Transcript

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

November 3, 2022, 3 – 4:30 PM ET

VIRTUAL

Speakers

Name	Organization	Role
Medell Briggs-Malonson	**UCLA Health**	**Co-Chair**
Aaron Miri	**Baptist Health**	**Co-Chair**
Jim Jirjis	HCA Healthcare	Member
Steven Lane	Health Gorilla	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 (00:00:05)

Mike Berry
Hello, everyone. Thank you for joining the HITAC annual report workgroup. I am pleased to welcome our co-chairs, Medell Briggs-Malonson as well as Aaron Miri along with our workgroup member, Eliel Oliveira. Shortly we are hoping that Stephen Lane and Jim Jirjis will also be able to join us today. Your comments are always welcome, which can be typed in the chat feature of Zoom or could be made verbally during the public comment later in our meeting. Now I would like to turn it over for Aaron and Medell for their opening remarks.

Aaron Miri
Medell, do you want to go first?

Opening Remarks, Meeting Schedules, and Next Steps (00:00:38)

Medell Briggs-Malonson
Sure. Good afternoon, everyone. Such a pleasure to have the workgroup back together. One of the things we are going to do is quickly go over the agenda, and then Aaron will walk us through the schedule of all our upcoming meetings. Then we will go back into some of the key objectives that we need to focus on for today's meeting. We will try to be as efficient as possible, just given the different content we want to review. So, we are going to first start off a discussion of the crosswalk of topics, followed by the discussion of our Illustrative Stories. Then we will open up for public comment before we close and adjourn the meeting. Aaron, would you like to walk us through the upcoming meetings?

Aaron Miri
Absolutely. Let us go on to the next slide, please. We are here with the November 3 meeting today. We will go through this. We have another meeting December 1. I cannot believe it is the end of the year, to be perfectly honest with you, so here we are. In the springtime, of course, wrapping this up for approval with the HITAC and then transmitting sometime in the late wintertime/early springtime timeframe there. Next slide.

For the full committee, we will talk about on the 10th where we are. Last HITAC, I sort of just gave an overview at a really high level. They will review the draft in January and then approval in February. As has been par for course in prior years, there tends to be a lot of good comments that come in towards the end, so we will continue to, please, try to get more comments earlier. After the cutoff at the end of the year, it kind of has to go in a parking lot for the following report. So, the next HITAC, we will really be trying to push team members to come up with any suggestions or ideas now, so we are not at the last minute trying to incorporate and shoehorn in great comments. We want to be inclusive of all. Next slide. I think this is your slide, right Medell? No?

Medell Briggs-Malonson
No, you can talk about the next steps, I guess.

Aaron Miri
So next steps here for development, obviously we want to keep refining this. The crosswalk today, we'll talk about discussion on the 10th meeting, and then reviewing the draft and the upcoming groups in HITAC in 2023. Next slide. Now this is yours. There we go.

Discussion of Draft Crosswalk of Topics for the HITAC Annual Report for FY22 (00:02:52)

Medell Briggs-Malonson
Now, here we go. One of the things we wanted to make clear during this meeting is really focus on the key objectives we want to get accomplished by today's end. The areas we are going to focus on today is reviewing the last two sections of the crosswalk, which is privacy and security, as well as patient access to information. But there is a new section of this crosswalk, as well, that we as workgroup do need to review, which is the new recurring topics section. Aaron and I both want to thank you, Eliel, as well as the rest of the workgroup members, and especially the ONC team for all the various different comments that have gone directly into this crosswalk. We hope to be able to go through this crosswalk relatively quickly, but really making sure that we still highlight any additions that we may need.

Following review of the crosswalk and the new recurring's topic section, then it is time to prioritize each one of the topics. We will prioritize each topics for both immediate implementation or long-term implementation. We just want to make sure we have everyone's feedback on that. And last but not least, we will review all of the Illustrative Stories, which will then be incorporated into the executive summary. Why don't we go ahead and get started with the crosswalk. Any questions or comments before we get started, from the group? Ok, seeing none, hearing none, we will go ahead and get started.

Once again, this is an overview of the primary crosswalk with all the various different priority target areas. We will zoom right on down to the privacy and security portion. During our last meeting, we were able to get through a couple of these, but just to refresh everyone's memory, let's just start at the top and go down. The very first area that we did focus on was the alignment of innovation and regulation. This actually does have two different components to it. The very first topic that was there was really focused on thinking about how providers and overall hospital systems are adopting APIs and making sure that that information is protected and that there is no form of unauthorized data exposure.

So, some of the various different opportunities we are thinking of is how do we continue to support and encourage the health IT industry to accelerate innovation in areas where we know we really need to continue to focus on innovation. But making sure that the appropriate regulations and guardrails are in place, and making sure, also, that the laws regarding any type of unauthorized use of APIs are also well integrated and to various different legislation on guardrails. Some of the proposed activities is learn about the federal regulatory activities affecting privacy and security, specifically in the areas of health IT innovation and where it actually pertains to APIs, contained to a course support bill and awareness and education of both patients, providers, innovators, and other stakeholders that are going to be engaged in this work. And further, just define some of those various different guidelines for development of the innovation in order to ensure that it's aligning with our regulation, but then also that it is truly assisting provider organizations in terms of providing greater care and protecting patient data.

So, I will pause there and see if there's any thoughts or comments from the workgroup? Does this capture what we are ready to proceed with?

Aaron Miri
It captures it to me. It makes sense.

Eliel Oliveira

I agree. I did review those a little bit, Medell. I think it covers quite a bit here.

Medell Briggs-Malonson
I agree with the two of you as well. The next section is alignment of innovation of regulation specifically for consent directives. The real challenge that we saw, which is why we wanted to incorporate this, was the ability to exchange computable consent directives across various different health IT systems. It is currently, right now limited, and this has been something we have looked at before with HITAC and wanted to bring it back up this year as well. So, some of this year's proposed recommendations are continue to explore the lessons learned from implementation of consent directly from TEFCA, itself and hold listening sessions to learn more about those methodology, those strategies that are currently underway. So, not create, necessarily, something new but really make sure we are aligning with what some of the other groups are doing and learning what others are also incrementing. Any additions here?

Great. We are going to zip through this.

Aaron Miri
It is spot on.

Medell Briggs-Malonson
Great. I will go to the next two and if there is anything that you all think that we need to add, because I know we did a lot of great homework offline, we can have that opportunity to do so.

So, the next topic, appropriately exchange and use of data. So, the primary challenge of why this topic was presented is currently there is no nationally adopted set of guidelines for exchanging data for the purpose of specifically of payment in healthcare operations. So the idea behind this is that what we can actually hope to advance is the development and adoption of additional guidelines that support improved data segmentation capabilities while also thinking about how to reduce the burden on not only healthcare providers but the healthcare systems overall and all of the healthcare professionals that are working in the space. And really making sure that we are evolving that privacy and that efficiency simultaneously. Some of the recommendations that we have brought to the table is to continue to track the work underway with TEFCA in order to adopt some of those various different use cases that support the exchange of data for payment and operation specifically, and continue, again, to learn from various different colleagues in terms of what the current state is in the existing privacy streamline efforts. And then also, what are some of those best practices to decrease the burden that we know is currently existing in various different areas.

Looks good. I see heads nodding. The last section here is privacy of sensitive health data. This is currently a topic that we have been grappling with, but definitely with some of the various different political changes that we have experienced in our country, we wanted to really center this, as well, so that we are thinking very thoughtfully and strategically through this. So the challenge, in general, was thinking up what the changing legal landscape, it is important to balance protecting this very important, sensitive health information, but also, ensure it is accessible when needed for clinical care and for other appropriate reasons.

So, one of the concerns include using gender information accurately and appropriately for patient matching, but also for accounting to the patient how their sensitive information is currently being disclosed. So, the

opportunity that was identified when looking at this topic is making sure that all stakeholders understand what current privacy protections are currently in place, as well as identifying additional opportunities to improve the technical and operational approaches for protection of that sensitive data, but, of course, also accessing that data when necessary. Some of the recommendations, encourage ONC to provide guidance to the applicability of information blocking exceptions to the exchange of sensitive data including reproductive health data. But then, also taking some steps towards that consistent technical and operational approach to protecting sensitive health data while enabling the exchange, including, now, with even some of our additional new emerging healthcare applications.

Any additions or thoughts on the section?

Aaron Miri
I like this. The only thing I think about in my head is the need to call it the new onset. This is both adult and pediatric, so this is comprehensive. Especially consent, assent, componentry when dealing with pediatrics. That would be the only thing I would maybe add into this. I agree with it all, but maybe call it out directly that it is both populations of patients.

Medell Briggs-Malonson
Great addition. Absolutely.

Eliel Oliveira
Along those same lines, Medell, I think a good point here, is the changing nature of some of these pieces. Individuals may have different perceptions of themselves over time. And that change, somehow, needs to be captured. At the same time, preserving that ability to record linkage that is mentioned here.

Medell Briggs-Malonson
Also another important piece of this, as well. And that is one of areas that we discussed, was that it is not only for individuals that identify as women, but we are now serving a highly gendered diverse population throughout the country. So, we really want to make sure that can, as we know, can actually change over an individual's lifetime. So, as you said, Eliel, just making sure that we are being as thoughtful and comprehensive of as possible. And Aaron, as you mentioned, that we are incorporating both our pediatric and our adult populations.

Aaron Miri
That is right.

Medell Briggs-Malonson
Welcome Steven, great to see you.

Steven Lane
Sorry to be late.

Medell Briggs-Malonson
Great. So, any other additions on this section?

Steven Lane
Can I just ask, Medell, you guys get the comments that I sent in last weekend? Did they make it in?

Medell Briggs-Malonson
Yes, the ONC team absolutely incorporated your comments.

Steven Lane
Perfect. I was trying to keep up with Eliel.

Medell Briggs-Malonson
We all try to. He is pretty speedy.

Steven Lane
It is amazing.

Medell Briggs-Malonson
Wonderful. We can move on to the next page.

Now, moving onto the next topic, this was patient access to information. And we really only have one topic underneath this priority target area. That first topic is patient consolidation of health information from multiple sources. This is an area that we have not had as much time to discuss; but of course offline, with all of us thinking about our homework assignments, really did try to provide some input here. So, the challenge that was initially identified was that overall, there are dilemmas when it comes to patient ability to access, consolidate, and share their health information across multiple sources. Whether it is healthcare providers, payers, portals, and other type of **[inaudible] [00:13:43]** applications. And so, one of the pieces that we are looking at here is that when it comes to patient's health data, it is often located in multiple different fragmented sources and systems. And therefore, it is very difficult for a patient to actually consolidate and track all of their information all into one source.

And there is a lack of applications that are also present to actually consolidate all of that information, but while also thinking about the specific needs of our most under resourced communities. As well as thinking about the needs of our patients when it comes to both cultural and linguistics alignment. So, some of the proposed recommendations that we as the annual workgroup are bringing to the table is, number one, proposing a plan to monitor and assess the successes and challenges with the implementation of 2015 Addition CURES update API criteria. But the second recommendation is exploring additional opportunities to support the development of apps that target the unique needs of both under resourced communities as well as other marginalized populations. And then the third is holding listening sessions on initiatives that have attempted solutions on this front in the past, such as Blue Button 2.0, of course HL7, KAREN Accelerator, and several others. And really kind of learning from them; what were their lessons learned? What were some of their pitfalls, as well, in order to move this work along.

So I will pause here to see if there are any additional comments.

Aaron Miri

I think it is good. Also looking at things like Da Vinci and others, what work they've worked on with API Fyre development. I think all of that, what you are mentioning here, is important. There is a lot of lessons learned. We can even go back to the Health IT Policy committee days, Steven, and pull stuff out of the past of what work we have been doing over the years and decade.

Steven Lane
The other thing that I will add, I think under the gap, we are talking about a single view, kind of assuming here that the patient is just a passive viewer of the data. And really, I think as we move along, we are going to have patients who are enabled with their own apps that really need to be able to see comprehensive data or they might be doing their own analytics. We have patients who are incredibly engaged and knowledgeable. So it is not just about the view. I was just trying to wordsmith a little bit, but the idea of allowing them to bring together their data from multiple sources into a single system or whatever the right word is, but it is more than just a view.

Medell Briggs-Malonson
Agreed. That is a really important point there, too, because one view might be a little bit too limiting, when a patient may want to trend or monitor some aspect of their care in various different ways. So, I agree, really changing and modifying that language there so that it is one of the systems, most likely with various different forms and functionalities, to allow the patients to use their data in the way that is most meaningful to them. That is a really great addition too.

Any other thoughts?

Eliel Oliveira
Medell, to be honest, I do not recall all of the comments that I made. So, if this comment was made to this report or to some of the group that I have been involved with. But a key aspect of this is, you know, based on the Cures Act, the idea that patients getting access to their data and then they then take ownership of that data. And they can share it with whoever they desire to. Which is a different way of doing things than what we have. And, I remember clearly hearing from both the former ONC coordinator, and our HHS director, how that basically moves data from a HIPAA perspective to an FTC perspective. When the data is being given to the patient, just like if you were walking out of the healthcare organization with a stack of paper or a CD-ROM. You can give it to someone else at that point. But it doesn't leave that reliability back to the provider to give the data to you.

As I was working on this in the past, it becomes quite important that there is some kind of framework or legal artifact that helped healthcare organizations to be able to do that and eliminate the risk to them that they are basically handing off access to your data on whatever app you are adopting. But not, you know, creating that fear from healthcare providers that they are now going to be liable for whatever you do with your data. So, moving from the HIPAA to FTC transition, that's something I think I have not seen. I think healthcare providers and app developers can utilize that maybe ONC can help with. Does that make sense?

Medell Briggs-Malonson
It absolutely does. As you all know, I'm an emergency physician. For at least 10 plus years, if not longer, we have always discussed wouldn't it be wonderful if somebody walks in with all of their protected health information. Especially when they come in and they are unable to give us their full medical history, or

whatever that might be. And we can literally take that information and incorporate it into our system, or at least have a viewable only interface to that, so that we can understand who this person, what medical conditions they have, what allergies and actually can provide the best care possible to them, even if they're unable to communicate with us.

So I am taking into indifferent extreme, Eliel, than what you are mentioning. I do not think that we have this and I'm opening it up to the rest of the workgroup, I do not think we have that any other place in our crosswalk about also, again, the true ownership of your own data, and really making sure that you have the ability, as a patient, to give your protected health information to anybody that you feel it is necessary for.

And yes, Steven, I do like the chip, or either barcode, as well. A barcode on the forearm. But that would make it a little dicey **[inaudible – crosstalk] [00:20:09]**

Steven Lane
– have them, right?

Medell Briggs-Malonson
I know, they do. But surely, even if it is on a wristband or a bracelet, that is still an area that it seems we should be able to actualize, at this day and time. And that would accelerate care for so many individuals in more ways than one. So yes, a great point to add there. Maybe our ONC team can assist us in trying to find the best place to wear that may potentially go, as well. Any other wonderful thoughts of ways we can add subcutaneous chips or barcodes to our bodies?

Aaron Miri
No.

Medell Briggs-Malonson
This is why this is the best workgroup. Well, thank you all so much. Not hearing any additions, thank you for all of the thoughtful comments. And now we are going to move onto the next section, which is a new section for this year. One of the things that we have been given as the workgroup as we're going through various different topics, it seems like several topics are recurring. So, we start talking about them every single year. So, it the wonderful idea was brought up to have a recurring topic section so that it is almost like a parking lot, but it is an active parking lot where we can put items that we want to continue to follow and address year to year to year.

So some of those different areas for recurring topics are first landing in the interoperability target area. And so, when it came to interoperability standards, priorities, uses for e-prior authorization, in particular, was one that was the first item placed on the recuring topics. And the challenge that we have continued to experience is the lack of standardized approaches for prior authorization, can lead to a large amount of administrative burden to the healthcare system. But I would also state that it also directly leads to delayed care of patients, as well as worsening patient outcomes because of that. So, e-prior auth is such an important piece that we really need to continue to refine and implement. So, some of the recommendations were to continue to monitor implementation of existing HITAC e-prior authorization recommendations. So, there have been many recommendations in the past, and really trying to make sure that we are staying up to date on where we are with the implementation of those recs. But then also receiving additional updates

from the industry on any other HHS initiatives or other ONC or CMS rules that directly apply to e-prior authorizations.

Any additional thoughts or additions for that topic? Okay.

Aaron Miri
I can't see any.

Eliel Oliveira
I think that group has done a tremendous job. So, yes. **[Inaudible] [00:23:16]**

Medell Briggs-Malonson
Great. So, the next section was directory standards and management. This again has been something that is currently being worked on and has been discussed over some of the past years. So the challenges, we do not necessarily have electronic identifiers or endpoints for various different entities because we still do not have a unified national provider directory. And so, the recommendations are still to explore opportunities and challenges for supporting the adoption of a national directory, and how to actually manage that directory so it stays up to date and is accurate and is not too unwieldy and it really is achieving the objectives that we would want it to achieve. So, that would be part of about recommendations to continue to understand what is occurring and whatever best practices are out there that we can apply.

Steven Lane
Just because there are a lot of different types of things that can be put into a directory; if we are talking specifically about provider directory, I would highlight that in the topic title.

Medell Briggs-Malonson
Great point.

Aaron Miri
The only thing I would say is that I know there is a bunch of other initiatives around directory services, and whatever else, I want to say coming out of CMS. I could be wrong. So, how does that correlate and overlap? What is the intersection point? Again, I think more listening and learning from other agencies, what they are working on, because there have been several initiatives to try to do this over the years and –

Steven Lane
CMS did look for input about directory. They have got an open --

Aaron Miri
Yes, that is right. Them and somebody else, too, my memory is escaping me. There have been a couple of major attempts recently and some learnings from there.

Eliel Oliveira
That is exactly going to be my point, that I got the IFI from CMS to respond to exactly on this line.

Medell Briggs-Malonson

All right. So, definitely, there is some other work that is stirring, so making sure that we follow up with where all of our other colleagues and stakeholders are on this topic.

Aaron Miri
So, maybe invite them in for a listening session there, as well. What have they learned?

Medell Briggs-Malonson
Yes, exactly. That sounds great. And then the last one is standards for patient matching. This was also moved down to the recuring topics due to the constant evolution of thought and strategies behind this. The challenge, as we know, is that there continue to be matching errors that can result in inaccurate record creation, as well as merged records, duplication. But it also directly impacts patient care and cost and safety. In addition, challenges are the inability to link deidentified data from multiple sources due to variations of how systems by be matching patients, making it very difficult for public health organizations, researchers, we can say social service agencies, any of our other partners to healthcare provider organizations to achieve their specific goals.

So one of the items we also wanted to highlight, and this was a new addition from this year, is we also wanted to make sure that when we're thinking about these new standards or approaches for patient matching, that they are also respectful and aligned with what may be needed, especially for our most vulnerable populations, and are also more of our healthcare institutions that may be more under researched than others. And so, the recommendations that we have so far brought to the table is, again, to hold a listening session with relevant federal agencies including the three that you see there to identify what they are doing in terms of best practices. So, we had spoken significantly in the past to be think about even the Department of Defense and how do they do this type of matching, especially when it comes to various different patient populations. And so there likely are some really good lessons that we can actually take from them in terms of how we can apply that to our settings as well. And then the second recommendation, exploring other industries' experiences, but linking deidentified data, as well other healthcare specific efforts. Any comments, thoughts?

Steven Lane
So, one thought is we get new people rolling onto HITAC every year, and in the sense that these are all recurring topics, I think it would be reasonable to ask ONC to schedule an annual update to HITAC on each of these topics. So, you can maybe do one per quarter or something. But have a team at ONC that basically puts together the background information and sort of where we've been with this, where we are, where we are going, and update that on an annual basis. So people who are staying on HITAC can see what progress has been made since the prior year and people who are new can get an introduction and come up to speed with it. As you know, as new people come in, they have new perspectives, they have new ideas. That just seems like one way to approach these recuring topics.

Aaron Miri
I like that, Steven. It is almost like an onboarding. That first session is an onboarding session, the closed door one. They can just take this page out, literally take this page, and say these are the reoccurring topics walking into HITAC, along with all the new work, so that folks get oriented. I love that idea.

Steven Lane

But not just orient the new people but really to update everyone else.

Aaron Miri
And update. You are exactly right. They are kind of like, "Welcome Aaron to HITAC and everybody brought on, you have been talking about this for a decade now, here is what is going on." I will throw out something that is a little different. We have been talking about this for a while and I have been really marinating on this recently, one, because we have a lot of data linkages issues here in this region, and a lot of disparate health systems we translate data with. We have a lot of MRN's we have to consolidate and multiple systems coming in and out. Baptist is ginormous. So, I have this problem ad nauseam. My thought is this, if you have these two items, which are great, listening session, whatever, is there a third bullet, where we explore is there a minimum viable percentage of accuracy that is allowable so that it doesn't specify a process or a method to do identification. You are allowed to figure it however you want to do it. It must be an error rate of, I am making this up, less than 10% or less than 5% of errors across patient matching.

That way you can use whatever modality, whatever sense you want to. So, we are not being prescriptive. We are not saying to use a number or biometric or whatever, that understandable concerns for privacy. But it is simply setting a minimum threshold of this is a minimum acceptable threshold for error that you have to somehow meet. Almost how we do quality measures. Is that a potential way to introduce and explore that idea of maybe that is the way to go about this? Because it seems like, this is Aaron's universal single opinion, please do not take this as industry, that the pushback is we do not want to mandate a method for privacy reasons or a Social Security number or whatever else because of potential compromise. Understandable. What if we left it open to the industry to figure out how do you make a less than five percent error rate on patient matching. You figure it out, Baptist. Figure out what you are going to do. Is that something we should entertain?

Steven Lane
You know, Aaron, another way to think about that is now that ONC is going to be in the business of governing a nationwide framework, which they never have been before through the TEFCA, some of these things will be specified in the QHIM technical framework or whatever the requirements are for QHIM performance, in each of these. EPA, when are we going to be doing it in EPA on TEFCA. The directory, TEFCA, it is going to have a director, patient matching. You have got to patient match inside of TEFCA. So, these things become less philosophical and more very practical. What is ONC directing the RCE to direct the QHIMS to direct the HIMS to what really our standards are as a nation for this.

Medell Briggs-Malonson
Aaron, I am sitting here thinking about your comment as well, and even what Steven just mentioned. I always think that we need to have something that we are aiming for. The only thing that I was also thinking about to add to that is still providing some direction. And, once again, I always think about both direction and validation. I would just say that. Because we would not want to create any incentives that may just match appropriately, or match inappropriately, which can actually lead to more harm to our patients and also more complexity in our systems. So, something really strong for some form of validation of that. But also, I am thinking about some of our organizations, again, that may not have all the various different levels of expertise and resources, one way or the other. So, with exactly as you mention, just having those clear best practices, recommendations, thinking about all the various different types of institutions we do have, to provide that and offer that, in addition to saying here is your guidelines.

Aaron Miri
I like it a lot.

Medell Briggs-Malonson
I always feel like we need to validate and support all at the same time, but I love what you're saying.

Aaron Miri
It's a great point. Some organizations have done a great job, have really gotten to a less than two percent or less than one percent error rate, so let's learn from them. Have a wall of fame and learn from them. And the Chapel can serve to give best examples. I am just saying that it seems we are stuck on the mechanics versus the intent. So if we lay out an objective for folks, to your point, however you strive, and you can borrow these great ideas, borrow all the great ideas you want, but to do something. Doing nothing is causing this issue. Anyway, food for thought.

Medell Briggs-Malonson
I think it is a good one. Any other comments or thoughts? Okay.

Well then, congratulations to us all. We have gone through all of the topics, and now what we get to do is go directly – I said that too prematurely. Never mind. Thank you so much to the team. I was hoping.

The next section here, these are still part of the recurring topics. Steven, your point of having these updates is wonderful. In fact, even adding on to it, perhaps in our annual report, we have those same similar updates. So, if someone is looking at our annual reports year after year after year, you can see the evolution of the work being done with each one of those topics as well.

Once again, privacy and security. The main area here was cyber security events across the healthcare infrastructure. I will go faster because I know we still have some work to do. So, the challenge, as we know, is that there have been several attacks across the country, and in terms of the various different skills and resources they are quickly evolving in front of our eyes. The proposal that we have on the table is there is a lot of people working on how to prevent cyber security events. Therefore, holding a listening session to explore, as well as continue to amplify any of the existing federal industry initiatives to improve healthcare cybersecurity in particular may be one of the best approaches for us moving forward.

And then, also gathering some of those best practices and lessons learned from those organizations, both healthcare organizations but also from our other governmental partners. Any other thoughts about cyber security?

Aaron Miri
I would say, my perspective, the only other thing is I have been hearing a lot of rumblings about a bill potentially coming out on the Hill around cybersecurity insurance and assessing this similar to how we do national flood insurance. It is underwritten by the federal government. Is there any need for reconciliation for other cybersecurity response like cyber insurance and understanding what are the other legislative bodies or the administration level doing so that we don't duplicate efforts? My understanding is that that

whole program, the national flood insurance program, which is reauthorized every 10 years, was a big bugaboo, but it is helping.

The same thing is potentially may come out from a cybersecurity perspective. Again, those kind of componentry, I think they are important for us to layer in, how that works and how to guide healthcare organizations toward signing up for that if they cannot get coverage anymore. The reason why it is important, also, is because the QHIMS require $5 million cyber security insurance underwriting if you apply to be a QHIM. Some of those folks who apply to be QHIM do not even have that availability to get a $5 million rider. So, they are having to self-insure to be able apply for this. There's a lot of question marks when it comes to cybersecurity insurance.

Medell Briggs-Malonson
Very interesting.

Eliel Oliveira
I have another thought here, Medell and Aaron. Looking at the OCR's reports on all the breaches they ever had since 2009, we see a move from breaches due to TEFand laws to hacking. We don't have as much social engineering going on that is real in the hacking. And a lot on the providers, not as much on the payers or HIMS, because I think providers are the ones that are going to be willing to move really fast to pay somebody to release their organization from a malicious attack. I keep wondering, the HIPAA regulations, the policies and procedures that are required for a covered entity to have in place are pretty well put together. It came from the federal government, from the VA. But this is still growing. I am wondering what is happening. Are there holes in those policies and procedures, because they are so old, that don't apply anymore? That needs to be looked at, because the numbers are staggering that I have seen on the rise from the provider side.

Aaron Miri
So, there is a HIPAA 2.0 or whatever they are calling it. There is an RFI out there. This may have been before you joined the HITAC, ELIEL, but they had the OCR come and update us, same with you Medell, on kind of what they were thinking. Steven keep me honest here, it was like two years ago now? I can't remember exactly.

Steven Lane
We have been waiting and waiting for this.

Aaron Miri
They gave us a briefing on what they were thinking about. It basically upped the reporting threshold to be less patients and faster turnaround, let folks know what you have to share. to really specify your point, Eliel, cleaning up some of those gaps on what constitutes a breach, what is not, what is reportable, what is not, penalties, negligence, the whole nine yards. It is supposed to turn HIPAA on his head and modernize it, in a way. Almost what the omnibus did to HIPAA, it is supposed to be another omnibus. I do not know where that is.

Steven Lane
The rumor is that it is almost here. It is almost here. Kind of like the ONC rule, it is like it is almost here.

Aaron Miri
So, TBD, Eliel. You hit the nail on the head. We have been waiting a couple years now for the final rule.

Eliel Oliveira
It makes even more sense now, Steven, to your suggestion of having that onboarding training.

Steven Lane
The annual update, yes. While we are in this privacy and security area, there is something that I have been on a bunch of calls about lately and that is crisper definitions of the various purposes of use, particularly treatment. And what are the details, what are the sub-use cases under treatment and when can people claim treatment. As clinicians, Medell, you and I, we have a pretty intuitive sense of what it means to be a treating provider, but lots of folks use treatment for their queries. And this comes up in care quality, it comes up within my new organization, Health Gorilla. I think it really has to be dealt with within TEFCA. It is a privacy thing. You are not respecting privacy if you make a query for one purpose of use, and it is really for a different purpose. I do not recall that we have talked about this at ONC. They always say it is OCR's problem. OCR never helps us. They are always quiet. I had dinner with Devon right now, she said they are understaffed and freaked out since the **[inaudible] [00:40:32]**. They are just not doing anything.

I think there is a need for greater clarity, especially as we move forward with TEFCA on what exactly is treatment, what are the boundaries around that. We know care coordination is in, but maybe other things are out. What are the sub-use cases inside payment and operations? Especially operations. We have been shrugging about this for years, but I do not think we have clarity. I do not know if that is a topic for ONC, but I know I would like clarity. I think we need to get it to move forward with TEFCA. So maybe it is an ONC project. I don't know if we can slip that in here under privacy and security. But it might be worth considering somewhere.

Aaron Miri
It is like an IRB for advance use cases, for lack of a better term. Like some sort of clearinghouse. Are you truly doing this for treatment purposes or not? And **[audio cuts out] [00:41:30]** why.

Steven Lane
And how do you prove that?

Medell Briggs-Malonson
Right, how do you prove it, and truly making sure everyone understands it. Steven, I think that is a great idea. Maybe our ONC team can actually help us find if it is someplace that we can put it in for this year or if there is another place as well. That's a very important piece also.

I am going to move us along, because I'm watching the clock and we still have some key objectives. Again, wonderful discussion. We are going to go through the patient access to information as efficiently as we can, and then, because we still have to do the prioritization and we still have to look at some of the cases.

Our next section under patient access to information is electronic patient record health record amendments. Eliel, I think this was one of the ones that you, also provided some great insight on. And one of the things

that we had discussed, since this has continued to come up also year-over-year is holding a listening session to better understand where we currently are, what is our current state, what are some of the proposed future standards for electronic patient reporting health record amendments, including views of those different amendments.

Any other items? We are kind of thin in the –.

Steven Lane
I do not think it is just amendments. It is amendments, addenda, corrections, deletions. There are a whole host of issues here, beyond simple amendments.

Eliel Oliveira
One thing that I mentioned, Mendel, in my email is that there is likely a way to maybe define it. That may be an ONC job. What are the pieces of information that the patient actually has a say so, in terms of this has changed? And others that are not even possible, like if you are measuring, for instant, somebody's height and weight, you cannot claim that you need to change my height and weight because that is what the device – I am just using a simple example. But it could be a DNA sequencer, that is basically storing out your DNA sequence. You cannot make an amendment to that. I remember seeing that there is three levels. It is pretty simple stuff that I decide that I want to change my gender so I would like you to update my record. It is my decision to make that. But with other situations, there is no way, like I just mentioned. And other ones may require a provider or a specialist to look at the request that you made and agree with that and then allow that change.

But anyway, that is a very high-level way of how to break down maybe the process of doing this. But I also wanted to highlight, this was a really energetic discussion during our health equity hearing, if you all recall. And there were even some people who shared their own experiences during the call of how it affected them. A very important point, for sure, to address.

Medell Briggs-Malonson
Absolutely. All great additions there. Any other comments.

Steven Lane
Just another comment. Sorry, Medell, you asked. I really wanted to thank you for the talk you gave on Tequity. I gave a talk yesterday at the NCQA meeting on SDOH. I riffed a bunch on the risk associated with SDOH data being used inappropriately and potential impacts of bias. And then today, literally the meeting I just came from was with the Shift Group working on the granular privacy controls. And there was a guy who was just going off about SDOH data and how harmful it is, and how it can introduce all kinds of bias and really hurt people. And there is clearly something there with all of these different perspectives about how we as a care system are going to start to integrate and us SDOH, whether we want to call it type data, in a way that is going to do more good than harm. I do not know where that goes in this or if it goes in this. But it has clearly been a motif in my conversations over the past few weeks.

Medell Briggs-Malonson
It is something that the industry is starting to grapple with and think about the pros and the con, and most importantly, as you said, the most appropriate utilization of the data. And which type of data. I do think we

have a little bit in our health equity section when we are talking about the collection of social drivers of health information. We did not really clearly states developing those guidelines, of which social driver data, for instance, we would utilize.

Steven Lane
Because it is not just collection, it is collection and utilization. As you have helped me to appreciate recently, everything based on the demographics, all of the things that people do just based on zip code or census tract. There is the publicly available data, that a couple of different companies are accessing and using. And there is that which comes from the patient. And even with that, there is the whole context around who asked the questions and in what context etc. etc. Did the patient actually validate? Was it a caregiver? Etc. And there are probably more. Which data, from whom? So I just think it may be does all go in the equity section. Which is interesting, because SDOH is not just about equity. But anyway. That is a fine place to keep it.

Medell Briggs-Malonson
At least for this year, but we are going to become more sophisticated over time. I think we are going to continue to build upon it and it should be in many other sections. So, really great points Steven, I really appreciate those.

So, the last two sections, safety and impact and mobile health apps. Really, in terms of summarizing this quickly, one of the challenges of use of apps that are built without using sound clinical or evidence-based knowledge can produce incorrect conclusions or ratings, not only for the patients themselves but also for any providers. So, right now, there is really no guardrails, again, of making sure that the information that is incorporated into these mobile apps are actively validated and accurate and rooted in evidence-based medicine.

Steven Lane
Are we just talking just about mobile apps, or are we also talking about digital therapeutics, as they are called? Should we lump these together and maybe have FDA come and talk to us about what they are doing with their plans to –

Aaron Miri
We did in prior years. We actually call that digiceuticals. We actually called that out in prior reports, Steven. So maybe we can borrow some of that language, Michelle can find for us on digiceuticals. Exactly that, what is the FDA's jurisdiction? Where does FTC intersect with some of this stuff? It was in prior years.

Medell Briggs-Malonson
Great. It sounds like there has been some work in this area. This is another area we want to make sure that we are supporting awareness. We do not have any recommendations here, but it seems like along this line, listening sessions, understanding where we are, current state on this, and then helping us to understand this to provide more recommendations in future as a recovery topic.

Any other items in this piece?

Eliel Oliveira

One other thing I was going to mention here, Medell, is that I feel like this is similar to what the White House released recently on AI. And, I think ONC was probably involved in that, I forget how specific they specifically called that term. But I think there is not anyone out there that basically validates. So when a new AI is created, it should be utilize. The same thing for the apps. I guess my key point is there might be an opportunity to leverage whatever knowledge ONC and the White House have been working on for background. Because it is similar in terms of the challenges of approving something like this.

Medell Briggs-Malonson
Agreed. And I am going to channel my inner Aaron as well, I think similar to what you are seeing Eliel, is I think that if we are going to provide safe mobile applications, they should be certified and they should be evidence-based. We really should not allow anything to be developed or distributed that may cause patient harm. At some point in time we are probably going to have to draw that line of saying whatever is going into your application that patient may use, that they need to be rooted in evidence-based medicine and have some level of certification on them. So, whether we borrow that for what we are doing of AI or create something else, it seems like we need to move that way in terms of those standards.

Alright. Cost transparency challenge –

Steven Lane
Could I request that we just change that title to "Price/Cost Transparency"? Because they are two different things. What they are asking is what you are paying.

Medell Briggs-Malonson
Can you say that one more time, Steven, just to make sure everybody gets it.

Steven Lane
In my mind, price is what they are asking, and cost is what you are paying. And those can be very different and have all kinds of variables in between them.

Medell Briggs-Malonson
And definitely even in between provider organization systems, you name it. Yes.

So challenges, implementation of compliance, what the cost transparency are ongoing, likely due to exactly what Steven just mentioned. We know it is so hard to really standardize various different costs. And so, we do not have any clear recommendations outlined for this, but the opportunities to further understand patient experience accessing and using cost transparency data.

Any recommendations from the workgroup?

Steven Lane
Actually, when I was thinking cost, you are right, there is the cost to the provider of the service, which is different than the price that they want to charge. There is also the net cost to the patient. And before you joined HITAC, we had a member on the group that was very vocal about the need to be able to tell a patient what is your true out-of-pocket cost for this service, relative to your deductibles and copayments and your

doughnut holes, and all of that. So there is both the cost on the provider and on the consumer side. And I think we should capture all of that.

Aaron Miri
And the payer component too. There are numerous challenges there , as well. And that data sharing firewall that sometimes, and does exist, to be real. So, there is a lot here to unpack. It is not just on the providers. It does drive me a little nuts when people are like hospitals do not want to share data. That is actually not the case at all. It is very interesting.

Eliel Oliveira
Medell, I think as a recommendation here, I know that at UT Southwestern, which is in Dallas and that area, the informatics team have done a tremendous job in analyzing the data that is available and doing research and providing some knowledge of what is taking place. I would expect that other informatics programs across the country are doing the same thing. It would be excellent to bring the knowledge that has been gathered from what is available today to us, maybe through a listening session or some other way to inform what do we do from this point forward.

Medell Briggs-Malonson
Sounds great. So, continue to find out who is doing this well throughout the country. And likely bring them in for a listening session to understand some of the strategies that they are currently using, to fully understand their cost, their price, of all stakeholders, and what they are doing to ensure transparency, and hopefully achieving greater value as well.

Aaron Miri
Right.

Medell Briggs-Malonson
Any other thoughts? Okay. So we are officially wrapped up with this session. Aaron, I am looking at the time right now. We still have two different sections. Number one, prioritization. But then also going over the stories. What do you think we should probably jump to next?

Aaron Miri
Prioritization. I think stories, we have time to work out over email. It is the prioritization so that Michelle knows where to rank things as critical. In prior years, the way that we did this is we – we actually simplified it because in prior years, we got really complicated with our matrixes of what is near term, immediate, intermediate, and long term. It was very confusing. So, this is very simple now. We cannot do everything at once, so we are going to place our bets and focuses in each of these sections. We need to figure out what is that tier we are proposing. Do we look at this immediately? Or do we look at this, you know, we know it is important, but we are not 100% there yet so we can table it and come back to it as the topic matures and those types of things. So I would say that we go section by section, Medell, if you are up to it, and we sort of talk about it. Okay? So, Accel team, do you want go back for me to the top of this thing? There we go.

So when we say something is a priority or not, we are not saying it is not important. So let's be very clear. Health equity, by design, is forever important. Forever. But the importance is do we look at this now, or do we look at it in two years? I think there is an obvious answer here. But just as an example. So just to be

clear, this is a public and listening session, we are not saying these things are not important. That is not what we are saying at all. We are simply saying we have limited resources.

So do we propose these **[inaudible] [00:55:34]**? Are they in the immediate future or sort of the medium future or so. Thoughts? By design, what do we think? Now, or later?

Medell Briggs-Malonson
So, I vote for now, Aaron.

Steven Lane
It is covered, absolutely.

Aaron Miri
I agree. Just, we are going to talk through it. So, immediately. So Accel team, hopefully you are keeping notes here because I am terrible at this. Hopefully you got it. Inequities in data collection, obviously, right, with doing these things about trying to identify best practices at registration, etc. etc. Is that immediate or long-term? Immediate, I would think.

Medell Briggs-Malonson
I also agree with immediate.

Steven Lane
We know your vote..

Medell Briggs-Malonson
I know, you already know what I'm going to say to this whole section. Actually, I may trip you up on one. I may have a different stance on one.

Aaron Miri
Ok, let's keep going. SDOH, really making sure that we are promoting that, moving towards a unified –

Steven Lane
I do not think we can wait on any of these. These are all such timely topics.

Medell Briggs-Malonson
I will add one little caveat for this. I 100% agree that we need to think about the exchange and standardization of social drivers of health data. What I am concerned about, though, is really making sure that we understand how to do these exchanges appropriately. And so, I actually put it as an immediate or in the near future, like next year or so, after we get a clear understanding of which data we are absolutely going to be exchanging once it is collected and in which format. So for me, it was just like we may need a little bit more education and experience, even as we are trying to do some of the other exchanges of demographic data, social driver data is even more complicated sometimes. So, that is the only reason why I put that as I/N. But, of course, I can be easily swayed for 100% now.

Steven Lane

The reason I would argue now is because, again, we are already seeing vendors, in particular, bringing forward data that represents people social and structural situation. And so even though we are in the process of, through gravity and pilots, figuring out what data to collect, how to collect it, how to exchange it, this data is already out there in the wild. RTI did a presentation. Have you seen RTI's product? They just announced it in the last week on social risk. I will try to find you the details. I will send you my slides. But the point is that I don't think we can wait for the reasoned discussion of how and what we are collecting because it is already being done.

Medell Briggs-Malonson
That is incredibly valid in every way. What I am most concerned about, which is why I think we need to do immediately, and of course, is I am also thinking about the implications of not doing this correctly. That is the only piece there. But you bring up such a great point. The information is already out there, so we need to structure, as quickly as we can, all the information that people are gathering and starting to exchange. I vote for immediate.

Aaron Miri
It's immediate in my mind. That also goes to the next part. There is numerous algorithms out there right now that are complete junk because the models they are trained on are not representative of the whole, and it is abysmal. We had a couple things here I had to scuttle immediately because it was completely ineffective because the models they were trained on were demographics that were inappropriate and not respective of my region, much less what I think the country looks like. So, when you look at a lot of these things and how that tooling comes out, it is both the intake of data and the output. So, if you are looking at bias concerns and algorithms, to me, that is immediate. This already happening. We are already see real-world affect because of that. The much-publicized Sepsis protocol out of Epic even was one, and a few other things that have already blown up because of this issue because there are no guidelines. To me, this is urgent. This is really urgent.

Medell Briggs-Malonson
I agree with definitely bias concerns is immediate as well.

Aaron Miri
Any pushback? No? Alright.

Steven Lane
Here, Medell, I'm going to give you a link to what RTI just came out with this week.

Medell Briggs-Malonson
Great, thank you.

Aaron Miri
Public health systems infrastructure. Not that this is not important or anything. Obviously –

Steven Lane
Here again, I do not think we need to have this. All we need to do is point to the work that is going on. There is so much work. There is a whole other task force that is going to have a detailed report out on all of this

in the next week at probably the same time we are presenting. Let them go first on the HITE agenda and we will just say, “What they said.”

Aaron Miri
I agree.

Steven Lane
We will just never capture the detail and the expert input that is going into those recommendations.

Aaron Miri
I would agree. It is immediate, we know this is top of mind for the administration. It's also the right thing to do because of what is going on with the country. I am just going to lump all these together. Infrastructure including of ECR and ELR, is there any reason to delay looking at this? I cannot see why.

Steven Lane
And Syndromic Surveillance and immunization reporting, and, and, and, right.

Aaron Miri
This is critical. **[Inaudible – crosstalk] [01:01:37]**

Eliel Oliveira
– ways to accelerate because I feel like we cannot wait for another pandemic. I do not know how to evolve it faster than the way it is going, to be honest.

Aaron Miri
Money. We have to have incentives. The hope is that we generate enough buzz around this that Congress allocates funding. Carrot and stick. That is the only way we are going to get it to move. Let's be honest. It's being considered as part of the recommendations, part of the public health taskforce. You have heard that. It will just take some adoption. That is really all we can do is recommend.

Steven Lane
I don't know if you have been attending these public health taskforce meetings lately, but I had a back discussion with Arian after the last one. It is interesting that the public health people are actually pushing back against the recommendations that we are coming up with. You know, with the storyline of we just do not have the resources, we cannot with it, we cannot upgrade our systems to Fyre. We just cannot do any of this stuff you guys are talking about. Just let us keep doing it the old way. It blows my mind. We are trying to make your lives better and you guys are trying to take out recommendations because you don't think you can deal with it? It's really an interesting dynamic.

Medell Briggs-Malonson
Steven, it is interesting because I had a conversation with someone in a similar setting that said that same thing. And one of the things they mentioned is that we appreciate sometimes some of the push, but when it comes down from a federal agency or state agency and it is not directly coupled with the resources to really get it done, it ends up being an even greater burden on us and sometimes pushes us back even more. It sounds like that is what we are referring to at this point. Yes, they agree with the concept, but

without it being directly affiliated with some of the additional financial resources or other personnel resources, it is a little bit more burdensome for them. That is something I have heard in several different arenas, as well. So the question is, as we do push and as we are making a stance and advocating for this, what else are we doing in terms of once again still supporting the industries or the organizations in order to implement this?

Steven Lane
It is hard for us to be able to see the big picture here, right? Weren't there billions of dollars in the stuff that came out of the pandemic? And there is money for public health modernization from the CDC on this and that. We don't see that. We are just asked to make recommendations. What should happen? Duh, They should all put on Fyre servers, and they should get with the program here. They should all be able to make queries across TEFCA. They are like no, no. It's like you are saying, until you give us the resources, we don't want anything close to those kinds of expectations put on us. My understanding is that the resources are there, it is just they are not coupled with our guidelines.

Medell Briggs-Malonson
Maybe they should be coupled with our guidelines as part of our recommendation. Do we have that authority of saying we believe this is necessary for the health and safety of our nation, but in order to do this and support the organizations that are going to execute this work, they have to have the resources to go along with that.

Aaron Miri
That is right. I think we are all in agreement. Immediate for all those things. Alright. Next section. Same thing here, right? There we go.

Steven Lane
The whole public health.

Aaron Miri
All that whole section. Interoperability. Health information exchange, listening session for the TEFCA, streamlining it. Is this now or later?

Medell Briggs-Malonson
Streamlining of health information exchange now, for me.

Aaron Miri
I think it is now, not later as well.

Steven Lane
These are the topics of the day.

Aaron Miri
It is, right? Closed loop referrals.

Steven Lane

There is so much discussion, especially about – the new discussion is about community service referrals. The old discussion, which is there are lots of open referral loops, just because it is a 20-year-old discussion, does make it less valid. We have new solutions, we have 360 X, we have Fyre. There is so many referrals open loop referrals out there that are harming people. I don't think this is something that should be waited on.

Medell Briggs-Malonson
Steven, I agree. I see the negative implications of lack of closed loop referrals every single day, which I'm sure all of you do as well. I think it is still a now, it is an immediate impact that we need to make.

Steven Lane
But again, emphasizing that it is not just physician to physician, but it is behavioral health, it is social services, it is all of that.

Medell Briggs-Malonson
Absolutely. That is even one of the reasons why I'm mentioning this. Even right now as we think of the healthcare and the social needs of patient populations, if we don't know if people are able to get food, if we do not know if they are really going to be able to receive transportation to come back for their visits, it is all related.

Eliel Oliveira
I see as immediate now, because we have the opportunity to prevent what has happened with EHRs. I use lab as an example where everyone came up with their own way of creating their lab nomenclature, and now we have a mess to address that. The same I start to see now with SDRH. We have the standards. I think Gravity has done tremendous work. There is so much there. But folks are still creating their own thing. Assessments is one example. There is no way to cross connect across that. It is immediate to me, otherwise we have a much bigger problem later.

Aaron Miri
Ok. Telehealth. I can't see how this is not immediate, but I'm just asking the question.

Steven Lane
None of these things are, "we could do this later."

Aaron Miri
It is almost like the whole thing is immediate, which is unfair but it's the reality of it. That is immediate. Next section. Privacy and security. Something at some point is going to have to give here. Alignment of innovation and regulation.

Medell Briggs-Malonson
I will jump out there. I said that I think we can wait given all that other immediate items that we are looking at. I did put this as it can wait and does not need to be immediate.

Aaron Miri
I would agree with that. Steven? Eliel? Thoughts?

Steven Lane
I agree that this could be downgraded a little.

Eliel Oliveira
I am trying to, at least for this first line, how we say this is related to what information blocking has just made a reality and everybody needed to comply with that but not having a way – It is so recent and important and required. To me, it has a little bit related to that and how that is not a priority. I guess because we still have a year or so of seeing people not fulfilling the requirements.

Aaron Miri
I will say it bluntly, my thoughts here, Eliel. Typically I tried to soften on here, but I will be honest because I am seeing this in the industry, people actually do not care about the October date because there is no penalty associated to it. Most health systems that are Epic systems are in Waves right now and most of them are not coming live until January at the earliest with ability to do an export just out of Epic. Not unless all the other systems that touch to it, so just picking on one system, one alone. That is way out of date from October compliance deadline. So, not to say people do not care. Everybody cares, we did everything we can do here personally. So, locally, I am good. But a lot of health systems across the country are like, "Eh, what are you going to do to me? Nothing is defined There is no penalties. You may refer me to CMS. You may refer me to OIG."

Steven Lane
The other part of the argument is they can do content manner. They can say, “I can't just give you a download out of Epic because it is not feasible for me today, but if you wait around for the next X number of days, we will work on getting it out of all the different systems.”

Aaron Miri
It is kind of like suggested speed limit is this. There's nobody watching you, but suggested speed limit is posted, the sign is posted. To me, and that will fix itself, it's going to be finalized eventually, it is just out of sequence in my opinion. Let's assume that is finalized in the next six to eight months, let's assume that happens. Now we will really be able to see, Eliel, where this intersection point happens and what can we use the data for? At least that is how I see it in my head.

Eliel Oliveira
Good point. I am convinced.

Aaron Miri
We will see. A lot of very proud people about their databases that they love to sell for money deidentified. It's going to be tough to crack this walnut, but it has got to happen. All right, alignment of innovation, regulation, and consent directives. Not that innovation is not important, this one could wait. Could.

Medell Briggs-Malonson
I felt the same way. This can wait. If we are really trying to prioritize, this is not one of the ones that I am like we absolutely have to get this done now.

Eliel Oliveira
Without solving identity and linkage, I do not know how this could be effective as well. I would agree with that.

Aaron Miri
Steven?

Steven Lane
Sure.

Aaron Miri
Appropriate exchange and use of data. To me, I think this is important. I think this one is immediate, in my opinion. Because TEFCA, to your point earlier, Steven, about the CRISPR stuff on the edge, just in general, without this solved and addressed, I do not know how we are going to do this.

Medell Briggs-Malonson
Agree.

Aaron Miri
Yes, Eliel, Steven? Immediate?

Steven Lane
Yes.

Aaron Miri
Okay. Privacy of sensitive health data. Nobody cares about this. Just kidding. I think this is urgent, in my opinion. This has become a big mess across the country that we have to address. It also ties back into equity, as well, my opinion.

Medell Briggs-Malonson
You all already know how I feel about this.

Aaron Miri
I know, Medell, I know what you are thinking. Just look at what happened with the Facebook pixel, as an example of just one little microcosm of why this needs to be addressed.

Next, patient consolidation of multiple information and multiple sources, etc., etc. I mean, this, I do not know how we can wait on this. This is how TEFCA is fueled.

Medell Briggs-Malonson
So, this is one that I think is highly important and I love the idea, and I would want to execute this and put this forward yesterday. But I also am sort of saying we do have a lot of other burning platforms as well. So these are all priorities, as we know, but this was one I was like it could be immediate or it can be near future, as well. I defer to the group.

Eliel Oliveira
My thinking is that we have had HIPPA for so long and we have done great from blocking everybody from accessing everything. And this aspect of portability of patient access, it has just been there on the sides for so long, that to me it is like it would be great to make some process. So I think it a very important priority. Especially for the other things we talk about. Health equity, SCOH coordination. If a patient is not part of the loop, I do not know how we can make advancements in other areas.

Medell Briggs-Malonson
I am just going to ask a quick question to the group as well, because I am one of the new HITAC members. When we really do send these recommendations, because I try to be very logical, if everything is a priority, nothing will be a priority and we will not move the needle. There are some things we have to move the needle in order to even get to these items, which I feel are almost contingent upon successfully executing other items. But historically with HITAC, when we do submit these recommendations, how often are they all implemented and taken into account?

Aaron Miri
Michelle, keep me honest here. They are all noted. Our recommendation reports stand. And then what ONC does, my understanding, is incorporate them into the work plan so that the filing of taskforces as it occurs over the years should, for the most part, align to how see how it at HITAC what we want to work on.

Steven Lane
It should at least be informed by it.

Aaron Miri
It should be informed, right. That is the word I am looking for, informed. So our work plan, which we are going to talk about this coming up HITAC for the next year work plan, has elements derived from what we recommend to do. Michelle, I may have said that totally wrong. Jump in if I'm incorrect. But that is how I see it.

Medell Briggs-Malonson
So in other words, the way that I am understanding is that when we say "This is immediate now" it will immediately be incorporated into the workplan and stay there until we actually start moving things along?

Aaron Miri
No. It is put in a parking lot of things that are coming up. So, all these items are public health, will be tasked to a public health data taskforce. Those would be sub elements for the taskforce to go out and investigate. They categorize or sort of bucketize these are the big topics that we want to go after. And then a taskforce is created, and they have sub elements of things to go solved derived from a lot of the things we brought up.

Medell Briggs-Malonson
Okay, great. So, there is direct action for everything that we say. We are putting it out for we want this to be part of our immediate plan, now?

Aaron Miri
For the most part. ONC team, jump in. Say, “Aaron, you are nuts.” But that is at least how we see it.

Medell Briggs-Malonson
Then I would say thank you for the clarification of how the process actually works. So yes, I would say let's include patient consolidation of health information for multiple sources on there because it will be nicely coupled with a lot of those other efforts, just like what Eliel was mentioning. So, that really helped me to understand where these are going to go and how they are going to live and be executed upon.

Aaron Miri
Before we go there, though, Michelle or anybody from the ONC team, state incorrectly that we said it wrong.

Michelle Murray
Aaron, you did a beautiful job of explaining the process.

Aaron Miri
Alright, perfect.

Medell Briggs-Malonson
Thank you.

Steven Lane
Especially, Aaron, since you are the HITAC cochair, you see how the sausage is made. You know how the year is laid out and how the agenda comes together. Again, these are just recommendations from HITAC back to ONC, and they decide what we are going to do. And we really cannot color outside the lines too much.

Aaron Miri
That is right. As long as it is in our statue of the things we are allowed to track or that Congress allows us to go track and go after. So, there are very specific topical areas, interoperability, privacy, security, etc., etc. The great thing, though, is this report goes back to Congress. So, it goes to the secretary, which is then transmitted over to Congress. So, the Hill does read this. We have often asked that question over the years, is anybody reading this? Hello, is anybody out there? They really do. So, I get a lot of feedback coming back from staffers that I feed back to the ONC team like, “Hey, they love this. This is great.” And that is how we came up with the stories. That is how we came up with a lot of the concepts because it is a bi-directional communication vehicle. So, beyond informing the work plan, it informs legislators and the staffers for legislators. “Hey, if you are thinking about cybersecurity, think about these dynamics from a healthcare lens.” It is very important. So, this report is not just a general report to inform the workgroup, it informs the country as to what we really think we want to do. That is why it is so important, the work product we put together.

Medell Briggs-Malonson
Excellent, Thank you.

Aaron Miri
No, those are good questions, Medell. Is that the last section or is there more sections here? Scroll down please, Excel team. Okay, perfect, that is what I thought. Recurring topics, let us quickly go through these proposed tiers. E-prior auth, is there a common standard of support prior authorization across payers. This one, I think could be intermediate. I do not think we are ever going to get there, personally, but whatever. Is this immediate or intermediate? What do we think?

Medell Briggs-Malonson
I am going to vote for immediate just to continue to push it along.

Aaron Miri
Other thoughts?

Steven Lane
This is another one that a lot of people are working on. It will move along whether we spent time on it or not. I think we have an interest in understanding what is going on. It is kind of like the public health stuff, this has been taken out of our hands. There is a whole community working on this through Davinci and others. So I do not think we need to make it a priority for HITAC.

Aaron Miri
So, Medell says immediate. Steven says intermediate. Eliel?

Eliel Oliveira
I think immediate, and especially with a lot of the work group that worked on this, talking about the fact that the patient is not ever a part of that discussion. It is about the payers and providers, usually. So, there is a missing piece there. So, I think, from that perspective it is immediate, as well. I never know what I am going back with when I walk out of the clinical office.

Steven Lane
It is a really good point, Eliel, that there is an overlap between price transparency and EPA that nobody really talks about it.

Aaron Miri
So in lieu of all the other items we privatized as like burning platforms, is this a burning platform for next year? That is the question I want to ask. Would you put this as more important than health equity? OK.

Eliel Oliveira
No.

Medell Briggs-Malonson
No. But, Aaron, I think that is a little hard to say that. I know that there has been some work on this for a while. But, there are different aspects of this as well. And actually, it does directly go into health equity because often times, our lack of E-prior auth, it affects many different populations, but it absolutely negatively impacts some of our most vulnerable populations, as well.

Aaron Miri
Okay. You convinced me, it is immediate. I am voting immediate now.

Medell Briggs-Malonson
You all convinced me with the social driver data. You were all like, "What is going on with you? It is a medium." I am like, "Of course it is. Let us do that." So, now we are fair.

Aaron Miri
Good point. All right, it is immediate. So, that is that one. Last two, really quickly here, so directory standards management, I think this could be a little elongated, personally. We get data standards right before we do this.

Steven Lane
It has been elongated for a long time. It has been a slow process. Again, I think tying it to TEFCA, what are the directory standards that are going to be needed for that. I think that piece of it needs to be immediate. They want to see TEFCA exchange next year. We need to know what are the standards for that.

Aaron Miri
OK.

Eliel Oliveira
I think that this was the one that we about the CMS location. So maybe not as immediate, given that they are focusing on that. So, it would allow us to stay in the loop on what that IFI and what they are going to recommend for the next round.

Aaron Miri
So immediate, immediate. Medell, you said immediate? .

Medell Briggs-Malonson
No, I also said not necessarily right now.

Aaron Miri
Oh, sorry, Eliel, you were saying not now. Sorry, I misunderstood. Sorry, got it. Pushed out. So, we are going to push this one out then. Steven, are you okay with that? I know it has been a long burn.

Steven Lane
Sure.

Aaron Miri
Patient matching, to me, this is critical. This is always critical. This is really a big bugaboo. This is immediate. Does anybody disagree?

Medell Briggs-Malonson
Agree.

Aaron Miri
Excel team, anything else? Cybersecurity events, this is immediate. I cannot imagine that we do not tackle cyber. It has always been immediate. Any disagreements? Okay.

And then a patient reported health amendments. This is important, but to me, this can be pushed out a little bit. Yes? No?

Medell Briggs-Malonson
I agree with that.

Aaron Miri
Okay. Push out. Eliel, push out? Okay, Steven, push out?

Steven Lane
Yes.

Aaron Miri
Stating the impact of mobile health apps, I think this is urgent, especially given what is going on. I say immediate.

Steven Lane
The thing about the amendments, just to be clear, it is really the corrections. That whole category is there are workgroups working on this. Within HL-7, they are developing the standards. They are starting to pilot it, I think. I do not think it needs HITAC input, at this point, except to acknowledge that it is important, and it needs to keep moving.

Aaron Miri
Fair point. It is not like the work is not stopping. All right. Safety and impact of mobile health apps, I think is immediate.

Medell Briggs-Malonson
I do as well.

Aaron Miri
Okay. Cost transparency, yes, that is important.

Steven Lane
It is happening.

Aaron Miri
It is happening. But I think we can push this out a little bit. And it is playing out anyways, in my opinion.

Steven Lane
Just to be clear, I think what we are saying is it needn't be HITAC's top priority. These are things are still super important, we are not saying they are not important. We are just saying that other people are working

on them, and they are still moving forward. HITAC, given its finite resources, it does not need to be what we focus on.

Aaron Miri
That is right. Sorry guys, we are over time. We need to get public comment in. I am about two minutes late. That is on me. I did not watch the clock close enough. Hold your thoughts. Can we go to public comment, please? And then we can continue.

Public Comment (01:24:32)

Michael Berry
Absolutely. We are going to open up our call for public comments. 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 are on the phone only, press *9 to raise your hand. Once called upon, press *6 to mute and unmute your line. Let us pause just for a moment to see if anyone raises their hand.

Steven Lane
We want to hear for Theresa and Marla and Corey and Roger, for sure, because they have been hanging in there patiently listening to us.

Michael Berry
So, not seeing any hands raised. I will turn it back to our cochairs.

Next Steps and Adjourn (01:25:04)

Aaron Miri
Medell, you were about to say something. I apologize I cut you off. Please continue.

Medell Briggs-Malonson
I was just going to completely amplify what Steven said and what you had said before, Aaron, because my understanding is it is immediate, meaning this year, versus near-term, which is some of the years to come, but everything is a priority. And these are all priorities, even for HITAC, itself.

Aaron Miri
Right. Ideally what we do is once we have a list of immediate, we then rank that. So, we actually go through that at some point and say what do we – from a work plan perspective. You would work and work through that list. This is the beginnings of that synthesizing. Other comments here as we wrap this up in the last minute?

So, we have the stories part. I would ask you all to please look at the stories and get that feedback to Michelle on the Excel team on what you think there. Again, the stories are meant to say in plain language what we are trying to express with all the technical items and what it would look like from a provider perspective, care provider perspective, patient perspective on these various dimensions if we got it right. Please take a look at those and provide comment back to Michelle.

Medell Briggs-Malonson

Thank you all for drafting all of those stories. They were really great. We will send back all of the comments back.

Aaron Miri
Great. Michelle, did you get everything you needed?

Michelle Murray
Yes, excellent meeting. Thank you.

Michael Berry
Hey, we got some public comment in the chat.

Medell Briggs-Malonson
We have a public comment from Teresa. "Thank you for this assessment, immediate status for interop standards priority use, e-prior auth. It is always appreciated by the nation's family physicians." Absolutely. We are happy to continue to push that along. Thank you, Teresa.

Aaron Miri
Thank you. Good to see everybody.

Medell Briggs-Malonson
Great seeing everybody. Have a great one. Bye-bye.