth providers like myself utilize a certified health IT product and electronic health record. Many do not. Many are using homegrown systems or even non-healthcare-specific systems. We should think about what are the potential benefits of incentivizing the use of certified health IT for telehealth. Obviously, that would include all the necessary interoperability tools that we have already developed in the EHR space, and/or whether there might be certification for telehealth systems. It is one of those examples, like public health systems, where it is different. Maybe telehealth is just certified health IT. Maybe they just needed the basic EHR tools. Maybe they need less than that. Maybe they need different than that. I do not think there is anything specific to telehealth, like video linkage or telephone linkage, within the certification requirements today, so, whether certification needs to expand to support telehealth in an integrated way will be a question we might want include here.

**Medell Briggs-Malonson**

Absolutely.

**Steven Lane**

I hope somebody is taking notes here. We are looking at a static document.

**Medell Briggs-Malonson**

I think they may be taking notes. I am sure they are. So, it sounds like we are all in agreement that this is a very important topic that needs to be included in this year's annual report, and it is very robust, and there are many different things that we can explore and recommend from the HITAC lens, so we will take that as we are going to include that in the annual report. Now, the next area is privacy of women's health data. This was also suggested at our previous HITAC meeting, and the gap that was discussed is that there is a lack of standards supporting the segmentation of sensitive data, including sensitive women's health data, and of course, with our current political and social climate, there is the changing legal landscape in which it is important to balance protecting this data with making it accessible as needed. So, this was another topic





that was brought up. I would love to hear everyone's ideas about this, and then, I have some additional thoughts as well, and especially because it is very centered on women, but I think we need to think about some other implications of this as well. So, any thoughts about this topic?

### **Steven Lane**

I agree with you, Medell, that the title is a little too restrictive. It is really assuring the privacy of sensitive health data, and I have been involved in many discussions now over the months since this came up, and the need for better tools for granular segmentation is a piece of the solution, the need for clearer privacy rules is a piece of the solution, the need to work across our industry to identify some best practices, to look for the high-value interventions in terms of operational changes that could be made so that patients are aware of their rights to restrict access to their information, their privacy rights under HIPAA and under state law. I think there is a lot of work to be done here. My hope is that the ONC will engage. I had a chance to talk to Steve Posnack last week about this in particular, and we had previously discussed the opportunity for ONC to publish, if not a formal FAQ, some sort of guidance about how the information-blocking exceptions may or may not be applicable to the protection of highly sensitive health data, including reproductive, gender, and sexual care for both women and men.

### **Medell Briggs-Malonson**

Great. Those are all excellent, Steven. Some of my additional thoughts to stack onto what you mentioned is that we also have a highly gender-diverse nation now, and so, people may oftentimes may not identify as women or male. However, our current electronic health record systems, while they are starting to transform to understand the various different identities, there are other clinical algorithm implications normally within our electronic health record systems.

So, while we are thinking about the privacy, and I agree, I think it should just be called "sensitive health data," I think this also provides an opportunity to start to think of some of those standards when we are dealing with gender-diverse populations, and also thinking about how those values actually do drive some of our preventative screenings that come out into our overall EHRs as well as the information that is provided to not only our providers, but also to our patients. And so, this is an area that can easily really be a paramount approach to how we ensure that we are taking care of people and some of their most sensitive health data, not only making sure that it is secured, but we are using it in the correct way to provide the most high-quality care possible to them as well by having clear standards.

### **Steven Lane**

I completely agree, Medell. Another key piece of this is the whole issue of accounting for disclosures and allowing individuals access to information regarding who has either access to or released their information, and to whom the HIPAA requirements for accounting for disclosures are fairly narrow in terms of which disclosures must be accountable to an individual, and I think that is something that, again, I hope that as rules are being written or draft legislation is being prepared regarding an update to HIPAA, that that is being considered because I think the scope of accounting for disclosures under the current HIPAA is too narrow for the current needs.

### **Eliei Oliveira**

I want to touch quickly, Medell, on something that you mentioned there about gender. Based on our experience here, we are implementing some systems expanding the use of gender as described in the





FHIR standards, and what we notice at that point is that we are capturing gender from individuals directly based on how the individual describes it, but then, when we try to match those individuals to their medical records, we cannot because the data coming from EHRs and from the health information exchange is not described in that way, so I guess the key point here is that as we are working through that implementation of the change of EHRs about the gender, we have to think of the repercussions in terms of record linkage that will take place. We basically had to revert the work that we were doing because we could not match anybody because gender is part of that algorithm that links health records. So, I just wanted to make sure that we capture that as we go along.

**Medell Briggs-Malonson**

Absolutely, and Eliel, that was one of the reasons why I mentioned that comment, because in most of our standard EHRs, we have legal sex, gender identity, and sex assigned at birth, and all three of those, for instance, have very significant implications, and some of those various different fields are used for interoperability, and others are not, and some of those fields are sometimes used for clinical care, and others are not, some of those skills are face-up to our physicians and other clinicians, and others are not. And so, it can lead to not only confusion, but also lack of patient matching, but then, also, significant clinical implications in terms of preventative care as well as treatment within our various different facilities. So, I 100% agree. That is the whole point of thinking through this, of not only the sensitive health data, but also how we are appropriately managing those standards and to ensure interoperability and the highest quality of care when we have all of those three, and probably soon to be even more, of those various different identifiers for our patients.

**Steven Lane**

I will just add that from the perspective of the standards, of course, USCDI continues to evolve in terms of its use of sex, gender identity, and other demographic factors, and I think that HITAC, as we discuss this area, needs to be aware that USCDI will continue to evolve as the Gender Harmony Project evolves and clarifies these standards.

**Medell Briggs-Malonson**

Wonderful. So, maybe a really tight linkage with the Gender Harmony Project as well as USCDI, all of those things, to make sure that we are all tracking in the same way.

**Steven Lane**

Good morning, Jim.

**Medell Briggs-Malonson**

Wonderful.

**Jim Jirjis**

Good morning. Sorry I was a little late.

**Medell Briggs-Malonson**

No problem. We are happy to have you, Jim. So, I think I know the answer, but the question on the table is if we also want to include this topic in this year's annual report.





**Steven Lane**

Now we get to use the emojis.

**Eliel Oliveira**

Yes, I think so, and if the comment was correct, it is not just to be about women's health data, but to expand that to other sensitive domains.

**Medell Briggs-Malonson**

Absolutely. So, expanding it to just sensitive health data, but also incorporating some of the various different items that we discussed about the importance of correct privacy levels as well as the interoperability and others. So, lots of thumbs up. Love it. All right, so we will add that topic as well to that report. This is going to be so nice and robust this year.

**Steven Lane**

We had to very sensitively get our thumbs working there.

**Medell Briggs-Malonson**

Thank you, yes. I see all of those thumbs up. And then, so, the next area is patient access to information, and then we are going to try to really go back to the overall crosswalk. So, consolidation of health information, and so, challenges persist in patients' ability to access and consolidate their health information across multiple portals and systems into a single view, and the opportunity that was already identified is streamlined access and consolidated viewing would actually enable, of course, our patients to share their data more easily as needed. So, this was something that was thought to not be present when we presented some of the draft topics to the HITAC.

**Steven Lane**

So, just a comment on this. I think the opportunity perhaps could be stated more clearly. "Streamlined access and viewing" does not necessarily mean that you can share your data more effectively. Those are two different things: The ability to access and view your data for yourself versus the ability to update that data, potentially correct that data, and then, in turn, share that data back with another user, and I think all of those components should be called out individually because sharing back is something that I think we all know is hardly ever done in an effective way, in a way that leverages the technology that allows that data to be reincorporated into another system, and of course, we spend so much time thinking about the challenges of data de-duplication, data reconciliation, data updating, and of course, who is in a better position to do any of that work than the patient themselves, who is the subject of that data?

So, I think as we talk about patient access to data and their ability to utilize it, we should also talk about their ability to modify, to contribute to, and then, as it says here, to share that data with members of their care team or other interested parties is critical.

**Medell Briggs-Malonson**

And so, you bring up a good point because they are very different branches, yet of course, they both correlate with one another. So, when we are thinking about the topics, do we want to parse this out, separate it, and say we are just going to talk about streamlined access and consolidated viewing, or do we also add





on the additional sharing with various different providers? Because it would be a much larger topic to discuss that.

**Steven Lane**

And we have the intermediary topic, which is patient's ability to make corrections or additions to their data, which Eliel added in a recent email, and we have had a separate discussion about that, so I would separate them into different topics. I think there is one of patient access and consolidation across sources and platforms, there is a separate one about patient review and correction, and then there is a third one about the patient's ability to share any portion of their consolidated data, including their input with other providers.

**Medell Briggs-Malonson**

Great. Any other thoughts? And again, although we love all of these topics and we are so committed to all of them, we still have to think about our length and all of our topics at hand. So, are there priorities in those three that we want to focus on as well, access, correction, as well as sharing, or do we think that all three are important to include?

**Jim Jirjis**

Hey, it is Jim. I have the hand up there.

**Medell Briggs-Malonson**

Yes, Jim?

**Jim Jirjis**

One quick question about this space. When I think about patient access to information, it seems like there are multiple different initiatives that have been launched by 21st Century CURES. It is about the standard FHIR 4 APIs, to start with. Are the resources ready? It is about USCDI. It is about information. So, when we talk about challenges persisting, I think many of us are thinking after the FHIR 4 public standard interfaces out there that part of this will be addressed by a potential market for app developers, and that that might create solutions for patients that get them access and consolidated viewing, so it is sort of like a doubling down on stuff we are already planning. Do we think that in this workstream, there are additional roadblocks that are not addressed in patient access? It strikes me that we see what happens on the other side of these interfaces coming up, and then check in with these companies that are developing apps for patients' access, and then see where the gaps are. So, I guess my question is what is the actual practical work we are suggesting in that row?

**Medell Briggs-Malonson**

Thank you, Jim. Go ahead, Eliel.

**Eliel Oliveira**

I was going to comment on that as well, basically saying that the CURES Act has very specific details about patient access to their data and sharing of their data, like we were just talking about, and I agree with Jim that we are doubling down on what the legislation is already saying. I think one aspect that I highlighted when the White House asked for a request for information about what to do here that we highlighted in our work with the communities is that maybe a place to highlight here directly related with health equity is that





there is an ecosystem to basically incentivize the development of apps like Jim is talking about that now is going to be possible with the APIs for underserved communities.

So, we have a whole ecosystem created by the mobile companies that we all use and love, and they do certain things for health, but we believe that individuals most in need have different needs, different resources and capabilities to actually access such ecosystems that they may not actually get to utilize. One example I mentioned here is that we are piloting solutions with underserved communities, and folks are like, "I love this solution, but I cannot use it because whenever I can charge my phone for a few minutes, I need to call my doctor, I need to do this or that, I cannot just use my units to use an app." So, there is an ecosystem of app development there for individuals that can pay even a dollar or more, but I believe there is a whole ecosystem where underserved communities are going to continue to be underserved because they do not have the tools and financial resources to be able to utilize the solutions that have come about.

### **Medell Briggs-Malonson**

Wonderful insights into that as well. So, what I am hearing is that No. 1, this is already outlined, and we already have efforts that are under way, and so, what additional value would this add if we incorporate this into the annual workgroup? However, what I am also hearing is that there is a potential for also just refining this a bit more to really focus more on how, yes, we can have the various different platforms and apps in order to try to streamline this information, but we are still going to face a gap for those that are part of more under-resourced communities that are actually having other various different challenges for them to access their information equitably. So, how do we want to go about this? I see some additional comments as well. And so, what does the workgroup think in terms of our next steps for this topic?

### **Jim Jirjis**

Hey, it is Jim. I typed in the comments a suggestion for the group's consideration, but it sounds like there are two areas here that we can suggest. One is there are gaps we know today that still need to be addressed, even though the FHIR APIs are not yet up and required, etc. And then, Workstream 2 might be suggesting we form a plan to formally assess the success and challenges once the FHIR APIs are up we start seeing developers use them. And so, maybe we divide the workstream up into those two. How do we advocate for gaps we know right now are not going to go away, and then, how do we recommend they collect an assessment after go-live, if you will, to determine what we learn from that?

### **Steven Lane**

Yeah, I like that, Jim, and we already have within the ONC a whole group that is focusing on measuring interoperability and tracking its evolution over time, and that group, which I have been quite involved with over the years, is well aware that tracking FHIR-based/API-based interoperability in addition to document-based and V.2-type interoperability is important, but I think rather than create a fresh workstream about this, really tapping back into that work that is ongoing, because I could not agree more. I have been trying to track our API use in our organization for years now, and continue to be impressed by how slowly it has been taking off, and I think there are a number of challenges.

I also added to the chat that one of those challenges we are struggling with right now is apps that want to come in leveraging IAL2 patient authentication as opposed to just having everybody keep reentering their portal password using OAuth, and this is a real issue that came up last week at the Civitas conference, and I know that ONC is aware of this, so there are a lot of pieces here. So, I think yes, looking at the challenges





regarding this access, identifying those individually, and working at those will be good, as well as measuring the success over time.

**Medell Briggs-Malonson**

Excellent. So, I am going to be very pointed with this question. This is all amazing, and I love the two branch points for the workflow. There is a lot of work that is already going on in this space, and we have already discussed several other topics. Is this a priority for this year's report?

**Steven Lane**

I would say keep it in. We will have a long report. That is okay. It has been done before.

**Medell Briggs-Malonson**

Okay, I see some thumbs up. I am trying to just keep us grounded.

**Jim Jirjis**

It would be a conspicuous omission given the importance of it. Hear, hear.

**Eliei Oliveira**

Agreed.

**Medell Briggs-Malonson**

Absolutely. All right, wonderful. Thank you all so much. So, we have actually discussed the three proposed topics, and Eliei, we know that you said some others as well. So, what we will do is go back up now to the top of the crosswalk and start going through each one of these different areas as well. Great. And so, just to take a step back even before we jump into the crosswalk, as mentioned, we are all in agreement that we have a new target area, which is a target area that is really focused on health equity, and so, there were some various different discussions even of the name of this new target area. We have one proposal of "use of technologies that promote and advance health equity," with really trying to use some more active, more power words like "promote" and "advance" in order to really emphasize the importance of this new target area and the work that actually leads up to it.

And then, there is another alternative as well that was proposed, which is also great, that aligns directly with ONC's principles of health equity by design, of "the design and use of technologies that support, or promote, or advance health equity." And so, that is just one piece there in terms of some of the nomenclature of this area as well, and I wanted to just take 30 seconds to see if one of those two names actually resonated most with the workgroup. So, again, "use of technologies that promote and advance health equity," or another alternative is "the design and use of technologies that either support, promote, or advance health equity." I must say I am always about promotion or advancement of health equity because it is more active and is more intentional. I feel "support" just lifts up whatever is currently in place, and I think that, as we all know, there is some work to do, so that is why having more of those action words is always important in this work, but I just wanted to also see what everyone's thoughts were.

**Steven Lane**

Go ahead, Jim.



**Jim Jirjis**

Go ahead, Steve.

**Steven Lane**

Medell, I was just going to say I think “design and use” is good language because, of course, we just are beginning our journey in terms of figuring out how to leverage technology to support equity, and there is much that has yet to be envisioned, designed, and implemented before it can really even be used, if that makes sense.

**Jim Jirjis**

Yeah, I was really going to just suggest that, by way of synonym adventure, “optimizing,” “optimizing the use of technology to support health equity.” Maybe that is too narrow because it sounds like we are optimizing something that already exists and are just trimming around the edges. Maybe not.

**Steven Lane**

We will get there.

**Medell Briggs-Malonson**

We will get there. Eliel, any thoughts about the two potential titles/alternatives? “Use of technologies,” “design and use of technologies,” and Jim threw out “optimize technology.”

**Eliel Oliveira**

I do like the “design and use” because I agree there is a lot still to be done. I think we can address a few things. But, some is related to use. I think what comes to mind, in my opinion, is certain pieces of data get captured accurately because they are related to reimbursement. Others do not. When it comes to social determinants of health, assessment of needs that are [inaudible] [00:37:55], that comes to mind. So, really important, but also, there are things that we are dealing with right now and we continue to deal with that we have not really thought out, so the design becomes important in my opinion too.

**Medell Briggs-Malonson**

I agree with all of you all. I think the design is critical to this, and again, it is beautiful because it also aligns directly with ONC’s health equity by design. So, I am going to throw out just one potential here. You all let me know if you all think thumbs up or to refine it. “Design and use of technologies that advance health equity.” How do you all feel about that?

**Steven Lane**

I like that. The other thing that I will point out, though, is I think “health equity” itself might warrant further clarification. In various discussions, I have suggested that we discuss “health equity,” “healthcare equity,” and “health data equity.” They are all quite different and important, so it may not belong in the title because you do not want it to be too wordy, but somewhere in the language, I think separating out health equity from healthcare equity is important. They are obviously related.

**Medell Briggs-Malonson**



Yes, they are. I will also say I love that you added data. I tend to call it data justice, and so, health equity, healthcare equity, and data justice, because there are some nuances of even equity and justice when it comes to how we use data as well.

**Steven Lane**

This just adds a whole other dimension, right? And it could be applied to any of them, the health, the healthcare, or the data, so maybe it is just equity and justice as it applies to all three.

**Medell Briggs-Malonson**

That would be good, yes, absolutely. So, we are taking all of these recommendations. I do not want to spend too much time. I really appreciate your thoughts and contributions to this. So, it sounds like we have a new title, “design and use of technologies that advance health equity and justice,” and we can put all those various different items, health equity, healthcare equity, data justice, or health, healthcare, data, and it is all underneath equity and justice. So, we will refine that a bit more, so thank you all for that.

**Steven Lane**

I would continue to say “health data” as opposed to simply “data” because otherwise, our scope just gets too unimaginable.

**Medell Briggs-Malonson**

Very true. All right, wonderful. So, we are going to go through some of the various topics and begin our crosswalk as well, and when we first get to health equity by design, we were discussing the various different efforts to promote equity as the core design feature of health IT initiatives, both in terms of our systems and our initiatives, and making sure that we are very intentional in how we are building out the various different infrastructures, making sure that we do not have any unintentional biases that are built into those designs, and I would also say that people understand how to use this technology as well, and so, the opportunity, again, is to continue to promote health equity by design and health IT initiatives.

So, I wanted to see where we all thought in terms of building out this topic for proposed recommended HITAC activities. There is a lot that is in here that I think we can just unpack, and I think some of the other topics feed back up into health equity by design when we are thinking about how we are doing appropriate data collection as well as using that health data appropriately, as well as the interoperability for all of our social drivers of health. So, first, at least for the first topic, I just wanted to see what some of those recommended HITAC activities are that we think as a group that we should highlight.

**Steven Lane**

I would say one thing that comes to mind is, again, the health IT certification program, and as you say, the equity was not a factor when that program was first developed, and it can be added on as a factor, potentially, in some or all of the requirements of certification. I am reminded that I recently had to fill out an application to be on a committee, and we added to the application a question about equity and diversity for the applicants, and we said, “And, in addition to telling us all about your background, tell us about how you will contribute to equity, diversity, and inclusion through this committee,” and we can do the same thing in the certification program. “Tell us how this certification concept or topic is designed to promote equity.”





And the first round could just be exploratory, just see what vendors say about that, and then, over time, through that process, developing some set of standards where this set of certification criteria actually could impact equity as we have described it, and we could actually create requirements in that area. I think those would be HITAC activities in particular, looking at the certification program of where equity could be identified as a factor and potentially included in the future.

**Medell Briggs-Malonson**

I really like that, Steven, and one of the things that I have actually done in my institution in multiple areas is not only how does this technology advance equity, diversity, and inclusion, but what I always like to tell people is also, what have you done in the creation of your technology to ensure that there is no exclusion of any more vulnerable or under-resourced population, so what have you done in your technology in order to ensure that it is inclusive by design? And so, that is another way of actually switching it because some of the technology, just as you are mentioning, may advance and promote it, but there are some technologies that, by the way they are developed, are just operational, but we want to make sure there are no unintended consequences, and by doing those equity checks, even in the design, it helps it to be more robust and inclusive as well.

**Steven Lane**

And then, also looking over time at metrics, just like we were talking about, metrics regarding interoperability and its success. Once we can define where technology can impact equity positively or negatively, looking at developing some metrics to actually check that and see how we can make progress over time.

**Medell Briggs-Malonson**

Correct.

**Jim Jirjis**

Yeah. Steve, I concur. It is Jim Jirjis. I was thinking about addressing through certification health equity's proper place in defining how these two should work in one step, but having metrics to say how you would assess an organization's health IT systems in a practical way without unintended consequences to grade where they are on their journey to deploy some defined practices around health equity. It sounds like it is easier to say than actually to develop those metrics, but maybe those who are close to it feel differently.

**Medell Briggs-Malonson**

Jim, I would say it is almost at the same level of quality. Equity is part of quality, period, except you are adding on some additional dimensions for the social drivers of health and thinking about individuals and who they are, but already, I think we have a fair number of ideas of how we can develop such metrics and how that can be incorporated into all of our health IT systems, just starting from the basics, and then we continue to evolve the same way that we have done in other areas. So, with metrics, I completely agree, and so, I triple agree with that that it is important for us to do in this piece.

**Eliei Oliveira**

One thing I wanted to add, Medell, is that when I am thinking about this, my mind goes to electronic health record systems and what sort of inequities may be created by the users, by providers, and all that, but then, the other core aspect is what we were just talking about a minute ago in terms of patient access to the information and all the apps that are going to come about now with the FHIR APIs, and then, how we





guarantee that there is equity there, because now, it is outside of the walls of the healthcare providers that have some regulatory requirements, so I do not think there is much there. I think we are saying yes, it is going to be available, patients are going to get easy access to their data to be able to share with others, but how do we guarantee equity? So, I think that might be an area of activity to recommend how ONC would maybe provide some oversight to that patient access.

**Medell Briggs-Malonson**

Agreed, and again, holding some of our app developers accountable for ensuring that all of these various different apps and other platforms are accessible to all, so, really good point there too.

**Eliei Oliveira**

Jim, one thing I was going to add is that one thing I learned well on that specific step of getting data in the hand of the patient, even from the previous secretary of health and some ONC coordinators directly, is that some of the app ecosystems are going to literally move data from a covered entity to the patient directly, and at that point, it is not under HIPAA anymore, it is under the FTC regulation, and that creates a challenge when [inaudible] [00:48:14] be able to provide some oversight to that app interaction with patients directly. So, there are all sorts of questions that are related to that patient access and equity, in my mind.

**Medell Briggs-Malonson**

Jim, your hand was up. Did you take that down?

**Jim Jirjis**

I did because I do not know if I am going out of order. Are you asking about any of these? I have a comment about algorithm bias, and I cannot remember if you asked for comments on all four of these or if we are going one by one.

**Medell Briggs-Malonson**

No, wonderful transition. We are going to keep on going down. So, I just want to recap this. What we heard a little bit is about certification of our health IT systems, No. 1, to ensure that as part of the certification, really exploring what are you doing in order to advance health equity and justice, but also, we discussed the design of new health IT systems, making sure that they are not unintentionally exclusionary and that they take on an inclusive design from the very beginning, and really thinking about some of our under-resourced and vulnerable populations, but then, we also discussed having metrics as part of that certification, and Eliei was just mentioning, again, outside of just some of the standard health IT systems, another piece of this will be for some our applications that ONC can possibly weigh in on how we can ensure, once again, very broad accessibility by diverse populations in general for some of the new apps and platforms that are coming out. Did I capture that really quickly, just to summarize? Awesome, love it.

So, let's keep on going really quickly into all of them because we know we are up against time. So, inequities in data collection. This is just in terms of inequities in data availability and use that often stem from inequities of data collection when collected health equity-related data is often collected inconsistently among and within sources. So, really, one of the challenges is that without, of course, consistent collection of health equity data, it is difficult to identify disparities in healthcare, and we need more industry standards on the appropriate collection of health. We will open up for discussion of proposed recommendations. Any thoughts?





**Steven Lane**

Just including the metrics and monitoring once we have those standards.

**Medell Briggs-Malonson**

Yes, metrics and monitoring, and this is an area that is very near and dear to my heart because I like to call myself a data nerd, and when it comes to doing anything with advancing equity, you have to have the appropriate data, so I do think having those recommendations of industry standards of how to collect patient-reported demographic information of race, ethnicity, gender identity, sexual orientation language as well as even faith, especially in some of our facilities, is critical, and having that standardized in a way that does not just overgeneralize our patients, which is historically what we have done, but really making sure that we are recognizing the diversity within each one of our various different racial, ethnic, and other demographic groups is, I think, very important as well, so, having some of those standards to collect that in addition to what we have already been working on with Gravity Project and others, a lot of our standardization of our social drivers of health information so that we have better analytic power, but also, we have better interoperability power as well.

**Steven Lane**

There is a sub-piece of this that I have been dealing with recently, which is this notion of data enrichment or enhancement when you have key pieces of data available from one source that can then be combined with data from another source to create a richer data set. I think it falls into this category. Clearly, the health data utilities and HIEs had some experience and success with that earlier in the pandemic, or the endemic, as you called it, Medell, and I think it is just something we should call out. Where are there identifying and exploring opportunities for data enrichment when these data are coming from various sources?

Whether we are talking about race, ethnicity, and language, whether we are talking about social drivers of health, all of that, being able to combine that because of course, so much of the health data, the clinical data, is coming from systems that may not have all of that richness or may not have it available, bringing that together from multiple sources, and then making it available back to the sources that may lack its access. And of course, as we have acknowledged previously, a lot of these social drivers change over time, sometimes very rapidly, and thinking about these as very dynamic data, like a blood pressure that could be different on Tuesday than it was on Monday if somebody loses their housing, income, or what have you.

**Medell Briggs-Malonson**

Absolutely.

**Eliel Oliveira**

I want to add two quick things, Medell. One is that I believe there is a challenge in terms of incentives for data capture. We see that data capture for codes that have attached directly to reimbursement by payers get captured using the right standards the right way, while the ones that do not, not necessarily the best example to give, is labs, and we talked about this more in previous calls that **[inaudible] [00:53:58]**. The codes are all there, but folks come up with their own, and it is messy. The same is likely going to start happening with other things if these standards are not attached to the data capture, so that is one thing I wanted to point out. The second one is that we are capturing data often in English, and I keep hearing from communities that we deal with that they do not have a way to understand. From Vietnamese, from





Ukrainians, from even Spanish speakers, I keep hearing on that, and I think the technology is out there, and we could make some inroads in maybe setting up the standards on how this gets translated for all individuals to reach health equity.

**Medell Briggs-Malonson**

Agreed. Language alignment is something that is completely buoyed in many of our systems, that we do need to really consider and make strong recommendations of how we do so because the technology is out there, but how do we make sure that we incorporate it nationwide? Yes. Wonderful pieces. Any other additions for inequities in data collection? And welcome, Aaron, and be safe, Bocchini.

**Aaron Miri**

Thank you.

**Medell Briggs-Malonson**

Any other recommendations? Okay, let's keep on going with the electronic exchange of health equity and social determinants or social drivers of health data. Everyone can read some of the gaps, so I will not go over them, but the idea or at least the opportunity was to promote best practices for the electronic exchange of health-equity and social-driver-of-health data, and we kind of spoke about that, about how we know we have various different databases or systems that may contain some information that others may not, and how do we ensure that No. 1, all of our systems are updated within individual social drivers, but also that we can incorporate them and integrate them as much as possible? So, again, opening it up for recommendations for this piece.

**Eliel Oliveira**

I think the same comment that I just made, Medell. I think we have the opportunity here to do it right in the beginning. Like with the example I gave on labs, now that we are here, when we try to normalize labs across health systems, it is a monumental task and is very expensive. Since now, we are trying to capture SDOH data, we have the opportunity to make sure that is done the right way, but there are no incentives in place for that to be done, and I think that is going to lead us to some challenges down the road, just like we [inaudible] [00:56:49] data.

**Medell Briggs-Malonson**

Right. So really, starting with that foundation of how the exchange should occur between all of these various different elements.

**Steven Lane**

But also, as Eliel said, looking at incentivization opportunities through ONC, CMS, CDC, etc. Well, CDC does not need money, but CMS, at least.

**Medell Briggs-Malonson**

My only other quick question that I want to throw out to you all is that we, of course, are now embracing a lot of our vulnerability index scores into our health electronic records systems, whether it is the Social Vulnerability Index, Area Deprivation, out here in California, we have the Healthy Places Index scores. Is this a space for us to also consider that, of really stating that when we are thinking about the social drivers, we may not know an individual's exact social drivers, but setting up new standards of the incorporation and





integration of these various different indices that we do have accessible, and many of them are publicly accessible, in order to incorporate so that we have a greater understanding, at least, of the community that an individual is coming from, so using that community proxy. So, do you all think that this is a nice space for that area as well in order to try to start building the foundation and pushing this along?

**Steven Lane**

Sounds like it. I think you know a lot more about this than the rest of us. Tell me again what the terminology was that was used to describe that family of scores.

**Medell Briggs-Malonson**

They are all called the vulnerability indices. Nationwide, there are two for sure, Social Vulnerability Index score, as well as the Area Deprivation Index score, and then, some of the regions and states have different ones, but the Social Vulnerability Index score is a score that was created by the CDC to assess a community's vulnerability for emergency reaction and preparedness, but several of us have started to use these indices in order to identify the state of one's community because it includes multiple different factors and domains, such as the built environment, how many people in the community use public transportation, the racial/ethnic makeup, the language that is spoken in that community, and the socioeconomic status, of course, so it just gives you a clear idea of the level of vulnerability that an individual is coming from, and most of them are built off of census tracts as well.

So, this has been completely validated, especially the SVI, and used by the CDC for a long period of time, and it is something that many of us in the health equity space have already integrated into our health electronic records systems in order to serve as an additional tool to address the social drivers for all of our individual patients and our patients as a whole as well.

**Steven Lane**

Great. Thank you for that.

**Medell Briggs-Malonson**

You are welcome. So, I would just recommend that that is something for us to explore how we can actually start incorporating some of these vulnerability indices almost as part of the standards when we are thinking about one's community and looking at the social drivers of health.

**Aaron Miri**

Yeah, and Medell, also, to comment on that, it would be interesting to look across all the states and say what are unique variabilities there in those determinants that are being captured. Case in point, here in Florida, there are specific demographics, such as racial, ethnic, and household demographics, that we are required to report to the state now based upon state law, which is interesting. I think every state has some variability, like what you just said in California, so that would be something from a landscape perspective. I am not even sure all of us know what those varying items are, and whether there can be a holistic view of it. I think it is an interesting point.

**Medell Briggs-Malonson**





Great. It would be wonderful to see, nationwide, all of the different additional indices in each one of the states. So, moving on with time, I know that we are coming up to our public comment in a few, but I wanted to take a look at algorithm bias as well, and Jim, I know that you had some comments on algorithm bias.

**Jim Jirjis**

Yeah, thank you. The only comment I was going to make is that I know that the FDA was looking into this whole area of algorithms themselves, artificial intelligence and otherwise, machine learning, and whether or not those were medical devices that need to be FDA-approved. I do not know where that landed. We talked to the head of the Digital Health Service at FDA about this, worried that it would slow down the wheels of innovation if every single algorithm change had to be, again, FDA-approved. But within the context of that discussion, they had talked about evaluating developers, people who develop algorithms, instead of evaluating each algorithm, evaluating best practices, and one of the best practices was having an agreed-upon approach to evaluate for algorithm bias. And so, I am just curious. Is that something where we would encourage the FDA to continue to pursue, or is that something that ONC has a role in? Those were my thoughts and observations.

**Aaron Miri**

Just as a matter of order, I would caution this committee to be careful how we word that. I think it is good to investigate, but recommending to other agencies may be difficult, and I do not want to over-speak my term here, but our goal to advise the ONC on what to do... Maybe it is a partnership or a listening session. That is the kind of language we used in previous reports. I am not discounting what you are saying, but I think we should be careful how we state that so that we stay within the charge of 21st Century CURES.

**Medell Briggs-Malonson**

All of those comments are all very important as well, and so, yes, thinking about trying to see what others are doing, especially in the AI space, but then, we also have the other piece of algorithm bias, and especially with some of our racialized algorithms that we know have actually perpetuated health inequities, especially racial inequities, within our current systems. One perfect example is the EGFR, and many, of course, are looking at PFTs as well that actually have race that is incorporated into these clinical algorithms that we tend to use on a daily basis, as well as things such as race and sometimes inappropriate uses of other demographic identities in order to make clinical decisions.

And so, it seems like from all of that, understanding FDA and ONC, almost having a listening discussion to understand what their approaches are currently with all of the preventing unintentional bias in our AI systems and machine learning, but then, also creating some set of tools, best practices, or recommendations when it comes to how to appropriately address racialized clinical algorithms and clinical decision-making tools that we now know have clearly perpetuated racial and sometimes even gender or health inequities, so that is another piece of this as well. Any other thoughts about algorithm bias?

**Aaron Miri**

I do wonder if there is also the element in here around the FTC. I have seen a lot of uptick around them wanting to step up enforcement, and they are asking for more ammunition, per se, from a policy perspective to be able to enforce more around deceptive trade practices. I wonder if there is an FTC angle here too around AI and combating algorithm bias based upon deceptive trade practices. I am not a lawyer, but it





would be interesting to hear from them what they are doing to crack down on the mom-and-pop app written in wherever that is inappropriately using data or has introduced bias into decision making.

**Medell Briggs-Malonson**

Absolutely. Any other thoughts? This has been a great conversation so far. Okay, well, if there are no other thoughts, we are going to move on to the next piece of the crosswalk. And so, now we have concluded the health equity target area, and moving more into our public health area, and so, we will see how much we can get through of these various different topics. So, the first one is public health data systems in terms of the infrastructure. And so, what this first topic was really looking at was addressing some of the gaps that impede sharing of data that is critical in order to support our public health. And so, the opportunity is how we think about bidirectional exchange of health information as well as public health information and data between not only our healthcare providers, but also our public health entities as well. So, any thoughts about what we can propose for additional HITAC activities?

**Steven Lane**

My feeling here is that there is real progress being made. There is a new workgroup that has been stood up that is just starting this effort or contributing to this effort. I do not know that we need to do anything more than say, "Good job, keep it up" unless we can identify specific things that we think are currently out of scope of the current CDC and ONC efforts in this regard.

**Aaron Miri**

That is a good point, Steven. To the point of it, that workgroup, though, is going at warp speed, so we should have some recommendations in the next several weeks that will probably inform this topic area, and I am sure there will be gaps.

**Steven Lane**

There will be leftovers, right?

**Aaron Miri**

Right, thank you, that is a better word, leftovers. Exactly. I think you are right on that maybe we pause, let that play out, see what comes out of it, and go from there. Maybe that is a good recommendation.

**Medell Briggs-Malonson**

Great. So, we are going to pause a little bit until some of that work has concluded, and then we can take their leftovers and say, "These are some additional areas that we need to explore."

**Aaron Miri**

Right. I guess a politically correct way to say it is we want to be complementary of those efforts, so we are going to do some complementary surrounding efforts. There you go.

**Medell Briggs-Malonson**

Great. Any other recommendations for this topic? No hands have gone up, so let's continue moving on. The electronic case reporting: This was something that we wanted to expand a bit more during our last meeting because initially, it was looking at, for instance, long COVID only. Now that we are entering into, again, various different phases of our public health, and especially we are in an endemic, and there is





monkeypox and all these other emerging diseases, really making sure that we can think about the infrastructure that is needed for not only electronic case reporting, but also for initial case reporting as well.

And so, really, the opportunity here is the expansion and adoption to support electronic case reporting by public health organizations as well as overall healthcare providers and health IT because we have many lessons learned from the past and current situations that we have been in, and really making sure that our standards are there so that as we continue to address emerging conditions and various different entities, we can respond to them in an appropriate way. So, proposed recommendations? Any thoughts about this one?

### **Steven Lane**

I am a huge proponent of ECR. I think it is great, and it is working, and it really needs to be expanded, both at the level of the reporters in terms of getting all the right alignment, and that is coming with CMS requirements, etc., but getting providers, labs, and others engaged in getting the ECR functionality up and running, and then looking at opportunities with the recipients not only at APHL, but the actual downstream public health jurisdictions, and doing everything we can to support them in updating their technology so that they can actually take advantage of this, receive it, utilize it in lieu of manual case reporting. We are just starting to see that needle move here in California. Very exciting, but I think there are a lot of spots around the country where that is still yet to be done. I think that the Public Health Taskforce and the idea of public health data system certification may be able to help move that along, but we need to stay on this one.

And then, the other point here is the notion of standards, that within the ISA, there are standards identified, but they are not required by either EHR certification, and certainly not by public health certification, since that does not exist yet, but the idea that we should really start moving increasingly towards the requirement of the use of the existing technical standards, and that includes bidirectional exchange. That includes not only the EICR, as you said, the initial case report, but also the bidirectional, the exchange, the return of the reportability response, and as we get that up and running and actually see its use more broadly in the community, it will become more and more valuable, and it will become a vehicle for meaningful information to come back from public health to reporters to inform the care and follow-up of the patient.

So, I think there are huge opportunities here. As you say, it is not just about emerging infections. There is a long list of reportable conditions that we are all responsible for reporting. We do a terrible job at it. It would be great to see this move forward, and then, again, metrics, and monitoring, and closing those gaps over time to improve that exchange. The other point I will make is we have ECR and ELR, but we do not have syndromic surveillance up here, and we may want to consider that. Syndromic surveillance is now limited implementation, mostly in emergency departments, but certainly there are opportunities to expand that, to encourage its use, both in the hospital setting, but also in the urgent care setting and the primary care setting, where these same syndromes are being identified early on. If you want to get those early warning signs of emerging diseases, I think we need to look beyond the ED. Again, that would be an add-on as sort of the third leg of the stool of public health reporting, but one that is notable in its absence.

### **Aaron Miri**

Steven, I want to echo that, because wasn't there a recent news article where somebody evaluated and was publishing that, in fact, doctors' offices communicating with public health is so rare? That is what you are talking about right there.



**Steven Lane**

Until you automate ECR, it is going to be incredibly rare, and once you automate ECR, it will be just as easy to automate syndromic surveillance. It will just be a different set of trigger codes.

**Medell Briggs-Malonson**

I think that is brilliant, and in fact, just overall electronic public health reporting, where we can have the case as well as the labs and the syndromic all together, maybe that is what the new topic is because they all go hand in hand in more ways than one, so I think that is a really important piece that you brought up.

**Steven Lane**

Maybe you combine those. Those two in the middle become a one about public health reporting and exchange because I want to make sure we capture the bidirectional and then have sub-items of ECR, ELR, and syndromic surveillance, so then we have infrastructural reporting and the informatics workforce. Sorry, Aaron.

**Aaron Miri**

That is okay. So, one thing I think would be also part of this workgroup that we have done in prior years is illuminate areas that we all need to become more informed on, and so, another area, I think, related to ECR, ELR, and all of those is what is the adoption rate outside of the acute care setting? I do not hear a lot about LTACs, rehab, all of those downstream who see and receive patients who could present with various conditions and what their mechanism of reporting is. I think there is a really great discussion here that needs to be had that we continue to come on themes on, which is we have largely ignored the secondary market within healthcare. We focus so much on the acute care setting. Being in a large tertiary care health system myself, I get it, but most people receive care outside of the hospital, so what does that uptick look like, and what is the state of the industry around that? It has been over years since COVID happened. What did we learn? I would speculate personally with no information that it is probably not that much in that space, and that is sad, so how can we help them?

**Steven Lane**

Aaron, you mentioned LTPAC as a potential source of this reporting, but of course, home care, therapies, community-based services, telemedicine, as we were discussing before you joined us. There are so many places where patients receive care and services where we could increase the signal here beyond, as you say, the acute care setting.

**Aaron Miri**

Bingo. Well said.

**Elie Oliveira**

I agree, Aaron, and I was going to add a point, maybe on the HITAC activity. Honestly, maybe we should suggest a recommendation to have drills and test runs of these ecosystems. We cannot afford to be in another situation like this pandemic, and by doing that, maybe we will try out exactly those organizations that you mentioned a few of. We could add pharmacies or other places that need to be involved in the process. We cannot get to another emergency to then figure out what we need to do at that point.



**Medell Briggs-Malonson**

Really. Those are really all great points, all spot on. And so, really making sure that we stop ignoring all of our non-acute facilities and we bring them directly on into the situation as well. So, all really wonderful. So, hopefully, our team has captured this and we can try to figure out how to streamline this when we are discussing that. And so, also, for the ONC team, please just let us know when it is time to transition to public comment as well. I am more than happy to do that. And then, the last piece here, we have public health informatics workforce, and really taking a look at challenges remaining to establishing and maintaining a well-equipped public health workforce with the opportunities of how do we improve all of our health IT and general capabilities and capacity to support the workforce.

**Jim Jirjis**

I know that in a perfect world, we would all have what standard we want people to adopt, other public health agencies, etc., and then the funding for the personnel and the technologies would come, but my understanding from the Biden administration a year or two ago was that there was funding for both personnel and technical investments for public health departments. Do we know if that happened? And then, No. 2, we have workforce, but do we also need to address whether there needs to be funding for actual technology itself?

**Aaron Miri**

Good questions. We have to research that. Those are good questions.

**Jim Jirjis**

Our fear is that they have money, they are now going to be able to invest in IT as well as personnel, and we will just have far more sophisticated silos. If we were going to define a standard of what we wanted people to do and address the workforce, maybe we should add a row or add within the workforce row also “and technology investments.” Just a thought.

**Aaron Miri**

Or technology training. Maybe it is not necessarily investments. How to use tools differently if that workforce is not equipped for that. Something to that degree, but it would be good to know what is going on. A lot of money has gone out into the workforce. ONC gave, what, \$80 million last year? So, we know money is going out. What has been the fruit of that money spent?

**Jim Jirjis**

That is it. But what I mean is the right training on it and stuff, but don't these public health departments also need funding to actually make technology investments? From our experience, some of them are almost back in the stone age with where they are with their architectures.

**Aaron Miri**

Absolutely. I do not know if Ike is on. He could speak to it directly. I could tell you from firsthand experience dealing with Austin Public Health and Texas Department of Health that they do their best, but they are operating on 1970s mainframes. It is what it is, right? They have been underinvested. So, I totally get it.

**Medell Briggs-Malonson**





And Jim, I was thinking that same thing while you were speaking. They are such a critical, critical workforce, but there has been underinvestment, and there has been lack of modernization of some of those technologies. And so, it would be quite interesting, so now, with this infusion of money, where are we now in the situation, and do we still need additional investments to make sure that even as we expand this highly equipped workforce that they have all the tools in order to do the jobs and the tasks that they are responsible for? So, it seems like an exploratory type of assessment of the current situation. Any other thoughts?

### **Eliei Oliveira**

Not specifically to this. I think this is a very important line, and yes, the technology gaps as well need to be addressed. Not to go back in time to what we just talked about, but I feel like for health equity, the same line applies, but not for the informatics workforce, but for the community health workforce. There is a big gap there. We are not going to be able to achieve health equity if we do not attend also to a workforce that can help with social determinants of health. So, I do not know if that is just adding more to a longer-growing list of things, but I think health equity is a major topic, and this workforce is also important there.

### **Medell Briggs-Malonson**

Absolutely. You know I agree in every way. And so, a lot of the work that is needed is truly on the ground in the community, and so, really making sure that we do have that infusion of support and funds, but then, also, even their IT capabilities, it goes hand in hand with what we are talking about right here as well. So, yes, we have to think about if we want to include that in some of our other topics as well about workforce expansion and making sure we are equipping that workforce as well. Okay, any other thoughts or comments about public health? And yes, we are going to get to public comment in approximately two minutes, so we may have an opportunity to go and actually explore one additional topic, so let's go to the next page, and we are entering into interoperability.

So, streamlining of health information. We sort of had a conversation about this before with the new topics that we decided to incorporate into the report, but this one in particular was really just looking at how we ensure that the adoption continues to grow interoperability between various different systems, and so, how the opportunity of leveraging TEFCA to advance interoperability and reduce the number of methods of electronic exchange that health organizations need to use in order to have a complete record system. So, recommendations, thoughts here?

### **Steven Lane**

Well, it is interesting, the term "leverage." Obviously, the whole industry is going to be trying to figure out how to make TEFCA work and what it is going to do. I think the activity for HITAC really is to stay engaged in that, to monitor that, to see and track very closely how we are doing with QHIN determination. I think that is the verb they are using; I am not sure. But, QHIN identification, onboarding, actually starting to see data move, looking at use cases, looking at participants. There is so much about getting TEFCA up and running, and getting traction, and seeing how CMS, CDC, or others require its use.

I just really think this is something that HITAC should be closely involved in. It should be a standing agenda item for us to get a TEFCA update from the ONC participants in the RCE effort because "leverage" is just so vague to me. And then, I think we should be looking for opportunities to throw HITAC recommendations onto... CMS has made some proposals about how they are going to be encouraging the use of TEFCA just broadly. "Yes, I am doing TEFCA exchange," check the box for promoting interoperability. But, what about





particulars? What about quality reporting? Where is that going to go? I think HITAC is in a great position to engage in a detailed way.

**Medell Briggs-Malonson**

Excellent. Agreed. Any other thoughts in addition to that, of really making sure that we are more focused in this area?

**Aaron Miri**

Medell, I apologize for interrupting. Just from a time check, I think we are at time for public comment, so maybe we should go there and come back.

**Medell Briggs-Malonson**

That sounds wonderful. Thank you for keeping us on time.

**Aaron Miri**

Yes, ma'am.

**Medell Briggs-Malonson**

So, we will transition. Mike, I will turn it over to you for public comment.

**Public Comment (01:24:11)**

**Michael Berry**

All right, thank you, Medell, and we are going to open up our meeting for public comment. If you are on Zoom and would like to make a comment, please use the hand raise function, which is located on the Zoom toolbar at the bottom of your screen. If you happen to be on the phone only, press \*9 to raise your hand, and once called upon, press \*6 to mute and unmute your line. So, we will pause to see if anyone raises their hand. Not seeing any hands raised, Medell, I will turn it back to you.

**Medell Briggs-Malonson**

Thank you so much, Mike. We will go back to the past slide, then. Steven, you were just wrapping up some of your various different comments. I just wanted to see if there were any other last pieces, and if not, we will have to table the rest of our discussion into the next meeting. So, any other last-minute comments, questions, or additions that any of the workgroup members would like to add?

**Steven Lane**

I just wonder if there is more in this item that we were looking at, the streamlining of health information exchange. Hans's initial suggestion was something he called "record completeness," and it looks like it has really headed off in a different direction with regard to supporting TEFCFA, so when we do meet next, I think we should start here and try to dig down into that, see if we can identify any more of the history of this item and what Hans was initially suggesting, perhaps.

**Medell Briggs-Malonson**

Great, wonderful.

**Eliei Oliveira**





The question I have, Medell, is the discussion that we just had is kind of capturing the activities column, or is that something that we want to propose, that some of those activities offline that can be added there? How are we completing the metrics?

**Medell Briggs-Malonson**

Yes, and I am going to have my cochair also just chime in as well, since he is definitely a veteran of this process, but at least from my understanding, what is happening is that we are capturing all of the discussion that we are having today, and then, all of our ONC team, which is also led by Michelle Murray, will help to populate some of those different recommendations, and we can then review it as well prior to taking it back to the HITAC full committee. Aaron, any other thoughts or explanation for Eliel?

**Aaron Miri**

I was trying to get off mute. No, I think you said it just perfectly.

**Medell Briggs-Malonson**

I have been taught well.

**Aaron Miri**

Yes, ma'am. You are doing good.

**Medell Briggs-Malonson**

Yes, it is my first time too, Eliel, so we are in this together in that regard.

**Steven Lane**

Medell and Aaron, I am just curious. Was this about as far as you expected us to get today, or did you expect us to get further or not this far?

**Medell Briggs-Malonson**

Steven, great question. We had a lot of topics to discuss, and we had those new topics that were proposed by HITAC, so we were trying to get through as much as we could. I was hoping that we could have at least gotten through interoperability, and we would only have one fewer target area to go through, but I think that during our next meeting, we will probably be able to zip through the others pretty quickly.

**Steven Lane**

Yeah, I think we made great progress, personally. I cannot wait to see how the team captured all the comments and how they flesh out the document, and I think getting through interoperability, privacy security, and patient access next time should be great.

**Medell Briggs-Malonson**

Yes. Wonderful. Any other last comments?

**Steven Lane**

Great job, cochairs.

**Medell Briggs-Malonson**





Well, we appreciate all of your contributions as well, and so, again, thank you again for everyone being here and being so engaged, and thank you as well for our entire ONC team, and we will reconvene next month in order to finish off these last pieces. So, thank you all again, and everyone have a wonderful day.

**Aaron Miri**

Bye, all.

**Eliei Oliveira**

Thanks, everybody. Bye.

**Medell Briggs-Malonson**

Bye.

**Next Steps and Adjourn (01:27:58)**

