ONC | HealthIT ADVISORY COMMITTEE

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) MEETING

November 10, 2022, 10 AM – 1:45 PM ET

VIRTUAL

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Speakers

Name	Organization	Role
Aaron Miri	**Baptist Health**	**Co-Chair**
Denise Webb	**Individual**	**Co-Chair**
Medell Briggs-Malonson	UCLA Health	Member
Hans Buitendijk	Oracle Cerner	Member
Steven Eichner	Texas Department of State Health Services	Member
Cynthia A. Fisher	PatientRightsAdvocate.org	Member
Lisa Frey	St. Elizabeth Healthcare	Member
Rajesh Godavarthi	MCG Health, part of the Hearst Health network	Member
Valerie Grey	New York eHealth Collaborative	Member
Steven Hester	Norton Healthcare	Member
Jim Jirjis	HCA Healthcare	Member
John Kansky	Indiana Health Information Exchange	Member
Kensaku Kawamoto	University of Utah Health	Member
Steven Lane	Health Gorilla	Member
Leslie Lenert	Medical University of South Carolina	Member
Hung S. Luu	Children's Health	Member
Arien Malec	Change Healthcare	Member
Clem McDonald	National Library of Medicine	Member
Aaron Neinstein	UCSF Health	Member
Eliel Oliveira	Dell Medical School, University of Texas at Austin	Member
Brett Oliver	Baptist Health	Member
James Pantelas	Individual	Member
Raj Ratwani	MedStar Health	Member
Abby Sears	OCHIN	Member
Alexis Snyder	Individual	Member
Fillipe Southerland	Yardi Systems, Inc.	Member
Sheryl Turney	Elevance Health	Member
Thomas Cantilina	Department of Defense	Federal Representative
Adi V. Gundlapalli	Centers for Disease Control and Prevention	Federal Representative
Ram Iyer	Food and Drug Administration	Federal Representative

Name	Organization	Role
Jonathan Nebeker	Department of Veterans Health Affairs	Federal Representative
Michelle Schreiber	Centers for Medicare and Medicaid Services	Federal Representative
Ram Sriram	National Institute of Standards and Technology	Federal Representative
Micky Tripathi	Office of the National Coordinator for Health Information Technology	National Coordinator
Steve Posnack	Office of the National Coordinator for Health Information Technology	Deputy National Coordinator
Elise Sweeney Anthony	Office of the National Coordinator for Health Information Technology	Executive Director, Office of Policy
Elisabeth Myers	Office of the National Coordinator for Health Information Technology	Deputy Director, Office of Policy
Avinash Shanbhag	Office of the National Coordinator for Health Information Technology	Executive Director, Office of Technology
Seth Pazinski	Office of the National Coordinator for Health Information Technology	Director, Strategic Planning and Coordination Division
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Tricia Lee Rolle	Office of the National Coordinator for Health Information Technology	Presenter
Gillian Haney	Council of State and Territorial Epidemiologists (CSTE)	Presenter
Vaishali Patel	Office of the National Coordinator for Health Information Technology	Presenter
Chelsea Richwine	Office of the National Coordinator for Health Information Technology	Presenter

Call to Order/Roll Call (00:00:06)

Mike Berry
Good morning, everyone, and welcome to the November 2022 HITAC Meeting. I am Mike Berry with ONC and I would like to thank everyone for joining us today. As a reminder, your feedback is always welcome, which can be typed in the chat feature throughout the meeting or could be made verbally during the public comment period that is scheduled at about 130 Eastern time this morning. Let us get started with our meeting. First, I want to welcome ONC's executive leadership team to the meeting. With us today is our National Coordinator, Micky Tripathi, Steve Posnack, the Deputy National Coordinator, Elise Sweeney Anthony, the Executive Director of the Office of Policy, and Avinash Shanbhag, the Executive Director of the Office of Technology. I am going to begin roll call of our HITAC members along with our federal agency representatives of the HITAC. When I call your name please indicate that you are here. I will start with our co-chairs. Aaron Miri.

Aaron Miri
Good morning.

Mike Berry
Denise Webb.

Denise Webb
Good morning.

Mike Berry
Medell Briggs-Malonson.

Medell Briggs-Malonson
Good morning.

Mike Berry
Hans Buitendijk

Hans Buitendijk
Good morning.

Mike Berry
Thomas Cantilina. Steven Eichner.

Steven Eichner
Hello. Good morning.

Cynthia Fisher
Cynthia Fisher.

Mike Berry
Cynthia Fisher.

Cynthia Fisher
Good morning.

Denise Webb
Good morning.

Mike Berry
Lisa Frey

Lisa Frey
Good morning.

Mike Berry
Rajesh Godavarthi.

Rajesh Godavarthi
Good morning.

Mike Berry
Valerie Grey. Sanjeev Tandon, who is in for Adi Gundlapalli.

Sanjeev Tandon
Good morning.

Mike Berry
Steven Hester is not able to be with us today. Ram Iyer. Jim Jirjis. John Kansky.

John Kanksy
Good morning.

Mike Berry
Ken Kawamoto.

Kensaku Kawamoto
Morning.

Mike Berry
Steven Lane.

Steve Lane
Good morning.

Mike Berry
Leslie Lenert. Hung Luu.

Hung Luu
Good morning.

Mike Berry
Arien Malec.

Arien Malec
Good morning.

Mike Berry
Clem McDonald. Meg Marshall, who is in for Jonathan Nebeker.

Jonathan Nebeker
Actually, Jonathan will be doing this.

Mike Berry
Great. Thank you, Jonathan. Aaron Neinstein.

Aaron Neinstein
Good morning.

Mike Berry
Eliel Oliveira. Brett Oliver.

Brett Oliver
Good morning.

Mike Berry
James Pantelas.

James Pantelas
Good morning.

Mike Berry
Raj Ratwani.

Raj Ratwani
Good morning.

Mike Berry
Alex Mugge, who is in for Michelle Schreiber.

Alex Mugge
Good morning.

Mike Berry
Abby Sears.

Abby Sears
Good morning.

Mike Berry
Alexis Snyder.

Alexis Snyder
Good morning.

Mike Berry
Fil Southerland.

Fillipe Southerland
Good morning.

Mike Berry
John Garguilo, who is in for Ram Sriaram.

John Garguilo
Good morning.

Mike Berry
And Sheryl Turney, who also has a brief announcement for us today. Sheryl? Okay. I do not see Sheryl on but she should be joining us shortly. All right. Thank you, everyone. Please join me in welcoming Micky Tripathi for his opening remarks. Micky?

Micky Tripathi
Okay. Great. Good morning. Can you hear me? My mic is working?

Mike Berry
Yes.

Welcome Remarks (00:03:35)

Micky Tripathi
Great. Thanks, everyone. Thanks so much, Mike, and thanks, Aaron and Denise. Welcome, everyone for our November HITAC meeting. This is our last meeting of the year. I want to thank all of the HITAC members and invited presenters for sharing your expertise and insights over what has been a busy year and a very productive year. We have accomplished a tremendous amount in 2022. We had 10 full committee meetings, each of which has a lot of work behind it, I think, as all of you know. That also included a half-day hearing focused on health equity. We also launched five subcommittees that includes the Annual Report Work Group, the Electronic Prior Auth Request for Information Task Force, the Interoperability Standards Work

Group, who examined the draft USCDI Version 3 and the Interoperability Standards Advisory, the Adopted Standards Task Force, and most recently, the Public Health Data Systems Task Force.

I want to thank all the HITAC members and other subject matter experts who contributed to these subcommittees. You provided a variety of perspectives and a depth of advice and expertise that will help shape HITAC's recommendations going forward. Thank you, so much for that.

In addition to the 23 recommended activities that are outlined in the FY21 Annual Report completed earlier this year, the HITAC submitted 165 recommendations to ONC this year. Thank you. The inbox is full and we consider all of them in the course of our work. We do. We appreciate everything you do and every of those recommendations are things we look at very carefully because we know all the work and thoughtfulness that goes into them. The FY21 HITAC Annual Report for Congress was also completed. Work continues towards completing the FY22 report by early next year. Thanks to each of you for a successful and productive year.

Let me give a couple of ONC updates. I would like to flag two new blog posts for your awareness. We have one that was released today and is related to the ONC Adopted Standards Review and the work of the Adopted Standards Task Force along with the final report and recommendations from the HITAC. And the second blog is to announce new pilots to advance social determinants of health standards from sandbox to production. We are working with HL7 and other partners from healthcare, federal and state government, community-based organizations, developers, providers, and others to launch a National Gravity Project Pilots Affinity Group. Visit the Pilots Affinity Group site for more information on how to engage with us or join the monthly meetings, which you can do as an observer or as a pilot participant.

We are excited about that and certainly excited about the blog and the tempo of the blog. We are aiming to, and I think successfully hitting, at least one blog per week. Hopefully, all of you are able to keep up and you find that informative and useful to the work that you do.

I would also want to invite health IT developers and anyone from the public to the upcoming quarterly ONC Health IT Certification Program Developer Roundtable. Those are important venues for us to have direct interaction and engagement with the health IT developer community. We will lead discussions tailored to that community on topics such as certification program updates, upcoming certification deadlines, and developer requirements. That roundtable is going to be on November 15th, from 12:00 – 1:30 Eastern time. You can register by searching events on healthit.gov.

Okay. Enough of the ONC updates. Let's talk a little bit about member updates. We have a lot of member updates. This is the last committee meeting for seven HITAC members whose terms expire at the end of the year. I want to take this opportunity to express my deep appreciation to each of you for your dedicated service and commitment over the past years and award a certificate of appreciation to the following HITAC members. The first I would like to thank is John Kansky. John served as a HITAC member since January 2018 and was also the co-chair of the TEFCA Task Force. John was also a member of the Information Block Task Force and the Public Health Data Systems Task Force. Thanks so much, John.

Next, I want to thank Les Lenert. Les has also been a HITAC member for the past five years and served on a number of subcommittees to include the Interoperability Standards Priorities, USCDI, Conditions and

Maintenance of Certification Requirements, Public Health Data Systems, and the Interoperability Standards Work Group. Thanks so much, Les.

Next, I want to thank Brett Oliver. In addition to serving as a committee member for the past five years, Brett was a member of the USCDI Task Force for several years in the Annual Report Work Group. Thank you, Brett.

Next, I would like to thank James Pantelas. For the first three years, James has served as a committee member providing his perspective as a patient and a caregiver. Thanks so much, James, for that.

Next, Raj Ratwani. Raj has served as a HITAC member for the past five years and has held multiple roles, including co-chair of the EHR Reporting Program Task Force and the Conditions and Maintenance of Certification Requirements Task Force, along with being a member of the Interoperability Standards Task Force. Thank you, Raj.

Next is Abby Sears. In addition to serving as a HITAC member for the past three years, Abby has participated as a member of multiple task forces, including USCDI, Public Health Data Systems, EHR Reporting Program, and the Interoperability Standards Work Group. Thank you, Abby.

Finally, a very warm, warm thank you to Denise Webb. Denise has been an instrumental member of the HITAC, having contributed five years of service with the past two as co-chair of the HITAC. In addition, Denise was a member of task forces to include TEFCA, USCDI, Conditions and Maintenance of Certification Requirements, Information Blocking, and Intersection of Clinical and Administrative Data Task Forces. Denise's leadership has been evident throughout her tenure on the HITAC, and especially while serving as co-chair. I think we would all agree that managing Aaron is a task in and of itself. So, Denise, thank you so much for your help there.

So, please join me in thanking each of these HITAC members for their significant contributions. We are expecting the Controller General of the United States, who heads the GAO, to announce at least four new HITAC appointments by the end of the year. And the Secretary of Health and Human Services will also appoint a new member soon. These new members are anticipated to start their three-year term on the HITAC in January of next year.

Regarding one more important item on the member update, is the upcoming co-chair vacancy. I am delighted to announce that Medell Briggs-Malonson will be the next HITAC co-chair, effective January 1, 2023. We are looking forward to Medell's leadership and vision for the HITAC. I want to extend my congratulations to her and thank you in advance for your help with co-chair of the HITAC.

Let me close and just say that this is our last full committee meeting before the new year. I want to extend my best wishes to all the HITAC members for a happy holiday season and thanksgiving and we will meet again in January. Let me turn it over now to Aaron and Denise for their opening remarks. Thank you.

Opening Remarks, Review of Agenda and Approval of October 13, 2022, Meeting Minutes (00:10:39)

Aaron Miri
Thank you, Micky. Denise, would you like to go first?

Denise Webb
Yes, certainly. Since this is my last meeting, I do have a few remarks to make. First off, I want to say that I am grateful to all those who gave me the opportunity to do meaningful work. That includes work such as this work in the HITAC and help make a positive impact on patients and families. This has been important to me. Before I went to college, I wanted to be a doctor but I ended up getting a degree in computer science and ended up in IT. I spent the first half of my career, even a little more, in technology, in the DOD. I started out at the Pentagon of all places. Then, I had the opportunity after leaving the Air Force to join the healthcare community.

The first part of my time in healthcare I was in IT but I could see right away that to leverage the power and the benefits of technology we needed the right laws, policies, and standards to get that full benefit. I moved myself and transitioned out the technology side and got involved in the policy side. As far back as 2006, I have been on this journey, this interoperability journey, and it has been terrific. I think we have moved the needle but we have a lot more work to do and a ways to go. I think this committee has an important role in doing that.

It has been in honor to serve the last five years, and one year I did not get to finish my term as co-chair. I think we are leaving the role, the post, in capable hands with Medell. What an excellent choice. Congratulations. I learned a lot from all of you. It has been a very positive experience. I am going to miss being a part of this committee and I wish you all well. I specially want to thank ONC, all of the national coordinators I have worked with, including you, Micky, and your teams, for all the tremendous work that you have done and the support you've provided this committee. With that, I just want to say Godspeed and it is going to be in your capable hands, Medell, after this meeting. Thank you.

Aaron Miri
Thank you, Denise. I agree with Micky's comments earlier. Thank you for keeping me in line and making sure I am on the right path forward. I will miss you as a co-chair and as a friend but we will always be in touch and you are always part of the HITAC family along with everybody else that Micky recognized. Medell, congratulations to you. Buckle up. It is a fun, and exciting, and busy seat. We will have a lot of fun.

Thank you, all. Welcome today to the HITAC meeting. Thank you, Micky, for your wonderful remarks earlier. I also want to echo what Denise said. Your team is amazing. They've done incredible work side-by-side with the HITAC members, and just hats off to you and the entire organization. Major credit. Today, we have a very action-packed agenda. We can go into the agenda and talk about what today looks like. Obviously, we just had our opening remarks.

We are going to talk about the HITAC work plan for the calendar year '23. We are going to definitely go into the Public Health Data Systems Task Force and the recommendations there by Gillian and Arien, who have done a phenomenal job leading that. We will do a quick break at about 11:55 a.m. At 12:05, we will do the ONC objectives, benchmarks, and public health data updates, led by Elise and team, who have been working hard on this. Then, we will of course come to something near and dear to my heart and Medella's heart, with the HITAC Annual Report Work Group. Where are we with the report? A lot of work is going on

there with Michelle and team behind-the-scenes churning out a beautiful report that is coming together. We look forward to your feedback on that HITAC and your thoughts there.

We will go to public comment about 1:30-ish or so and then we will adjourn somewhere around 1:45 today. It is an action-packed agenda. Should be a great end-of-the-year. We will be sure to send Denise and the entire team out on a high wave of success because they helped lead us through a lot. It has been a lot with the pandemic. It has been a lot with things that are going on, and then launching these little things like Information Blocking and TEFCA and others. An amazing year it has been.

All right. I am going to call now for an approval of the October meeting minutes. Hopefully, you all got a chance to read that. May I have a motion to approve, please?

Medell Briggs-Malonson
This is Medell Briggs. I move to approve the minutes as written.

Aaron Miri
Thank you, Medell. May I have a second, please?

Hans Buitendijk
This is Hans. Happy to second.

Aaron Miri
Thank you, Hans. All those in favor please signify by saying aye.

Multiple Speakers
Aye.

Aaron Miri
Any opposed please signify by saying nay. Any abstentions? Okay. The meeting minutes pass for October. With that, we will go right into the show I am going to transition off to Mike and Tricia Lee, please. Talk about the HITAC work plan. Mike, I think you may be on mute, my friend.

Mike Berry
I am on mute. Thank you, Aaron. I just wanted to tell Denise how much I will miss her co-chairing the HITAC and thank you for your service on the HITAC. We wish you the best of luck in your new HITAC-free life.

Denise Webb
Thank you, Berry.

CY23 HITAC Work Plan (00:16:45)

Mike Berry
Sure. I am back to talk about the HITAC work plan for next year. If we could move to the next slide, we will talk about the process we went through here at ONC. We all worked together to determine what the work plan looks like. We think you will be pleased with what we have come up with, but there is a process to do that. We, of course, review the transcripts and the meeting notes from our discussions and the annual report

that comes out. We pull from that and look for themes that repeat themselves from year to year. We do have legislative requirements to meet and our own ONC work plan to consider. Then, we met with the co-chairs a week or so ago to get their input as well. We are now at a point where we want to review the work plan with HITAC members and get your input and talk about anything else that we may have missed that you want us to consider adding to the work plan for 2023. Let us go to the next slide.

Here are the areas in the Cures Act that the HITAC's work falls within. We have interoperability, patient access, privacy and security, technologies that support public health. You'll notice at the bottom that we have a new priority area the HITAC is considering adding. That is the design and use of technology to advance health equity. Later on in the program today, Aaron and Medell will be talking about all of these priority areas and the work that would fit into these priority areas. HITAC's role is to provide recommendations to the National Coordinator. All of those fit into one of these priority areas.

As Micky mentioned at the top of our meeting, we have been busy this year, as always. I listed here what we have completed so far for this calendar year. Back in February, the HITAC voted to adopt an annual report for FY21. We had the e-Prior Authorization Task Force that met earlier this year. Then, from January to June, the Interoperability Standards Work Group reviewed the USCDI Version 3 and the ISA and provided many recommendations related to that. Then, the Adopted Standards Task Force also met. That is the blog post that I authored that is on healthit.gov that we encourage you to read. What is still in progress for this year is the annual report for this year, which will be wrapped up early next. Then, as you all know, we are eagerly anticipating Arien and Gillian's commendations from the Public Health Data Systems Task Force. Lots of good recommendations in that report and we hope you had a chance to review it. Next slide.

Here is our work plan. It is just a snapshot. We are planning full committee meetings every month of the year next year except for December. Same with this year. If we have determined we do not have agenda items or we want to give you a break maybe midyear, we will cancel one of those. When we do release the Federal Register Notice we are planning for 11 full committee meetings. Then, the next row is the HITAC Annual Report Work Group that I mentioned will wrap up in February. Then, it picks up again about May and then it will meet throughout the rest of the year. We are expecting the Interoperability Standards Work Group to be reconvened to review the USCDI Version 4 when that comes out and other priority uses of health IT. We have also been talking about the ONC NPRM Task Force. At this point in the year, being November 11th, whenever the NPRM is released for public comment we are planning to be convening this task force, we have asked for HITAC volunteers. Many have volunteered and I appreciate that. Once the public comment starts, we will convene the task force and it will roll into the new year. I do not have dates because I do not know when that an NPRM will be released.

Next on the list is the Health Equity By Design Task Force. As you know we had a health equity by design hearing back in March. It was a half-day hearing that was very successful. We are building off that hearing to the pull the task force. We are currently working with the team here to determine that looks like. We will be asking for input when we get close to that. Last year and this year we had the Public Health Task Force. We are anticipating that reoccurring next year. I am not sure what the focus is going to be on, but I am sure we will have one to focus on. If we do not do a task force we could do individual feedback sessions. That is our thought there.

A new item on the list, which I hope excites you because it excited me, is a Pharmacy Interoperability Task Force. We are looking at a pharmacy use case to talk about. I want to turn it over to my colleague Tricia Lee Rolle, who is going to walk us through the next few slides. Then, I will come back. Tricia Lee?

Tricia Lee Rolle
Thank you, Mike. Can you hear me?

Mike Berry
Yes.

Tricia Lee Rolle
Awesome. Good morning, Aaron, Denise, and Medell, Good morning all of the committee members of the HITAC. I am excited to present on this important topic. During the pandemic we met with and heard from a number of federal partners. We have had a number of different stakeholder meetings, whether it has been workshops, listening sessions, various staff engagements with different industry partners, and we have identified four compelling needs around pharmacy interoperability and emerging therapeutics that I would like to briefly share with you for discussion today.

On the next slide, you will see our first, which is about supporting clinical pharmacy services and care coordination. The little graphic there shows you a schematic of where we are right now. For the most part, we can all declare that the transactions that support pharmacy services are **[inaudible] [00:23:01]**. E-prescribing is an amazing use case and billions of transactions that flow annually. It works and it works very well thanks to the standards that we have in place. There are increasingly more and more pharmacy clinical services that are being provided today, from immunizations to laboratory, some laboratory testing, and adjustment of medication therapies. There are different states that our allowing for the prescribing of contraceptive medications and a whole host of different arrangements between pharmacists and primary caregivers to help provide care to those in need.

Where we are not right now is at a point where this is all fully coordinated. Some of these services are happening and the information is not getting back into EHRs. There are black boxes for some of these pharmacists providing a variety of clinical services who do not have the full health picture of the patients they are providing care for. In general, we would like to identify opportunities and recommendations to improve interoperability between all pharmacy stakeholders, not just those providing clinical services, but realizing there is an entire ecosystem that includes prescribers, pharmacists, dispensers, PBMs, the payers, and everyone. We need to identify how to ensure that data is available where it is needed and when it is needed for the delivery of those services. We have heard from other federal partners, including OASH, that they have an interest in understanding how pharmacy clinical services may be better integrated within the primary care landscape and how we can ensure that when patients are receiving care from different healthcare providers that information is available across the board.

On the next slide, we want to think about what is necessary to support public health broadly, specifically emergency use authorizations and new prescribing authorities. Right now we are aware that there prescribing authorities for pharmacists to help assist in distributing and getting patients on Paxlovid therapies. Specifically, it requires them having access to a patient's medical history and medical records.

We know there are gaps in that access that can affect some of the administration's goals around the test-to-treat pathways where a patient can be tested and then be initiated on treatment within a short time period.

We have heard from another advisory committee, from CDC's Advisory Committee to the Director, that they are also interested in understanding and have been discussing some of the roles of pharmacists in getting access to these records to support some of these emergency authorizations. Generally speaking, this is a compelling and very timely use case but we know there is a whole lot more. We are aware of private sector initiatives. We know that NCPDP has worked with a number of different organizations, Experian Health and FCC Health, to see how they can use their infrastructure to support opioid surveillance and data sharing to help support data sharing and surveillance around COVID. We are seeing that there are different initiatives and efforts underway to help build out some of this, where we can see pharmacists as frontline in helping to identify patients in need or at risk. What role might there be for ONC? How can we understand where standards can be helpful in connecting some of the dots and better integrating our pharmacists, frontline providers and frontline locations, to help have this data available?

Quickly, let me describe the next two. I know this a lot, but we are putting it all out there. We have heard from a lot of different stakeholders and this is a great opportunity to consider what we can do next year to help address some of these need areas.

On the next, I will also discuss emerging therapeutics. What is interesting is that there is a whole category of drugs known called specialty medications. They are accounting for an increasing amount of drugs pend. They are also an increasing amount of volume. Right now, if you consider Part D prescriptions, about 40 percent of new Part D prescriptions may be considered a specialty medication. It accounts for about 88 percent of drug spend for the Part D program. More and more, you are going to see these emergency medications and patients being prescribed them. However, unlike routine E-prescribing, the specialty prescribing space is mainly fax, some portals, some limited electronic routing, but nothing like the E-prescribing network connectivity that we see and are so used to.

There is a huge need in how we can bring these drugs and medications into a space where they can be easily prescribed and managed. You will see also we are thinking about emerging therapeutics and what we can discuss or consider for digital therapeutics. We are aware that CMS has a new medial code for digital behavioral therapies, so we can expect to see more and more of those treatments being prescribed. However, there are some obvious gaps here because we still do not have a universal definition of what is a digital therapeutic. How are we going to get data from these devices, tools, and therapies back into the EHR so that the entire care team can be aware of what is happening with a patient that might be on a therapy at home?

Finally, there is genetics. This is exciting. There are orphan drugs being developed. There are potential cures for diseases that we could not have imagined previously. As we are approaching 2025, we are expecting there will be at least 10-20 new FDA approvals for gene therapies. What does this mean for how we are thinking and making decisions around drug gene interactions? What does it mean about the availability of genetic information for clinical decision making? Again, emerging therapeutics and emerging use cases that we have an opportunity to get out ahead of so that we can make sure workflows are in place and the data is available where it is needed.

Finally, on the next slide, I want to share with you direct-to-consumer medication services. For example, these are services that typically provide services around sexual and reproductive health and some STI testing and treatments. This is a whole area that is running the gamut from providing dispensing services to full-on telehealth modules. They are advertising themselves direct-to-consumers as a way to easily, and discreetly in some cases, get access to medication without the rigmarole that might be involved in having to seek out care. These are becoming increasingly popular ways for individuals to get access to certain medications and certain treatments. However, we do not want these types of care and access happening outside of view of fully coordinated care. What do we need to know about this? Is there a role for ONC? Are there ways to have information with consent available for those who need it? What is the way that we should be thinking about this from a policy perspective and from a technology perspective?

We are all for ease of access. We are all for the use of apps. However, we also want to make sure that data is available for those who need it when it is needed to evaluate an entire patient's care profile and care need. I know I said a lot of things quickly, but I wanted to get through it all and leave some time for discussion. Thank you so much.

Mike Berry
Great. We have a few more slides to go and then we will open up for discussion. Thanks, Tricia Lee. Like I said, we are excited about the pharmacy topic. It is something different for us. I know there are several HITAC members that are interested in being on that task force. I believe Tricia Lee will also be adding a few public SMEs to that task force as we normally do just to augment our HITAC team.

This slide has some of the potential topics for discussion for next year. Some of these are carryovers from this year. We have added some new ones, especially the health equity being at the top of the list there. We are looking for opportunities to either turn these into a potential task force or a listening session. I just wanted to provide this list to the HITAC members so you can see the ideas you are providing to us through your annual reports. Next slide.

We are heading towards our discussion. I wanted to just ask if there are additional topics we did not capture that should be on the list. What are the key factors for these topics as we develop the charge? I think this would be useful related to the Pharmacy Interoperability Task Force. What is the form for these topics? Is it a subcommittee, a task force, or a work group? Is it a panel hearing, or is it just a listening session perhaps during one of the committee meetings? Finally, how should we prioritize these topics? Next slide.

Our next steps are to get the HITAC members' feedback today. Of course, we are also monitoring the chat from the public members. Then, we will adjust and finalize the work plan this year. Then, my plan is as always, during our January 2023 HITAC meeting, we will present the final work plan to the HITAC members that incorporates all of your input. With that, I will turn it back over to Aaron to start discussion. We are happy to answer questions.

Aaron Miri
Wonderful. Thank you very much and appreciate you, Mike and Tricia, for your great overview. And I do not think Tricia went on too long. You did a great job, so good job with your presentation. All right. Opening up to some questions here, I see first up in the chat window Dr. Steven Lane. Go for it, sir.

Steven Lane
Tricia, I want to thank you for that great presentation. What an exciting concept for us to move forward and throw our attention around pharmacy and medication informatics and interoperability. If you are monitoring the chat, there are a lot of good ideas going in there and I hope we capture those and hand them off to the team that is looking at this. As a practicing physician, I can tell you that the need for medication data is so acute, and to have that be more complete, more accurate, more granular, and to be fully shared amongst all members of the care team, including clinical pharmacists and prescribing pharmacists, is a great opportunity for us to improve the safety, quality, and continuity of care. Thank you for that attention.

Aaron Miri
Thank you, Steven. Next up, my namesake, Mr. Aaron Neinstein. Go for it.

Aaron Neinstein
Thank you, other Aaron. I appreciate it. Two comments, as another practicing physician, tack on to what Steven mentioned, which is great thanks To Tricia Lee. I agree that there are so many fantastic use cases here related to pharmacy and prescribing. Everyone is always very excited about trying to eliminate faxing and manual work and this is a space where there is a lot of it. When it comes to durable medical equipment, there has been such success with prescribing of regular medications and prescriptions. However, durable medical equipment is a world untouched by modern health IT, so lots of opportunities here for HITAC and ONC to have an impact.

Second, I want to add my vote Mark Savage's comment in the chat about a possible topic for 2023 related to patient generated health data and patient reported outcomes. When it relates to use cases, there is a lot of telehealth increasingly happening across the country, a lot more virtual care and remote monitoring capabilities that health systems are trying to deploy. I think this is a space that the ONC should lean into as we think about the future of clinical medicine that is less geographically based. It would be good to get ahead of where the puck is going here.

Aaron Miri
Great comments, Aaron. I agree with you 1000 percent on getting away from being geographically based. Very well said. Hung Luu, you are up next.

Hung Luu
Yes. I just want to make some comments on the direct-to-consumer pharmaceutical needs. I think I need to stress the need to respect patient privacy and autonomy while balancing the need for a complete history and medication history in providing care for the patient. Some patients may have a restricted access to healthcare and may not have that many options to healthcare providers. There is a reason that they may resort to these direct-to-consumer options in order to gain care while preserving their privacy needs. To not have some kind of gatekeeping mechanism where the information is only provided with their authorization and full knowledge, I think, would be a disservice to these patients. I feel very strongly that whatever direction we go has to balance patient privacy and autonomy with it.

Aaron Miri
Great points. See, the whole chat here is blowing up in appreciation of what you just said, Hung. So, well said. Next up, Cynthia Fisher.

Cynthia Fisher
Yes. Hung, thank you for your comments in looking at the patient perspective. This can be a big overreach on negating the patient's ability to even know that all of this data is being collected and shared behind the scenes among so many parties, and that it is potentially being used, marketed, and re-brokered to many other parties as well, combined with their financial information on AI applications that oftentimes are used in conjunction with the medical health records. I just think there needs to also be a big sensitivity to the privacy of the patients and the ability for informed consent. The patients should be able to opt out of sharing any of this information as well. We should not assume that the patient is engaged in participating. I think it also goes to data that is collected and sent on maternal health, on actualization of prescriptions, that could provide potential harm. I do think privacy is substantially needed and also informed consent that this is actually taking place. I think people should be able to opt in or opt out and have the right to have control over their data.

Aaron Miri
Good point, Cynthia. I would also say a plus for the pediatric community with informed assent. If you are not of the consent/assent age and being able to go down the entire lineage there across the care continuum. Great points there, Cynthia. Thank you.

Cynthia Fisher
Could I also add that there is a significant problem right now in the Epic systems and the Athenahealth systems. That is the digital pen. Today, patients sign their signature when they check into a hospital or they check into a doctor's practice. No longer are they provided even a printout, a screen, of what they are signing. They think that they are just signing in for their appointment, and they do not know that they are signing and informed consent to release all of their health information, and to bill their insurer, or that they would stand to pay whatever they are being charged without knowing prices. I do want to bring to the attention of HITAC that we have had patients surveyed across the country. This is standard practice that you cannot even get a printout from the reception desk. You have no idea or see a screen of what that digital signature is doing. And people are being gamed, that they think they are just signing in for the appointment.

Aaron Miri
Appreciate that, Cynthia. I will also say PLOS ONE for the research community, with signatures needed there, too, for clinical trials. I think those are all important points, and they speak exactly to why this is such a hot topic and why you are seeing in the chat everybody totally agrees with the need to double-click on privacy. Great point, Cynthia. Next up, Medell.

Medell Briggs-Malonson
Good morning, everyone. I do want to echo all of the gratitude for both Mike presenting this to us and also Tricia for bringing in the pharmacy interoperability. These are incredibly important topics. One thing I wanted to add, especially as we are thinking about what we are planning on doing next year. I recommend thinking about both community vulnerability and how we can actually utilize that data appropriately as we are thinking about greater interoperability across all of our various systems. Hung brought up a very important point about accessibility to pharmaceutical services, but we also know there is lack of accessibility to other health services and public health services. It would be great to center some of the data and think about how

we integrate that. For instance, the social vulnerability Index score, the area deprivation index scores, and several others, so that it allows much greater latitude to understand a patient's different access to various resources in order to elevate the level of care we can provide or the public health interventions we can provide.

I just wanted to bring that to this discussion because I have not yet seen that as a priority for speaking about it for HITAC, or even a recommendation to ONC. This goes directly into all those aspects of making sure we understand the ecosystem, the environment, that our patients are coming from.

Aaron Miri
I love that, Medell. You are exactly right. It is that wider lens view. Great points there. Rajesh, you are next up.

Rajesh Godavarthi
Thanks. First of all, I want to thank Denise for all the wonderful work you have done, especially me being a poster in HITAC. I learned a lot from both of you. Number two, on the pharmacy interoperability, I just want to make a comment that the Electronic Prior Authorization Task Force we have done earlier this year had concerned groups and many of the people commented in the chat as well. We have learned a lot about what interoperability would look like. I think it would be good to bring some of the expertise into this mix and to learn from those lessons, even potentially the NPRM comps. I think it will be a great opportunity to collaborate on two ends to make one interoperability work rather than designing two different standards. I just wanted to make that comment.

Aaron Miri
Great point, Rajesh. Keep it simple, basically, but tapping into the brilliance that is already there. So, good points. Good points. All right, any other questions or comments from the HITAC? That was a good first opening foray. Great job, Mike and team. Great job. All right. If there is nobody else? Going one, going twice –

Clem McDonald
I was trying to talk and I left myself muted.

Aaron Miri
Oh. Clem, go for it. All right. There you are. Go for it.

Clem McDonald
I would like to reinforce Cynthia's issue about people signing stuff and do not have any idea what they have done. That stands out. There are a whole lot of issues that have been brought up here but we ought to just jump on that and fix it. That is terrible.

Aaron Miri
Yeah. Agreed, Clem. Totally agree. I think Cynthia wants to say something to that end quickly. Go for it, Cynthia.

Cynthia Fisher

Yes. Thank you. To add to that, we have had patients tell us that across the country, when they go to check in and change the form that they do not want their records shared, or they are paying cash, the form that is standard in Epic or in Cerner basically says your insurance will be billed and your information will be shared. There is not an option on the form to say no to insurance because they are paying cash. They are actually denied care if they refuse to sign it, that they can charge the insurance as well as be paid cash. What happens is the administrators will not allow them to get their surgery or care unless they sign the standard form with the hospital. They have no option to articulate that they have already agreed with their surgeon they are paying cash. And they are not going to pay insurance. They are even blocked and denied care or their appointments are late because the processes and the procedures are not there to empower the patients with choice.

This has allowed for double billing where the patient does pay cash. The surgeon has already ran the credit card in advance or paid directly with a debit card. Then, it goes to their insurance as well. Or, they are denied care to say, "Well, you are insured and you cannot pay cash." There is a whole protocol at the front-end of getting doctors' appointments and care that patients are denied being empowered on opting not to have their data shared if it is a very personal thing they do not want share. Then, they do not have that option. This really does need to be addressed because the patient has these rights and they are being denied.

Aaron Miri
Yeah. Great points. I appreciate that, Cynthia. Thank you for the additional coloring. Truly an important topic we should definitely double-click on, especially with a whole group of folks from different perspectives. I think it is a very important topic. All right. I think, if that is it, we are now up next to transition to the Public Health Data Systems Task Force. We are going to be going for a vote here, so we will go over to Gillian and Arien with Denise helping them moderate this. I'll leave it over to Gillian and Arien. You are up.

Public Health Data Systems Task Force 2022 Recommendations – HITAC Vote (00:47:14)

Arien Malec
Good morning.

Gillian Haney
Good morning, everyone. I will be kicking things off today and walking us through the overarching points of our presentation. Then, led by Aaron, we will get into some of the detail of our recommendations. First off, thank you very much for having us here today, I am Gillian Haney. I am the Director of Surveillance and Informatics Programs with the Council of State and Territorial Epidemiologists. Formerly, I was at the Massachusetts Department of Public Health overseeing all of their infectious disease surveillance systems for over 20 years. I am delighted to be here today. Arien?

Arien Malec
I am definitely delighted to be here. We have done a lot of hard work. We have suffered through illness and we are pleased to offer these recommendations for consideration by the full HITAC.

Gillian Haney
If we could, just move to the next slide, please. This is our agenda for today, and I am going to give a little bit of background before we get into the specific charges of the task force. There is an adage that is often said by public health that if we are doing our job effectively we are invisible and forgotten. In the past several

decades, our role in the background has resulted in a lack of sustained funding to support critical infrastructure necessary for response. Could you please move to the next slide?

Like many specialties with regard to healthcare, public health has broad legal and federated authority over many domains, ranging from the monitoring of shellfish beds, to provisioning immunization records and vaccines to providers, infectious disease surveillance and follow-up, injury and violence prevention, vital records, and situational awareness and readiness. That is just to name a few. A single dataset and a single pipeline cannot be used by neither healthcare nor public health to meet all of our needs, to meet our shared goal, of improving the wellbeing of people seeking healthcare and those who live in communities in our jurisdiction.

Historically, our funding has been siloed, which has resulted in some unique legal requirements at the state and local level and an uneven distribution of resources across program entities. When outbreaks have occurred, such as HIV, Zika, or H1N1, Congress allocated further disease specific funding to support that response but has limited sustained resources to invest in infrastructure to modernize public health data systems. It is important to note that much progress has been made since the enactment of HITAC. Data are electronically flowing. Many public health jurisdictions have developed comprehensive electronic laboratory reporting for reportable conditions, flexible surveillance systems to support case investigation and acceptance of electronic case records, immunization registries that track immunizations in close to real time, and syndromic surveillance to provide situational awareness.

However, as demonstrated during the pandemic, and again with monkeypox, large sections of public health are still not receiving the data we need to respond to and stop the disease spread. The substantive investment with COVID dollars shored up some of our response systems and provided for new resources for others, such as vital records. As outlined in the Data Modernization Initiative, it is critical that public health receive relevant data in the correct format from healthcare providers to be able to efficiently use the data for public health purposes and to support timely data-driven decision-making. Lack of interoperability and the inability to provide our systems to efficiently send data to public health can further create nano reporting burdens on providers in the public health workforce. This task force was established to address some of these issues.

We have reviewed the existing public health certification criteria known as that F-criterion in the ONC Health IT Certification Program and have developed the recommendations that we will present before you today with the ultimate goals of improving data quality while reducing existing burdens on providers in public health that further delay public health actions. Our overarching charge is before you on the slide. It is to build on the previous recommendations of the HITAC public focused task forces and inform ONC's continued collaborative work with CDC in improving public health data systems in support of data modernization. Specifically, we looked at the F-criterion to certify transmission of data in order to identify gaps in those functionalities and standards and to address those gaps in functionality and the implementation by developers and provide recommendation in advancing those criteria testing guidance and standards to address those gaps.

We look to assess the specific functions, such of the receipt of data, ingestion of data, and analysis of data, supported by public health data systems that would benefit further standardization and potential

certification. W recommended which data flows aligned with those existing criteria that should be prioritized for standard receipt of data. Next slide, please.

We had a very robust task force from all sectors, from public health, private healthcare, and government. It served to have extremely lively and collaborative conversations. The members are listed here and include many members of the HITAC. Next slide, please.

We had an extremely short timeline from which to develop a common level of understanding, offer recommendations, debate those recommendations, and then pull everything together. We kicked off at the end of August and met weekly, and had our final meeting on Monday. We are now before you today with our proposed recommendations. Next slide, please.

Our approach was to review the F-criterion and develop a nano level of understanding. We determined what are the core questions we needed to ask of each criteria. We invited presenters with subject matter expertise, from providers, public health, and various organizations. Then, we debated, and proposed, and debated some more, and drafted the final recommendations that are included in the report before you today. Next slide, please.

These are the F-criterion we were focused on, including transmission to immunization registries, transmission of syndromic surveillance data to public health, transmission of laboratory data to public health agencies, cancer registry data, electronic case reporting transmission to public health, antimicrobial use and antibiotic resistance reporting, and finally, healthcare services. Next slide, please.

The following slides list our presenters. Again, we had representation of subject matter expertise from all sectors engaged in this effort. We began with an overview and then for each meeting went specifically into each of the F-criterion. Next slide, please. As you can see we were extremely thorough. Next slide, please. The last presentations included level setting from HL7 and network for public health law as well as comments from the vendor and industry. Next slide, please.

We asked each of the subject matter experts to prepare a presentation that looked at our current state, what those gaps are as it related to functionality of the F-criterion, and recommendations they had for advancing criteria in terms of testing guidance and standards and implementation specifications. We asked them to also each provide level setting in terms of what specific functions that were supported by public health data systems that could further benefit from tightening its standards and implementation specifications, and what recommended data flows would align with those criterion and should be prioritized for standard receipt of those data. Next slide.

The task force came up with many recommendations, which we are going to get through in a minute. Ultimately, in terms of higher overarching recommendations, we are recommending the inclusion of expanded and standardized testing criteria for certification of technologies. We are looking to reduce burden on providers in public health systems to improve standardization and interoperability. We are looking to establish certification criteria for public health technologies to create a common floor to support the exchange of data inclusive of all providers and public health and inclusive of methods by which providers primarily electronically exchange with the public health authorities. A common floor supported by robust certification criteria for public health technologies and compliance with submitted message board netting

completeness requirements will assist healthcare systems and public health authorities to address the missions of public health at a lower overall burden and reduce special effort.

Importantly, we are not recommending the certification of functions and behavioral attributes of public health data systems outside of interoperability functions, nor do we recommend certifying the programs of public health authorities. Finally, I would like to note that we are making these recommendations under the assumption that new resources will be provided to state and local public health authorities to achieve and maintain certification of the relevant technologies. I would like to point to the Public Health Information and Technology Infrastructure Report by HIMSS. The public health infrastructure requires significant investment and support for the certification of these technologies and will necessitate new and robust funding specifically for this purpose. The link is provided therein. Next slide, please.

Next, are the overall summaries in more detail in terms of focusing our efforts on the certification of interoperability and not other functions or attributes of other public health data systems outside of interoperability or the programs of public health authorities. Next slide, please. Again, I would like to just recognize that the responsibility for state and public health authorities are created and directed by those governments and federal law. Accordingly, the certification criteria for public health technologies is not intended to limit or circumvent those authorities to request to receive in a manner which specifies to fulfill their missions to address emergent needs. Rather, the goal of certification criteria is inclusive of all providers in public health inclusive of the methods by which data are primarily exchanged by public health authorities. I am going to turn it now over to Arien to start walking us through the specific recommendations that we have. Next slide, please.

You can see on the slide the summary recommendations. I believe there are over 50 in total. We have broad recommendations for those existing criteria, as well as new standards and implementation guidance before we get into the specifics of each specified criteria. Arien.

Arien Malec

We have one question. Yes. Not only do we have a ton of recommendations, we have an actual suggestion. We will get into that. Let us go to the next slide. All right. I will not go over the detailed recommendations, particularly in areas that Gillian already covered in our high level. As noted, we recommend establishing certification criteria for public health technologies, making sure that we have a plan to roll out certification criteria in ways that address disruption in funding, dual running, etcetera.

We do recommend that ONC work with the named organizations to create a set of success criteria and outcome criteria associated with the certification program. As noted, we believe a properly functioning certification program that addresses both the pitchers and catchers of public health data will overall reduce burden and improve the effectiveness of public health responses. We believe that the outcome measures should be tailored both to the efficiency and the effectiveness of the exchanged data. Go on to the next slide.

We learned a whole lot of hard lessons in the EHR certification program, most of which are memorialized here. Number one, is that we need to certify interoperability as opposed to functionality, except for functionality that is directly associated with interoperability. Number two, that we need to drive to modularity in ways that provide flexibility and freedom for public health authorities to select mix-and-match

technologies to address the overall aims and outcomes of their programs. A lot of focus on making sure that we have standard terminology. There was a fair amount of expressed frustration that is not new to anybody in the HITAC, that certified EHRs did not emit in practice structured information that was helpful for achieving the plurality of public health missions. Most of the root causes for that were data oriented, where the data that was being exchanged was not in fact coded correctly in ways that allowed for incorporation and use to do, for example, case investigation, contact tracing, surveillance, etcetera.

We believe, as we think about certification and we think about the certification criteria, we need to double down on the content side and not simply the structure side of our interoperability specifications. Patient matching is a key consideration for public health as it is for healthcare generally. We recommend that ONC works carefully and diligently with standards development organizations to make sure that we upgrade all of the standards and implementation guidance to be inclusive of common standards, such as Project US@, and to make sure we have contact and demographic information that is sufficient for enabling contact tracing and patient matching and linking. Next slide.

Again, there is a major focus on value sets and data content, not just data structure. We noted two root causes of not getting structured information at public health. One is a variance between the EHRs as certified and EHRs as practiced. In some cases, collecting information that is nonstructured and in other cases using value sets that were not the ones they were certified to. We also noted issues in updating systems to be inclusive of the latest value sets. Some of the larger EHRs were able to have their value sets updated in near real time as the COVID crisis emerged. Other systems were left without updated value sets and that impeded the ability, for example, to use ECR and trigger conditions on ECR, as well as the ability to receive, for example, electronic lab results that were LOINC encoded with the correct codes for COVID related laboratories, or in some cases in syndromic surveillance, to get diagnosis or chief complaint codes that were aligned with the latest in terminology.

We recommend that the certification program be updated to include the ability to demonstrate the ability to update terminology without special effort, and make sure that we have got incentives up and down the chain to make sure we are capturing source terminology. For example, we will see this in our lab results section, the ability to transmit electronic lab orders and capture lab tests and test results with correct coding. Let us go on to the next slide.

The notion of real-world testing came up time and time again, so we want to make sure that we have got a certification program that is inclusive, not just of the systems as certified but also the systems as used. In particular, with respect to this notion of value sets, we also believe that ONC should work to create and align standard operating rules for the timely updating of value sets, and then work to make sure that we have got the programmatics that ensure that value sets are updated in a timely manner for the reasons already noted. We recommended that ONC work with a variety of organizations to make sure that we harmonize all of the implementation guidance associated with public health interoperability. In particular, we want to make sure we are taking the latest and greatest in terms of USCDI updates in areas that drive health equity by design, inclusive of SDOH and SOGI data. If we can go on to the next slide?

Really importantly, the current race and ethnicity value sets are the OMB five plus two race and ethnicity codes. We believe that is insufficient in practice for driving health equity by design and tracking disproportionate impact of conditions, diseases, etcetera, on a variety of populations. We believe that ONC

should work with partner agencies to create a more granular subset value set that addresses the needs of, among others, public health to create equity by design. An aligned value set that would reduce overall burden. Right now, many states, localities, tribal organizations, and territories are driving their own subset value sets. That is driving variation on the ground. The alignment to a common, more granular, value set would overall reduce burden as well as improve our ability to drive equity by design.

This notion of optional and optionality in implementation specifications and guidance came up again and again. The issue here is that many implementation guides have a set of mandatory elements and then a set up optional elements. Optional elements are often taken in practice to mean never provided, whereas those optional elements may be necessary for effective public health response. We recommend that certification criteria include support for optional elements, particularly those that are most impactful for public health reporting and response. Let us go on to the next slide.

All right. Again, this notion in certification that we drive certification that addresses not just the structure of data but also the content and meaning of data, the semantics of data. We believe that certification should address not just the happy path, but also address cases where data are not encoded properly, data are not provided properly, so that we have certification criteria that more effectively map to the ability to receive data efficiently and effectively in public health.

Again, this notion of real-world testing and the ability to address real world data gaps and to put in place a system of continuous refinement to address and close real world data gaps. We recommend that ONC work to harmonize all of the standards of implementation guidance to address the need for incorporation and integration by public health authorities. As examples that were mentioned, we have immunization data, lab results data, and electronic case data, which at some point all need to be combined in order to provide effective case reporting and case tracking. Go on to the next slide.

Okay. Those are our overarching recommendations. Those are the recommendations that either provide an umbrella set of recommendations across all of the F-criterion or address key considerations that go above and beyond the existing F-criterion. We also noted a number of areas where there are opportunities to address new standards and implementation guidance that might one day become certification criteria. We will go through those new standards in the implementation guidance and potential certificate criteria. Number one, there are a couple of areas where there are public health data flows that often originate in EHR systems that could help the public health response. Number one, recommend that ONC convene a variety of partners to develop a comprehensive approach with standards and implementation guidance for situational awareness. This could eventually turn into certification criteria.

The same thing for vital health statistics, in particular birth/death, that again could reduce overall provider burden and public health burden by allowing data on births and deaths to flow automatically into the respective public health authorities using standards and implementation guidance. Same thing for other newborn spot screening. Next slide. Same for other newborn screening services, such as audiology. We also recommend that ONC work with public health authorities, as well as the RCE and QHINS to address TEF query for public health. We noted that the expanded set of certification criteria that we are calling for includes, for example, electronic case reporting for the initial case report offering public health the ability to leverage the trusted exchange framework network, provides additional means for public health to follow-up on case investigations, in particular in areas and conditions that are emergent, or in areas that require more

specialty focus. For example, some public health authorities have recommendations for cancer registries. Some public health authorities have focus areas for neurodegenerative diseases and others. The ability to follow up to an initial case report and request appropriate use of data that is specific would be incredibly helpful.

We noted in the details here that the ability to open this up to FHIR based queries would provide public health additional tools to do that scalpel-based approach as opposed to the all or nothing consolidated CDA based approach that is currently used. Go on to the next slide.

I believe that does it. Oh no, we have more. As we think about TEF query subsequent to creating the implementation guidance, this is an area where we are actually calling for certification criteria on all of the parties to address the need for public health TEF query. We had a bunch of discussion about decision support and push notification, where we believe public health could be helpful in a broader healthcare ecosystem. We recommend that ONC work with a variety of organizations to coordinate the development of standards and implementation guidance to push notifications and enable decisions for EHRs. There were successful examples of pilot testing this in the time of Zika as well as COVID. We can think of multiple examples where providing focused decision support would be useful. We also noted that immunization forecasting is an area where the ability to provide finely targeted decision support inside HER workflows would be useful.

Finally, we recommend that ONC work on interoperability between and among public health authorities. Let us go on to the next slide. Oh, no. There is more for new standards and implementation guidance in certification criteria. We note that there are a variety of healthcare settings where data for public health originates. They are not currently covered or not often certified to. We recommend that ONC work with its federal agency partners to look at those areas, including long-term post-acute care, laboratory, pharmacy, in areas where we could expand the net of certification. Then, I believe now actually are final. In looking at areas where we can leverage common consent and data sharing policies and directives in ways that can expand the ability to address interoperability between jurisdictions that may have different requirements for consent and authorization.

All right. Let us go on to the next exciting suggestion. In most cases, we have formal recommendations. Here is an area where we have a strongly worded suggestion. The main reason we did not go to a recommendation here is that this is a somewhat thorny topic that addresses issues of jurisdictional lawmaking. It might be useful is across jurisdictions there was a common floor policy framework that better facilitated information sharing for public health. It might be useful for ONC to coordinate a review of policy and the need to address a common policy floor that could facilitate information sharing.

All right. Now, I promise we are on to the next slide. You have been disappointed so many times. Transmission immunization registries. Now we are in the thick of it. We have addressed the common requirements and overarching recommendations. We have addressed the areas where we are recommending new standards of certification criteria. Now we are going to go through the existing F-criterion and look at our broadscale recommendations. Overall, we are recommending that we establish certification criteria for public health technology. Number two, we noted that AIRA, the stakeholder organization that looks across the variety of immunization registries across the stilts, has published some report material that looks at predictable variation against the immunization HL7 implementation

specifications, and looks at areas where public health is needed to customize that. Oftentimes that was through a predictable variation of inventory and consent requirements. It would be useful to go back and do a re-look at the implementation guidance to see if we can raise the floor and reduce implementation variation.

People may be surprised to hear there are currently two test methods for transmission and immunization registries. One is a legacy test method. And then, subsequent to that legacy test method, HIMSS and AIRA created the HIMSS AIRA IIP test method. It has been a public partnership to address and reduce variability in the transmission and immunization registry support. And ONC has very helpfully allowed that as an alternative test method for certification. We believe at this stage it is time to deprecate and dismantle the legacy test method and go forward with the test method that HIMSS and AIRA have worked jointly on. Next slide.

As we think about query response, it is important to look at areas of automatic reconciliation of immunization data into the EHR record. We believe that ONC should work with public health provider organizations, technology developers, standards development organizations and others. We should look at means for ensuring that immunization data can efficiently flow into the patient record. Oftentimes, this is a provenance issue, so it is useful to know, for example, that the immunization record that you queried this time is the same immunization record that you queried the last time, and that there are no changes, and so there is no need to go through a reconciliation workflow. There are also opportunities to make sure that terminology standards and patient identity standards facilitate incorporation into workflows.

We noted that there is a broad variation across different settings of care about the timeliness of updating into immunization registries. There is an opportunity to address at least a common consistent floor in terms of updating immunization registries across settings of care. Again, we would note primary care, acute care, laboratory, pharmacy, and long-term and post-acute care as the settings of care that may need to be harmonized and aligned. The CDC worked on the immunization gateway in conjunction with APHO. It would be useful to certify the immunization gateway via modular certification for immunization reporting and for query retrieve because that would help facilitate interoperability. Go on to the next slide.

Okay. So, we are at syndromic surveillance. I think I skipped over something in wanting to get through these criteria relatively quickly. As part of our recommendations for certification for immunization data, CDC has an implementation guide for the transportation side of both the transmission to immunization registries and the query retrieve. Current test methods do not incorporate the transport requirement. We are recommending that we update the certification criteria to include transport and certification of transport standards as part of the immunization certification requirements.

All right. We will now talk about syndromic surveillance. We generally believe that syndromic surveillance works reasonably well. Information was flowing from EDs into public health agencies. We believe there's an opportunity to expand the sources and settings of care for syndromic surveillance including long-term post-acute care, urgent care, and ambulatory care. That could provide a wider net for potential signals for emerging crises. We recommend that ONC phase out and replace to the latest version of the syndromic surveillance a standard. We are just making sure that we raise the floor in terms of the syndromic surveillance standard implementation guidance. Go on to the next.

All right. This is the last section that I will go through in exhaustive detail. I will turn it over to Gillian to recommend you into submission. This is a very important and very meaty one. We are now on to reportable labs and value test results. Previously, the Interoperability Standards Work Group published a long and lengthy readout full of recommendations, and we had a section on laboratory orders and results. This task force believed that that report had some very useful detail that addressed some of the key concerns for public health. I will enumerate those concerns for public health. I think this was well-publicized during COVID, but there are often gaps in practice in the receipt of ELR into public health in areas including terminology, so the ability for the received electronic lab result to include the latest and greatest in terms of standardized terminology. Sometimes proprietary codes were used. We did not have Link and SNOMED CT codes in the appropriate places.

Then, the second major issue was the lack of patient demographic and essential contact information that can facilitate case investigation. In many areas, all of that information was either not collected at source because the laboratory did not code labs and results using appropriate terminology or because we do not have a full end to end chain of information. We were doing things like transmitting an order that did not contain all of the contact information appropriately and then leaving it up to labs to be able to search LexisNexis, for example, and fill in patient demographic and contact information to transmit on to public health at exceedingly high operating expense and in ways that reduced public health effectiveness. In many cases, we just had a full chain that went from the order to the lab. If we had labs and Analyte machines coding correctly, we could address some of these issues at source and make sure the final end to end chain from lab to public health contained the correct information. Generally, the task force agreed that just addressing the ELR chain was insufficient to address the effectiveness of ELR for public health.

All right. We recommended that ONC follow the relevant guidance in the Interoperability Standards Work Group in ways that would address the needs of public health. We recommend that ONC adopt certification criteria of public health technology to receive ELR. We recommend that ONC adopt certification criteria of technologies used by laboratories to send ELR. Let us go onto the next one. We will see this pattern of multiple actors and recommendations and certification criteria for the multiple actors. We recommend ONC update the certification program for EHRs to send electronic lab results to public health. We recommend that ONC adopt certification criteria for EHR technology to send electronic lab orders and receive electronic lab results with standard syntax. We may have missed one. We make the same recommendation for LIMS systems, that LIMS systems be certified technology

There are cases where public health run their own electronic lab reporting systems via web interfaces and we believe certification criteria should be sufficiently flexible to allow those systems to be certified for electronic results capturing. Go on to the next slide. There is the LIMS recommendation. Finally, this was a very nuanced recommendation. There was a lot more meat in the actual recommendation. In many cases, ELR is capturing information because it is the sole source for triggering case investigation. The additional information that is captured in ELR is very useful for driving case investigation, but it is also often requiring information that is somewhat unnatural to be captured in, for example, an orders workflow or at a laboratory.

In cases where ECR is broadly deployed, we are generally recommending rolling out ECR as a certified means of interoperability, both for provider organizations and for public health. In a context where ECR is broadly deployed, we believe there is a need to reconcile the information flowing through ELR. ECR, again, nuanced because there are some cases where we have walk-in labs and there are cases where the

laboratory may be the sole source of information for contextual information. In those cases, we believe those labs should send ECR as well as sending ELR. I believe that is the end of our lab test and value results criteria. I know it was a lot to throw at you. I am going to turn it back to Gillian to cover the rest.

Gillian Haney
Thank you, Arien. I will bring us home and then we can embark on some discussion. In terms of cancer registry reporting, which is, I think, one of the newer forms of data interoperability, we are looking for ONC to collaborate across partner organizations to update the standards for exchange of the cancer related information, and also to draw on existing pipelines that are currently used by, for example, electronic laboratory and electronic test reporting efforts. I think there is a lot of utility that could be drawn from those that could be helpful to cancer transmission. Next slide, please.

Getting into electronic case reporting effort, I think it is important to note that this is still very much in its infancy. Although the pipes and the infrastructure are being built in a centralized fashion, we wanted to make sure that we are learning lessons from our rollout of electronic laboratory reporting and specifically looking to ensure there are test methods that are robust enough to get the content flowing and to eventually turn off paper-based reporting. We would like to ensure that we are creating certification criteria and testing methods to do so. The next one.

We are recommending case reporting criteria for testing require certification to establish the associated TEF methods, as included in laboratory reporting, that trigger codes from which ECR is drawn from are based on Link and SNOMED. It is important to include those in our case reports. And then we specified the transfer guide from HL7 as this was missing from listing in the previous criteria. This would be the minimum for certification. Next slide, please.

These next set of recommendations for ECR focus on reportability responses and making sure that those are received with standard and advanced syntax certification and semantic certification criteria that public health technologies can receive and send those reportability responses with full criteria as defined in the full report. As mentioned previously, we also recommend that ONC work across federal and state agencies and public health authorities to establish a national organization directory including OIDs and national provider identifiers and other critical identifiers for relevant organizations enabling consistent use and look up. Next slide, please.

These next two recommendations involve a standard adoption of the trigger codes to ECRs in a timely manner using the HL7 FHIR Implementation Guide, or most current implementation guidance. Finally, we recommend that the certification program for public health technologies reporting of those trigger codes are distributed and maintained in a timely fashion. Next slide, please.

Regarding the sixth criteria, antimicrobial use and antibiotic resistance reporting, we recommend that ONC phase out and replace reference to the HAI implementation Plan that's included in the CARES act final rule and consider adopting a reference to the most current version in the next regulatory update so that we can modernize our ability to transmit those information. Next slide.

Then finally, we had no further recommendations or healthcare surveys. This is a very specialized criteria. It was felt that the existing recommendations are sufficient at this time. That concludes our

recommendations. I would just like to thank my co-chair and my fellow task force members. This was a very thoughtful and robust set of recommendations that we have developed to put forth before you. Thank you very much.

Arien Malec
And grueling. We did our fair share, both of panelh sessions and then caught up very quickly at the end to write a very large number of, I think, very thoughtful and well written recommendations. Hopefully, the full HITAC will concur. It definitely took some effort. I also want to note, it is very on-brand that both Gillian and I came down with COVID at certain parts of this work. It was not easy at times, but we got there and got you a set of hopefully thoughtful recommendations for your consideration. Aaron, let's turn it over to our Q&A.

Denise Webb
All right. So –

Gillian Haney
I can still very much hear it in my froggy voice. Pardon for that.

Denise Webb
I think I am moderating the Q&A for you, Gillian and Arien.

Arien Malec
All right, Denise. Go ahead.

Denise Webb
Thank you for your leadership in this task force, and the entire team, for this body of work. It is tremendous. I know it was probably very grueling to get through all of this. Thank you. If we could entertain questions or discussion? We will start with Steven Eichner. Go ahead.

Steven Eichner
Thank you so much. I participated as a task force member and was thrilled to do so. Arien and Gillian provided wonderful leadership working through the process. I was wondering if one or both of you might comment just for a moment, not just looking at the diversity of programs across public health, but talk a little bit about the way data is used and collected differently across those programs, and speak just a moment about how certification of other functions might be a bit challenging rather than looking at interoperability as a primary focus area for certification.

Gillian Haney
Thank you for the question. We spent quite a bit of time doing level setting in terms of what data are sent to public health and how does public health use those data. I think that that is important to note because there are data that are coming from electronic health records systems, or coming from hospitals in the form of data for situational awareness, and then, data again for electronic case reporting, for example. And those two separate data feeds, while they may contain some similar data elements, they also contain totally different data elements and are used for very different purposes at different points of time during a specific event. We did spend quite a bit of time trying to do a level set on that, and then to focus specifically on each

of those different pipelines to improve the quality and the interoperability of those data coming into public health.

Arien Malec
I would just add that our goal, as well covered in the front matter of this presentation, is to raise the floor and reduce total effort while improving the effectiveness of exchange data to support the variety of the plurality of public health missions. Just as it would be unrealistic for us to expect that we have full semantic interoperability for every possible situation, for every possible specialty area, for clinical medicine, it would be unrealistic for us to expect we would have a floor that covers every variation of every programmatic across public health. We think it is very achievable that we can raise the floor to create a common nationwide set of four standards that address the commonalities of public health data flows in ways that reduce provider burden, reduce public health burden, and overall taxpayer burden while improving the effectiveness of public health. If we were able to do that, just given the experience we have all been through, I think we can all point to that as a significant win. But we also ought to have reasonable expectations that raising the floor does not mean addressing every programmatic variability.

Gillian Haney
I think key to that will be looking at the different value sets across the different standards groups to make sure that we have common implementation, so that we can improve the data quality that are coming from providers into public health and reducing the burdens on both for sending and receiving.

Steven Eichner
Thank you both for your eloquent response, and again, thank you for your leadership of the task force. I really do appreciate it.

Arien Malec
Thanks, Ike. And thanks for your passionate and informed input during the process.

Denise Webb
Any other questions or comments from our committee?

Gillian Haney
I do see a question about self-reported tests. There are mechanisms to report those self-reported tests through centralized approaches from the testing company. You can report your results that way and then those can be sent on to public health in certain situations. However, I do not think that we would want to have individual consumers or patients submitting their tests directly to public health. I cannot foresee an electronic or automated fashion by which to do direct sends on that. I am not sure if that was exactly your question, but as I said there are existing mechanism through the testing companies to submit your results.

Arien Malec
That is right. We struggled mightily to get a high-quality report to the full HITAC that was very detailed and had multiple recommendations attached to it. We did so by sticking to the charge that was given to us, which was constrained by the existing F-criterion and the need to certify both the pitchers and the catchers of public health interoperability. There is a need for additional information for at-home testing. It is one of them that we just did not get into based on the charge that we had for the task force.

Denise Webb
Thank you, Arien, for clarifying that. All right. Any other questions or discussion? Wow. Well, the content was quite meaty. If there are no other questions, I think we can move to a vote. If I can get a motion to adopt the Public Health Data Systems Task Force Recommendations to advance the ONC from someone on the committee, please?

Female Speaker
So moved.

Steven Lane
So moved.

Denise Webb
All right, Dr. Steven Lane. Thank you. And a second?

Male Speaker
I second.

Denise Webb
All right. All those in favor say aye.

Multiple Speakers
Aye.

Denise Webb
Anyone who opposes, no. Any abstentions? All right. It looks like we are good to go. Thank you, Gillian and Arien, and the entire task force.

Arien Malec
Thank you so much.

Gillian Haney
Thank you. It was a real pleasure.

Arien Malec
Thanks for the full task force and all the panelists. Thank you so much.

Denise Webb
All right. With that, it looks like we have a 10-minute break now. Then, we will reconvene and turn it over for the next presentation from the ONC.

Break (01:40:23)

Mike Berry

All right. Welcome back, everyone. We hope you enjoyed the short break and we are going to get restarted for the second half of our agenda. I would like to turn it over to Denise to introduce our next presenters. Denise?

Denise Webb
Thank you, Mike. Next, we are going to hear about the ONC objectives, benchmarks, and public health data updates. I would like to welcome and turn it over to Elise, Seth, Vaishali, and Chelsea.

ONC Objectives, Benchmarks, and Public Health Data Updates (01:41:03)

Elise Sweeney Anthony
All right. Thank you so much, Denise. Hopefully, everyone can hear me okay? Yes.

Denise Webb
Yes.

Elise Sweeney Anthony
Excellent. Hi, everyone. My name is Elise Sweeney Anthony and I am the Executive Director of the Office of Policy here at ONC. I have the pleasure of kicking us off today. Really, you will hear from some of the wonderful cross office team here at ONC. If you have worked with ONC, you have seen that we work in a very collaborative way across different offices. Anything we are doing it ONC, whether it is the technology side, it considers policy. If it is on the policy side, it considers technology. All of our work considers the clinical experience, the patient experience, etcetera. We really try to make sure that our work is collaborative and we are considering all of the pieces to a puzzle that would make something a success. That is part of what you will hear today.

Along with me presenting is Seth Pazinski, who is our Director of Strategic Planning and Coordination Division at ONC. Also, Vaishali Patel, who is our Deputy Director of the Technical Strategy and Analysis Division at ONC. Also, Chelsea Richwine, who is an analyst in the Technical Strategy and Analysis Division. Today, we will talk about the ONC objectives, benchmarks, and also hear some updates regarding some of the data analysis that ONC has engaged in.

To start us off, I want to talk a little bit about generally the presentation today and the objectives and benchmarks. You can see here that this presentation fulfills one of the requirements in the Cures Act, which is in Section 4003, and talks about ONC with the collaboration of the secretary establishing objectives and benchmarks. Those are important in terms of the HITAC and their consideration of your annual report. The details in the objectives and benchmarks will also help to inform your next annual report. In addition, the details that are included here give you a look into how we are implementing and advancing the 2025 Federal Health IT Strategic Plan. This is an update to a presentation you received last year, so for those who have been around this will sound familiar. For those who have not, this is new, but you will see the framework is very much the same. We welcome your feedback, of course, as we are going through this.

Now, to highlight a bit about how the objectives and the Federal Health IT Strategic Plan work together. Next slide. All right. Here on the side, you see ONC's objectives. Our first objective at ONC is to advance the development and use of health IT capabilities. Our second one is to establish expectations for data sharing. And we accomplish these two objectives through different activities that we undertake at ONC. For example, when it comes to advancing health IT capabilities, activities you might think of are adopting

standards and certification criteria that are part of the ONC Health IT Certification Program. When you think about data sharing expectations, you may think of TEFCA and the work we are doing under the Trust Exchange Framework and Common Agreement requirement, also from the Cures Act.

Those two objectives are critical to our work at ONC and help to frame our activities and what we are engaged in. They also support Goal Four from the Federal Health IT Strategic Plan. And that goal is to connect healthcare with health data. Our two objectives are a lot of what we think about when we think about execution of ONC's work under Goal Four in the strategic plan. As you are looking at the presentation, keep that in mind and keep in mind that these are some of the activities that we have underway at ONC, and, of course, we appreciate your engagement and your feedback and we hope this will be helpful to you as you continue the wonderful work on the next annual report and the work that's currently underway to close out the current annual report as well.

We appreciate everything. I have to take this second to give my appreciation for the work that I heard today. I really appreciate all of the work on the Public Health Systems Task Force. It is just tremendous work. It is just generally everything that you have been engaging in. I know this is our last full meeting before the new year, so I am also going to take this point of opportunity to say thank you for everything throughout the year. It has been such a pleasure working with you, working with the chairs. Of course, Denise, we are going to miss you. Thank you so much, everyone. With that, I am going to turn it over to Seth.

Seth Pazinski
All right. Thank you, Elise. We can go to the next slide. The actions we take to support those objectives and implement those objectives are bucketed into four areas that we use in ONC for purposes of planning our work and tracking progress. These are on the slide here standards, certification, exchange and coordination. All of ONC's work maps back to these activities. As HITAC members, I would encourage you to think about these areas as you work on various recommendations or even the context of hearings and discussions, to consider these as the way that ONC can take action related to the recommendations that you provide to ONC. These are essentially the tools in ONC's toolbox that we can use to influence and drive impacts related to the HITAC target areas, which I will cover at the end of the presentation, Mike Berry mentioned, when going over the work plan for the coming year for the HITAC. These are things like public health, and health equity, interoperability, and patient access.

Next, I will go over some of the progress we have made of the past year and then look ahead at what is coming up in the Fiscal Year 2023. Go to the next slide. In the area of health equity by design, this is one that a few months ago the HITAC talked about as adding as a priority target area for the committee. I wanted to highlight some of the ONC activities in this space. This is also a priority for ONC. Earlier this year, we embraced the health equity by design as a key principle for ONC's work, so working to address equity considerations in the build, design, and implementation of health IT systems. We also launched the ONC Public Health Informatics and Technology Workforce Development Program, which we affectionately referred to as the PHIT Workforce Program. With that, we have made 10 awards to a mix of Historically Black Colleges and Universities, Hispanic-serving institutions, as well as Asian American and Native American Pacific Islander-serving institutions. The last item to mention here related to USCDI Version 3, which included new data elements that are highly relevant for addressing health equity.

On the next slide, I will go a little bit more into USCDI Version 3. This group is very familiar with this but we released USCDI Version 3 to support the administration's direction on health equity and public health. Since Version 1, which included 52 data elements and 16 data classes, we have now expanded with Version 3 to 94 data elements and 19 data classes. Then, transitioning from Version 2 to Version 3, we have now added 24 data elements across the data classes listed on the slide here.

Next, I will talk a bit about how we are building on USCDI. We can go to the next slide. USCDI+ launched about a year ago. This initiative builds off of USCDI. It is focused on domain or program specific datasets that operate as extensions of USCDI. These are datasets in particular that will be federal agency programmatic needs. There are three collaborations currently underway with federal partners. ONC is working with the CDC, DMS, and HRSA as well as other federal partners in their focus on public health quality and the uniform data system reporting through HRSA.

Next, I will touch on how we are facilitating some progress through the USCDI versions with industry. We can go to the next slide. We are executing our annual cycle through the standards version advancement process. There were 10 staff approved standards in 2022 and these include the USCDI Version 2 data elements related to social determinants of health and sexual orientation and gender identity. In addition, we are also implementing a new HHS policy that was established to direct ONC to establish and oversee a consistent HHS wide approach for incorporating standard health IT record requirements language and **[audio cuts out] [01:50:27]** maximize the use of HHS approved standards in their policies and programs. The intent there is to maximize the use of open industry, nonproprietary standards and approaches. This includes things like USCDI and FHIR APIs. The intent is to multiply the impact of HHS regulations and purchasing power to drive forward interoperability. We can go to the next slide.

ONC, along with many others across the industry is very active in the FHIR standards space. Over the past year, I worked on the release FHIR Roadmap to support TEFCA, as well as transitioning the FHIR at Scale Task Force to be an HL7 FHIR accelerator, as well as doing additional work to update the FHIR US Core Implementation Guides and other work with HL7 to accelerate our advancement. In the public health space, we also started the HELIOS Initiative, which is focused on using FHIR based approaches to support public health. To talk about standards activities, I am going to pivot to going over certifications so we can pivot to the next slide.

A lot of the emphasis here on certification is around the implementation of the ONC Cures Act Final Rule. The steps over the past year included the first steps on real world testing and that condition as a component of the ONC Health IT Certification Program. We have seen a lot of progress with certified health IT developers working to get their products certified based on the new requirements in the Cures Act Final Rule. Lastly, putting in place certification testing to support the new certification requirements.

In addition to this, we focused on activities related to exchange. We can go to the next slide. The focus here for the Trusted Exchange Framework and Common Agreement, so ONC along with the TEFCA recognized coordinating entity, The Sequoia Project, put the foundational pieces in place with the Trusted Exchange Framework and Common Agreement and the qualified health information network technical framework, getting those pieces in place. The RCE also put out over 10 standard operating procedures that will put us at a point where now prospective QHINS have all the necessary information they need to consider applying in the potential onboarding process. In addition to TEFCA, we also saw some results on previous

investments in exploring health information exchange services to support public health exchange. We can go to the next slide.

The strengthening the technical advancement and readiness of public health via health information exchange program. That is a mouthful. We refer to it as the STAR HIE Program for short. We saw some great progress here with the recipients of these cooperative agreement awards led to a variety of results that were positive including increased vaccination uptake, increased data sharing between HIEs and jurisdictional IAS systems. Fourteen recipients also signed new or modified agreements with public health agencies to support COVID-19 related use cases. We also saw within these grantees, they established new electronic reporting capabilities through reduced burden on the participants, and demonstrated the ability for real time reporting of hospital capacity data using the **SANER** **[01:54:37]** Implementation Guide.

Lastly, I will touch on information blocking. We can go to the next slide. For information blocking, a policy went into place on April 5, 2021. Recently, as we talked about at our last meeting, on October 6th the definition of electronic health information is no longer limited to the USCDI Version 1 data. Based on information received through ONC's Information Blocking Portal as of November 4th, we have received around 500 possible claims of information blocking. The majority of those claims come from either patients or third-party folks acting on behalf of patients. The majority of claims are identified as healthcare providers is the potential active information blocker. We will continue to monitor and report out this information on healthit.gov. We can go to the next slide.

Now, I want to pivot to looking ahead to what is coming up in Fiscal Year 2023, so now through September of next year. We will continue to work in the adoption of the use of USCDI. We are also supporting federal efforts to focus on alignment of interoperable granular data used on race and ethnicity. This issue came up earlier in the Public Health Data Systems Task Force discussion earlier today. We will also continue to implement the continued PHIT Workforce program. The aim is to train 4,000 students over the next four years in public health informatics and technology. We can go to the next slide.

Picking up on what is ahead for standards in the year to come, we will go through the annual cycles of the SVAP and USCDI processes. As Mike Berry mentioned earlier, the HITAC work related to USCDI Version 4, we are anticipating that starting off just after the turn of the new year. We have got the three initiatives currently underway with USCDI+, so those will continue to progress and the possibility for additional efforts to come. Also, in the standards space continuing to work on FHIR. We can go to the next slide.

We will continue to support releases of FHIR and annual updates to the related implementation guides. We are also beginning to implement the new HHS policy to incorporate health IT requirements into HHS investments and policies. We can go to the next slide. In the public health space, CDC and ONC are continuing to work the HELIOS Initiative, supporting advancing uses of FHIR and to support public health exchange needs. We are also looking to incorporate USCDI+ into their development activities and FHIR profile development, as well as using public health grant language to try to advance FHIR. Next, we will take a look at what is coming up in the certification program. We can go to the next slide.

Two significant items coming up from compliance with the ONC Cures Act Final Rule. By the end of this calendar year certified developers will need to update and provide technology that meets the Cures Act Final Rule criteria. Then, coming up in March, we will have our next key milestone with the implementation

of the real-world testing condition under ONC certification, and certified health IT developers' results will be published on the CHPL. Two more items to mention. We can go to the next slide.

The new exchange space, continuing operationalizing TEFCA, so QHIN selection, onboarding, and sharing updated to begin. Also, RCE will continue to release additional standard operating procedures to support additional exchange purposes. We can go to the next slide.

Lastly, on information blocking, as I mentioned earlier last month, the definition of EHI is no longer tied to USCDI Version 1. ONC will continue a variety of education and outreach efforts to support industry and organizations that are working to comply with these information sharing requirements. As Elise mentioned in the beginning and before I hand it off to Vaishali and Chelsea to jump into the electronic public health reporting data overview, I want to bring it back to the HITAC target areas that were established in Cures. Again, we group our work in standards, certification, exchange, and coordination as the ways we can take action related to your recommendation and the authority that we can use to influence these areas, like public health, and health equity interoperability, and patient access. Anticipating based on conversations a few meetings ago, the HITAC Annual Report Work Group will be incorporating a new target area focused on the design and use of technologies that advance health equity.

I want to thank you for the opportunity to present, and we hope this will be helpful as you consider ONC's work coming up in the year and how that can inform your recommendations, both for the HITAC Annual Report and other task forces and work groups in the coming year. With that, I will transition over to Vaishali and Chelsea. Please, take us through the public health reporting data.

Vaishali Patel
Great. Can we move to the next slide, please? Can you all hear me?

Seth Pazinski
You are a little soft.

Vaishali Patel
A little soft. Can you hear me now? Is that better?

Mike Berry
Yes. It is for me.

Seth Pazinski
Yes. That is better.

Vaishali Patel
Great. All right. Sorry about that. Today, I will first provide an overview describing the data sources that are available to ONC that we're leveraging to provide insights on electronic public health reporting. We thought this would be a timely update given the recent task force recommendations today that were shared. Then, Chelsea Richwine, who is a Health Economist in our division, will share findings related to a recent data brief that has been published that looks at hospitals' experiences with public reporting during the pandemic.

In terms of data sources that ONC has available and we have been leveraging, one of the sources we been us is from the provider's perspective. We partner with American Hospital Association to conduct a survey of hospitals nationwide on health IT and health information exchange capabilities. Since prior to the pandemic, we have been focusing on public health exchange and we did a much deeper dive during the beginning parts of the pandemic, once that started, but we also have data from prior to the pandemic. Listed here are links to two different data briefs that have been published over the last year or two. The first one listed is the most recent one, which Chelsea Richwine will be presenting the findings on today. This data brief was just published a few weeks ago. It is sort of hot off the press.

Then, we also have a survey that we do with the National Center for Health Statistics, which is part of the CDC, that looks at physicians' use of electronic health records and health information exchange capabilities. We have some questions in there from prior to the pandemic, so just better understanding physicians' readiness as it relates to public health reporting and engagement in that from prior to the pandemic. That data brief is also available if you all are interested. The link is provided right there.

Another data source that we have leveraged and I think will be more useful in the future, relates to the CMS program data from both on the hospital side promoting interoperability program participants as well as for eligible providers, merit-based incentive payment system program data. They have new requirements in place as to public health reporting, so we will be getting that data from CMS and to leverage that to complement the self-reported data that we get from both hospitals as well as physicians from the surveys that we conduct. Next slide, please.

In addition, we are working with LOINC Regenstrief through a cooperative agreement that we have with them on a national survey of CLIA certified laboratories looking at electronic exchange and awareness and use of LOINC. That survey is in progress and we hope to have some results to look at early in the year next year. Additionally, with regards to public health exchange, we also are making efforts to understand the role that entities plays in enabling public health exchange. This includes health information exchange organizations and entities. We have a national survey that will be underway later this year, or early next year, that does a deep dive on how health information exchange organizations are supporting public health exchange between providers and public health agencies.

Additionally, through the EHR reporting program, we have recommendations from the HITAC task force that was in place last July or August. They made a set of recommendations around looking at public health exchange that focused on immunization. Looking at vaccine administration sent electronically to an IAS as well as electronic queries to an IAS during an encounter. This would be part of the EHR reporting program in which EHR developer would be reporting to ONC through the certification program on various domains, including public health exchange.

That just provides an overview of just the different data sources, both from providers including laboratories as well as entities and enable exchange, that ONC is trying to leverage to gain insights into public health exchange. I will turn it over to Chelsea, if we could move it over to the next slide, to do a deeper dive and share results from a recent data brief that was published that she led on electronic public health reporting amongst nonfederal acute care hospitals in 2021. Chelsea, take it away.

Chelsea Richwine

Great. Thanks, Vaishali. As Vaishali just mentioned, ONC has access to a number of different data sources that can shed light on engagement in public health reporting. This work focuses on hospitals' engagement in electronic public health reporting during the COVID 19 pandemic. Next slide, please. The goal of this analysis was to look at hospitals' level of electronic public health reporting as well as their stage of engagement towards electronic exchange reporting during the pandemic, and the extent to which that was conducted through automated versus manual processes. In addition, we looked at how rates of electronic public health reporting varied by geographic location as well as hospital characteristics.

Finally, we looked at different methods used by hospitals to support electronic public health reporting, such as through their EHRs, through other electronic methods, as well as through health information exchange organizations. These data came from the most recent wave of the American Hospital Association IT Supplement Survey that was field dated from April to September 2021. These analyses are all limited to nonfederal acute care hospitals. It's about a sample of almost 2,400 nonfederal acute care hospitals. All results were weighted to reflect national estimates. Next slide.

Before taking a deeper dive into the results from 2021, I want to provide a little bit of background. These findings come from a 2019 data brief using again the same data source, the American Hospital Association survey. Prior to the pandemic, we found that about seven in 10 hospitals reported experiencing specific barriers to public health reporting. Seventy-one percent of hospitals said they experienced one or more challenges to public health reporting. On the right-hand side, it shows the different types of challenges that they report experiencing. Among those that experienced a challenge, about 50 percent of nonfederal acute care hospitals said that they lack the capacity to exchange information with public health agencies. And this could reflect their perspective that they lack the capacity to send information or, from their perspective, that public health agencies lack the capacity to receive the information.

In addition to this challenge, about 40 percent in 2019 said they experienced interface related issues. There were also a number of hospitals that said using different vocab standards in the public health agency made it difficult to exchange as well as difficulties extracting relevant information from the EHR. Next slide.

To fast forward to 2021, we found that most hospitals, 89 percent, indicated that they electronically submitted data to PHAs for at least one type of public health reporting. It is important to note that when we say electronic submission, this could occur through a number of different methods. It could be electronically through the EHR, through other types of electronic methods, through HIEs. For example, for electronic case reporting, this could occur through the AIMS platform but it could also be electronic reporting of case reports through other types of electronic methods. It is just important to keep in mind that electronic here can represent a lot of different methods of reporting.

In this slide, even with that frame of reference, we see that hospitals that indicated that they were actively electronically submitting production data varied by the reporting type. This was 88 percent of hospitals at the highest indicating that they were electronically submitting data for immunization registry reporting. Rates were also high on syndromic surveillance and electronic lab reporting. However, they were much lower for electronic case reporting, public health registry, and clinical data registry reporting, which tend to be optional reporting types. At the very bottom, we see that only just under a quarter of hospitals indicated that they were electronically submitting data for all six reporting types that we looked at here. Next slide.

Keeping the first column in mind where I saw active engagement in reporting types, this is important to think about as the denominator throughout the presentation because in this slide we see that among those that said they were actively submitting data, this shows the processes that these hospitals use for submitting data. Across the different reporting types, we found that a majority of hospitals that were submitting data did so through fully or primarily automated processes. And this was particularly true for those more common reporting types or the ones that hospitals were actively engaged in, so immunization, syndromic surveillance, and electronic lab results, 89-92 percent of hospitals said they were using fully or primarily automated processes. However, for public health registry reporting, electronic case and clinical data registry reporting, it was more of a mix of automated and manual processes to submit data. About a quarter across the board, and 36 for clinical data registry reporting were using a mix of both types of processes. Next slide.

Now that we have the level set, the following slides will show different types of variation in electronic public health reporting. Next slide. This first one looks at rates of electronic public health reporting at the state level. In the data brief we did this for all of the different reporting types, but for purposes of illustration here, and comparing syndromic surveillance reporting at the state level compared to electronic case reporting. In the figure on the left-hand side, if you recall syndromic surveillance, rates of electronic reporting for this type were quite high at the national level and this is reflected here as well. While there is some variation at the state level that we can see indicated by the different shading, overall we see fairly high rates of reporting across the board.

On the other hand, for electronic case reporting, which was lower at the national level, we also see quite a bit of variation at the state level. For instance, in Wyoming it was 11 percent of hospitals that were submitting data electronically compared to in Virginia, 89 percent. Quite a bit of variation for electronic public health reporting, both at the state level and by reporting type. Next slide.

Similar to rates of active engagement in electronic reporting, we also look at hospitals use of automated processes at the state level. This varied as well by reporting type and within state. For instance, if we look at the column for electronic case reporting, this varied by state with 100a percent of hospitals who were electronically submitting data and doing so through automatic proceeds compared to Colorado, which was only 69 percent. Quite a bit of variation looking across states. However, when we look within a state we see similarly quite a bit of variation. If we look at California, hospitals that were electronically submitting data for syndromic surveillance, 86 percent of those were doing so through automated processes, whereas those submitting data for electronic case reporting, only 67 percent for using automated processes. Next slide.

In addition to this geographic variation, we also looked at variation in public health reporting by hospital characteristics. We found that on average lower resourced hospitals, such as small, rural, independent, and critical access hospitals were engaged in fewer types of electronic public health reporting compared to their higher resource counterparts. At the bottom, we have circled the national average. On average, hospitals were electronically submitting data for about four out of six public health reporting types. But when we look at small hospitals this was only about 3.6 types of average compared to 4.3 types in medium to large hospitals. This pattern was pretty true when we looked at critical access and rural versus urban as well. Next slide.

Thinking back to the very first slide that I showed you among hospitals who experienced challenges to health reporting in 2019, we were actually able to match that sample to the hospitals that responded in both

2019 and in 2021. We wanted to look at whether those who experienced barriers to reporting in 2019 were actively engaged or still experiencing those barriers in 2021. We found that hospitals experienced major public health reporting challenges in 2019 were less likely to be engaged in electronic public health reporting in 2021. This was true across the board but the asterisks here indicate differences that were statistically significant. For instance, for hospitals that experienced a reporting challenge in 2019, only 78 percent were electronically submitting data for syndromic surveillance reporting compared to 91 percent of those that did not experience a challenge. This suggests that the hospitals that were experiencing challenges in 2019 may still be doing so in 2021. Next slide.

Finally, while we were not able to look at those specific barriers again in 2021, they will be reoccurring in the next round of the survey, we did look at whether the pricing structure of public health reporting had any effect on rates of public health reporting. What I mean by this is hospitals were asked, "Does your EHR developer charge additionally or separately to submit data for public health reporting activities?" While most hospitals, 62 percent, said this was not the case, almost a quarter said there was a separate charge for this reporting. It is important to note that when we say a separate charge, it does not mean that they were necessarily charged more but that the pricing structure may have been different. In some cases, the services may have been available as an add-on rather than included in a package. This was notable because hospitals that said that they were charged separately had significantly lower rates of electronic public health reporting for certain types of reporting.

This was particularly true for some of the optional reporting types. If you focus on the left-hand side of the chart on the right, of hospitals that said that they were charged separately for reporting, only 36 percent of them were submitting data electronically for electronic case reporting compared to 56 percent of hospitals that indicated their developer does not charge. Taken together, this suggests that the pricing structure may have an effect on hospitals' decisions to submit data electronically for certain public health reporting types. Next slide.

Along this line of thought, we also dug into a little bit the different hospital characteristics associated with saying that their developer charged more or separately for reporting. We found that small, rural, independent, and critical access hospitals across the board were more likely to indicate their developer charged additionally for public health reporting services. It is worth noting, however, that these hospitals were also more likely to indicate that they did not know, but this still provides some important insights given that these lower resourced developers may also be more likely to be using some of the smaller EHR developers by market share, likely for cost reasons. If they are more likely to use these, and more likely to report being charged additionally, as we saw in the last slide, those reporting that they were charged additionally or separately were less likely to engage in reporting type. This may just have some downstream implication for lower resourced hospitals and their ability to make progress towards electronic public health reporting. Next slide.

Now that we have talked a lot of of the different variation in public health reporting observed, this final section is going to look at the methods used to support electronic public health reporting. Next slide. Overall across the board, we found that about 41 percent of hospitals used a health information exchange organization for at least one type of public health reporting. Perhaps unsurprisingly, this varied quite a bit by state level and I imagine would vary regionally as well. Just to highlight again, this is submitting data for at least one public health reporting activity. Next slide.

In contrast to submitting data for at least one activity, this figure shows the primary method used by nonfederal acute care hospitals to electronically submit data for each specific reporting type. This question was asking specifically about the primary method. It does not mean that multiple methods were not used for any of these but this one is showing the primary one. Across-the-board we see for each reporting type, most hospitals indicated they use their EHR to directly submit data for public health reporting. While the use of an HIE was fairly constant for each type, there was greater reliance on other electronic methods for electronic lab result reporting as well as the optional reporting types for public health registry and clinical data registry reporting. Next slide.

Interestingly, we also found that small, rural, independent, and critical access hospitals were significantly more likely to primarily rely on HIEs for public health reporting compared to their counterparts. This table for each row shows the methods most commonly used for public health reporting for at least one type by hospital characteristics. For instance, if we look at the first row, small hospitals were significantly more likely to indicate that they relied on HIEs for public health reporting compared to medium or large hospitals. Across-the-board, this was true for lower resourced hospitals, whereas higher resourced hospitals were more likely to submit data primarily using their EHR. This suggests that, based on the greater reliance of HIEs, their services might be helping these lower resourced hospitals to submit data for public health reporting. Next slide.

Okay. I presented a lot of information here, so I just wanted to highlight a few key takeaways. The first one being that in 2021, during the pandemic, we found that a majority of hospitals indicated that they were submitting syndromic surveillance, immunization registry, and lab result reporting data electronically in an automated format and largely via EHRs. However, electronic automated reporting was lower for other reporting types, such as electronic case reporting, and public health registry, and clinical data registry reporting. There are a number of reasons why this might be. First, state-level differences may reflect differences in state policy and reporting requirements. That would have an effect on different reporting rates for these types. Specialized public health IT infrastructure by reporting type may also lead to different variation.

Reporting types that are not required, such as public health and clinical data registry reporting, we found these were more sensitive to being charged separately for these services and that may have an effect on engagement in these types as well as different methods for transmitting data by reporting type. Next slide.

Across the board, we found that lower resourced hospitals had lower rates of engagement in electronic public health reporting to their higher resourced counterparts. These hospitals were also more likely to be charged separately for public health reporting as reported by hospitals, which may explain greater reliance on HIEs to facilitate public health reporting. Finally, we found that hospitals that previously reported experiencing challenges to public health reporting in 2019 had lower rates of engagement in electronic public health reporting in 2021 during the pandemic, which indicates they may still be experiencing these challenges. Next slide.

Lastly, I just wanted to highlight this limitation, which I have tried to emphasize throughout, but these data are self-reported from hospitals. They are naturally subject to the hospitals' understanding of the way the questions were asked. It reflects their understanding of their engagement in each of these reporting

activities. To make sure that we were capturing the information we need to better understand barriers and opportunities, we are actively working with the CDC and others to verify these data and to continually improve the survey questions to make sure we get the information that we need. Next slide.

You have these slides as a resource. This just shows the links to the various data briefs that highlight these data, including the newest ones and some of the prior data briefs that I referenced. After that, we will lead us into a discussion. Next slide. Thank you so much.

Denise Webb
All right. Thank you, Elise and team, for all of the useful information you presented. It is now open for any kind of questions the committee might have or discussion. Jon Kansky, you are up.

Jon Kansky
Thanks. Thank you, Chelsea. I heard this at AMIA earlier this week and I appreciate the attention to this. One of the things we discussed briefly at AMIA during the question and answer, was that I think it would be helpful to reconcile this data. If survey data is the best data we can come by, reconciling this data with future HIE survey data, the public health authority survey data, alongside the hospital data, and if we can reconcile that state-by-state, I think we would get the most accurate possible results. There is just some differences in the relationship between HIEs and hospitals, HIEs and the public health authority, that vary from state to state that I think would lead to **[audio distorts] [02:27:46]** data. Thank you.

Vaishali Patel
Yeah. I think that is a great suggestion, John. Yes, we will definitely triangulate as you suggested across the data sources that we have available to make sure, not only that we are verifying but also can glean the most insights on where things need to improve, where there are robust capabilities and where there are not. Thanks.

Denise Webb
Any other questions? All right. Elise, Seth, Vaishali, and Chelsea, thank you very much.

Seth Pazinski
Thank you.

Denise Webb
All right. With that, I shall turn it over to Medell, our new co-chair, and Aaron.

HITAC Annual Report Workgroup Update (02:28:48)

Aaron Miri
Absolutely. Hello, everyone. Time to go through what is near and dear to Medell and my hearts, the Annual Report Work Group and giving you an update. I agree. I am still processing all the information that Elise and team just gave in the last presentation. That was a lot. We have had a lot of good discussion today, so great job. We will launch into this now with the Annual Report Work Group update. Medell, anything you want to say opening up?

Medell Briggs-Malonson

No. I just echo your sentiments. It has been so much rich information that we have received. As we go through the Annual Report Update, you will see that we have tried to incorporate so many of these different elements and even more elements into the work group. Aaron, before we proceed, I just want to say thank you to all of the HITAC members that have provided such significant service on this committee, in which this is their last meeting. I do want to extend a sincere amount of gratitude also to Denise for her leadership publicly. Denise, thank you and thank you for passing the baton. I will do my best to step up to all of the various challenges that you have been able to conquer. Thank you so much for everything you have done for this committee.

Aaron Miri
Great comments, Medell. All right. Let us get into it. Next slide, please? We are going to talk about membership, meeting schedules, and next steps. Of course, we will have a discussion of the draft crosswalk. Medell and I will split this section between contemporary and reoccurring. Next slide? This is all the folks on our report work group. Several amazing people are sadly rolling off, like Brett and others. To the degree of it, we appreciate that. If you have interest in serving, it is my plug to please volunteer for next year when we restart this thing. Just think about it. It is fun. Next slide. We can move forward.

All right. We have our meeting schedule here for the Annual Report Work Group. Next meeting is on December 1st. We have been meeting robustly to go through the topics and synthesize your feedback and questions into one comprehensive report. Next slide. And then, in full committee, we are scheduled today to talk through this. We bring you back in January to review the draft. Today's discussion is important because we want to get those ideas in or be able to curate any data points we need further extrapolated. We look to improve it in the February 23 HITAC meeting before sending it onto Micky, and the Secretary, and eventually to Congress as per law dictated. Next slide.

All right. Next steps are developing the draft report during the meetings and presenting that to HITAC in early '23. Next slide. All right. This is the draft crosswalk. I believe I will turn this over to you, Medell.

Medell Briggs-Malonson
Thank you so much, Aaron. We know we are at the tail end of today's meeting so we are going to try to make sure we add also some additional energy into this discussion as well. Next slide. One of the things we are going to go over today is our five primary target areas. Those five primary target areas that you will see the topics defined in the crosswalk are design and use of technologies that advance health equity. Now, this is the new target area that is being recommended by HITAC as well, and which we can do so underneath the Cures Act. The other topic areas include use of technologies that support public health, interoperability, privacy and security, and then we will end on patient access to information. Next slide.

Now, one of the things that you'll notice that we did a little differently, we want to hear some of the feedback from this as well, is that we have now separated out the topic areas into contemporary topic areas. Those are the areas that we believe are critically important for us to address in-depth during this year's annual report. Then also, we recognize there have been several other topics in all of the various target areas that we have seen year after year and we want to make sure that we still keep that on the radar in order for us to seek additional updates and also to monitor where our progress is in terms of mitigating some those challenges or those opportunities for improvement. We will dive into first some of the contemporary topics that we proposed to be included in the annual report for this year. Next slide.

Starting off with the design and use of technologies that advance health equity. This is a very new and robust topic and I do want to thank all of the work group members for all of their contributions to this crosswalk. We had amazing conversations during our meetings and hopefully everyone can see those thoughtful conversations reflected in this crosswalk. Starting off with health equity by design. The primary gap that we are looking at and trying to mitigate is making sure that we are promoting and advancing equity as a core element in all that we do, especially when it comes to the design, when it comes to policies, and when it comes to overall procedures and initiatives. Those recommended HITAC activities are, number one, we need to continue to explore ways the ONC Health IT Certification Program can truly support health equity by design so that we can actually start moving even more in terms of achieving health equity and data justice.

Also exploring metrics to track our progress to ensure we are being very inclusive in terms of our design and we are not leaving out any vulnerable populations or other communities and incorporating this into the Health IT Certification Program. Then, number three, thinking about considering the creation of a new position, the Equity Officer at ONC, in order to help drive additional initiatives to recruit additional equity leaders that will help to inform and drive some of these processes.

The second topic is inequities in data collection. As we have speaking about all of today, there are so many different ways in terms of collecting data and making sure we have the standard definitions for that data. However, when it comes to overall elements, especially those elements when it comes social drivers of health as well as promoting health equity, we have seen even more inequities in that. Some of the recommendations that we are proposing is continuing to explore the adoption of improved standards for capturing patient demographics, including USCDI and some of our other efforts, making sure we are getting down to race, ethnicity, language, sexual orientation, and so many other important identities in order to assess our progress. Also, ensuring that we are not overgeneralizing populations and thinking that we are **[inaudible] [02:35:47]** are really capturing the clear diversity within each group.

The second item is holding listening sessions in order to identify those best practices at registration and other key important areas throughout that patient's encounter so that we can accurately collect information through the portals and the apps in order to support our health equity initiatives. Then, last but not least, exploring the opportunities to increase the use of the data enrichment strategies to bring together multiple data sources, so not only those data sources within our healthcare providers but also bring in social service information and public health information so we can have very comprehensive databases that will help us drive better care. Next slide.

When it comes to the electronic exchange of health equity and social determinants, or drivers, of health data, this is also a key important area. As we are collecting this data, we have to make sure that even the social driver of health data that we are collecting is present and is not uneven. Some of the activities that we are proposing are exploring opportunities with HHS to incentivize standardized exchange of both health equity data and social driver of health data. Also, as we are thinking about incentivizing this, incorporating those vulnerabilities indices as previously mentioned earlier so we can actually see the community vulnerability in which our patients reside and we can incorporate that into the health IT certification program so that we have a robust view of our patients and what their health and social needs are.

The third area is inventory state reporting requirements for health equity and social driver data so that hopefully we can get to that point where we can have those mandated state reporting requirements and we are collecting information nationwide in a very intentional and thoughtful way. Now, bias has been one of the top priorities that we have discussed throughout our various industries. I am diving into algorithms in clinical decision support tools and patient interview data. It as a topic that we thought was also a very important one to bring up. The gaps that we are looking at are as we are launching so many new artificial intelligence algorithms, machine learning intelligence algorithms, national linguist processing, you name it, when we are bringing in various demographic data or social driver data, we want to be very thoughtful and intentional with our approaches.

Some of the CDS tools and other algorithms that exist within our systems may actually perpetuate bias if we do not evaluate them or if we do not derive them appropriately. Therefore, some of the various recommendations that HITAC is recommending is holding listening sessions in collaboration with the relevant HHS agencies and others in order to focus on how best to develop new clinical decision tools, various clinical algorithms, that we can mitigate as much unintentional bias as possible in these various tools. Also, when we are interviewing patients and their techniques, making sure we are providing recommendations to also prevent perpetuating any additional health inequities.

Number two, in terms of exploring the impact of the use of sexual orientation and gender identity data. This is also very important when we are thinking about our new artificial intelligence algorithms, especially with all of our gender diverse populations because we want to make sure that what we are developing and what we are using in our systems directly benefits our patients and their identities as well as their overall preference on how to receive care and understand even the data that they are receiving. Last, perform a literature review and produce a summary of some of our current state as well as our areas for improvement as we are proceeding in this area. Next slide.

Now, moving onto the next target area, which is the use of technologies that support public health. You will see an asterisk here because we have had such a wonderful discussion earlier in this meeting from our Public Health Data Task Force. We even within our work group were very cautious in order to provide any recommendations before this task force's recommendations because, as we all saw, the task force delivered in every single way some amazing robust recommendations. Our standpoint is to incorporate those recommendations from the Public Health Data Systems Task Force into the annual report. But at a high level, several of the different topics that we discussed during the work group was first learning public health data systems and looking at the infrastructure. Once again, diving in and learning more about the status of some of the federal resources and the modernization efforts for public health.

Also, when it came to public health data reporting, especially our ECR cases, we know that there has been a rapid expansion and adoption of ECR, but we also still know that there needs to be enhanced communication between all the various stakeholders. Deferring to what was mentioned by our task force earlier today, but in addition to that, making sure we are continuing to collaborate with the various groups across federal, state, tribal, local, and territorial governments, and other healthcare providers and laboratory associations so that we are all moving in an aligned way in order to advance the technology and standards to support bidirectional data exchange for public health purposes.

Also, continuing to look at ISA identified standards for bidirectional ECR in the ONC Health IT Certification Program and then also thinking about those key metrics in order to track progress on the adoption and use of bidirectional technologies between the public health organizations, the health provider organizations, laboratories, and others. The ELR, in terms of this next topic, once has also seen a drastic increase, especially during the pandemic, and now as we are in endemic and still continuing to see additional emerging conditions. We did not identify any additional annual work group recommendations right now but knowing it tracks very closely with many of the other public health sides that we are looking at right now as well. Next slide.

Now, in terms of syndromic surveillance as well, one of the things that we want to make sure of in terms of the gap is that looking at syndromic surveillance today is often limited to acute care settings. We know also in the long-term settings as well as in the ambulatory settings this is critically as important. Some of the recommended HITAC activities are to encourage ONC to work with the CDC and public health organizations to expand additional participation in the syndromic surveillance to home healthcare facilities, or certain providers, to our long-term facilities, and community-based and telehealth settings, but then also to continue to hold listening sessions from the current national data networks so that we can hear what others are referring to and recommending so we can continue to amplify that surveillance and especially for some of the different entities listed there.

Then, going back to what is on the work plan, from ONC in terms of our Public Health Informatics Workforce, continuing to advance in creating and expanding a diversified workforce in order to meet the persistent challenges of making sure that we have the public health workforce present for not only we are currently in various public health crises, but also when we are not in those public health crises, when there are blue skies. Our recommended activities are to hold continuous listening sessions to learn about progress from the existing federal initiatives to increase that capacity, but then also trying to identify those funding pathways because we know we need those financial resources that will continue to support the public health agencies to hire and retain public health informatics workforce staff in order to continue to advance the activities identified by ONC, CDC, and other federal agencies. Next slide.

The next target area focuses on interoperability and three primary topics in this target area. First, starting with streamlining of health information exchange. As we always center and prioritize health information exchange, we also want to make sure that we are bringing in the different health IT systems that have been a challenge in the past. What we propose is to hold listening sessions specifically around social drivers of health data exchange as well, where in some cases oftentimes this data may be referred to other entities such as community information exchanges in order to help support. We want to bring them all together to advance our health equity efforts.

In addition, when it comes to interoperability standards and priority use of this, closed loop referrals was a topic we discussed pretty significantly also during our work group meetings. The reason why is because we know that with all of the coordination of care that is needed, not only for both medical care but also for social services, oftentimes those referrals are one or unidirectional. There tends to be a lack of cross organizational support for closed loop referrals, including for social services. We recommend holding listening sessions to learn more about the progress, especially among various projects, such as the 360X Project, in order to determine what additional opportunities do we have or that currently exist to truly close the loop of referrals. In addition to that, identifying areas to advance these standards in terms of adoption

so that we are truly incorporating both health and social support sectors so that we can have that comprehensive book of referrals out to both medical as well as social service providers but then we can ensure that those are closed so that the patients are receiving all of the various services that we need.

Then, last but not least, use of telehealth. There are several different unique interoperability considerations when it comes to telehealth as we have all learned over the past two-plus years. We want to make sure telehealth is equitable, not only in terms of access, but also in terms of functionality and usability in order to prevent any further advancement of the digital divide. Our recommendations from the work group are to explore the additional benefits and challenges of encouraging and incentivizing equitable adoption and accessibility and the use of certified health IT by telehealth providers so we can make sure that when there are various telehealth providers that that may not be directly connected to our public health systems, that we do have that integration to allow for that bidirectional exchange of data. Next slide.

Privacy and security. There were two primary topics that we wanted to go into in depth during our annual report for this year. That focuses on the alignment of innovation and regulation, and then also alignment of innovation and regulation, especially when it comes to consent. Looking at the first topic, one of the areas were identified, as well as HITAC members, is that providers in the hospital systems are adopting various forms of APIs, but were actually very concerned about unauthorized data exposure as well as added liability. Therefore, some of the recommendations it is to learn more about what some of the other federal entities are doing as it affects privacy and security for areas of health IT innovation, especially when it comes to the various forms of APIs, but then also making sure that we are increasing the awareness and education for providers and patients and other regulatory efforts as well in order to ensure that they understand the importance of these regulations as well.

Then, supporting the development of guidelines that assist provider organizations in terms of truly efficiently resolving the concerns around data access as well as around data privacy. Now, this also goes directly into thinking about our consent directives. The pace of the industry of innovation is moving very quickly as we know, but we also know that sometimes that fast pace may not actually keep up with some of the regulatory environment. The recommendations from the work group also are to explore additional lessons learned from the implementation and the consent in TEFCA in particular, and to continue to hold listening sessions to learn a bit more about those methodologies and strategies that are currently under development nationally for distributed and/or centralized consent management processes. Next slide.

Now, the additional two are in terms of appropriate exchange and use of data. And this can actually take on multiple different kinds of insights when we actually dive deeper into it. The gap that has been identified is complying with both the HIPAA minimum necessary standard, which is difficult without having some form of improved electronic data segmentation capabilities, and then also making sure that the data, even though it may be minimally necessary, is the data that is actually usable by those that need to really utilize that data to provide care. Some of our recommendations are to continue to track work underway in TEFCA, especially that work to adopt use cases that support the exchange of data for payment as well as for healthcare operations and delivery of care, and to continue to hold listening sessions to identify the current state of existing privacy harmonization efforts and those best practices to reduce the burden as we are evolving our overall privacy landscape throughout the country.

Then, privacy of sensitive health data. This especially has become very relevant, even over the past several months. The gap that has been identified is that there have been lack of standards supporting the segmentation of sensitive health data, and especially when it comes to our women, pediatric, and gender diverse populations. We want to make sure that that data is protected but yet also is in the form that we can use it to provide the most high quality, compassionate, equitable care for our patient populations. Some of those activities that we have actually devised and recommend are to encourage ONC to provide guidance on the applicability of this information, especially when it comes to blocking exceptions to exchange of sensitive data, including for reproductive health, but then also suggest steps toward a more consistent technical and operational approach to protect sensitive health data while enabling its exchange in the most appropriate way. That also includes thinking about how this data can be exchanged within our healthcare applications.

The last one here is patient consolidation of health information from multiple sources. Now, we have discussed throughout our meeting, the challenge that persists with patients' ability to access their data from multiple different sources, but then also consolidate that in order to share your information across multiple sources, everything from portals, to labs, to payers, and other forms of health IT systems. Some of our activities that we recommend are to propose a plan to monitor and assess the successes and challenges with the implementation of the 2015 Edition Cures Update API Criteria, but then also to explore where are those opportunities for improvement to support the development of apps that are specifically targeted to the unique needs of those communities that are under resourced or historically marginalized so that we can ensure that the patients have their data, can also consolidate it, but also it can be appropriately used for the delivery of care. Then lastly, to hold listening sessions on the initiatives that have attempted solutions on this front, including Blue Button 2.0 as well as the HL7 care accelerator. Next slide.

All right. That was a whirlwind. We tried to go over that as quickly as possible. Aaron, I am going to turn it over to you in order to review some of the recurring topics.

Aaron Miri

Yes, ma'am. Thank you. Great job, by the way, Medell. Excellent job. That was a lot of stuff. All right. Recurring topics by target area. Next slide, please. All right. These are some of the key topics that continue to come back in order to be refined year over year, taking your feedback into account. These topics are important, as previous the ones that Medell just went through, so please pay attention and let us walk through this. Reoccurring topics. Interoperability. Interoperability standards, priority uses around e-Prior Auth. The gas is there is a lack of common standards to support a prior auth across payers. I think we have established that in this committee many times. Our proposed activity there is to continue to monitor implementation of existing HITAC e-Prior Auth recommendations, including updates from industry and on related HHS initiatives so there are ONC and CMS rules.

The Annual Report Work Group noted a lot of work that has been going on here. We do not want to duplicate efforts/ We want to learn from those efforts and continue to help advance that in our way as we can help. We do not want to stand in the way of other groups are doing good work around e-Prior Auth. Next, director standards and management. The gap is there are industry partners who struggle to find digital contact info toward healthcare providers and for health information exchange. We want to explore the opportunities and challenges to supporting the adoption of directory standards and management approaches that support

complete, accurate, and usable electronic endpoint directories. That is not a topic that is not new to any of us. We know we have had challenges here.

Next, is one I mentioned in my chat comments a little bit ago. Standards for patient matching. This continues to come up over and over again as a major gap. The gap is patient matching when sharing data needs to be improved, especially for vulnerable populations. The recommended activity is to hold listening sessions involving federal agencies, such as NIST, DHS, DOD, to identify best practices to improve patient matching in varying patient populations. This is becoming a key and key inhibitor to right place, right time care across this country. The second item here is exploring other industries' experiences with linking deidentified data as well as healthcare specific efforts. This HITAC has noted several times that deidentified data perhaps is not deidentified. If there is a specific comorbidity or information in there, you still could double-click and drill down to find out. That is really patient error if have the right criteria. How do we do this in a way that is safe, secure, and truly is equitable by design? Next slide.

Cybersecurity events across the healthcare infrastructure. Now, we do not have a concern around cybersecurity, do we? Of course we do. The gap is cybersecurity events continue to increase. We propose this. We need to hold listening sessions to explore and amplify existing federal and industry initiatives to improve healthcare cybersecurity, such as cybersecurity insurance, which is becoming harder and harder to get. The session should include best practices on how healthcare organizations can partner with both the government and the industry. We are seeing a ton of work come out here. We are even proposed letters by folks like Senator Warner and others. We know focus is double-clicking on cybersecurity and learning to get a shared best practice. How can this HITAC help enable that behavior and communicate this issue to be mitigated? Next slide.

Patient access to information. The issue here is electronic patient reported health record corrections and amendments. I think this HITAC has been very, very passionate about this. The gap is transparency about the accuracy of patient data and consent to share it are lacking for patients which in turn thus affects patient safety. Our recommended activity is to hold a listening session to better understand the challenges and inform future standards for electronic patient reported health record corrections and amendments, including patients and organizations use.

Next, patient generated health data, that PGHD component. The use of PGHD may present liability concerns if inaccurate, the PGHD is used in clinical decisions, or if the clinician chooses not to act based on the personal generated health data received. What we want to do here is to hold a listening session to assess progress on integration of PGHD and EHRs and clinical decisions identifying remaining barriers. We all know more patients are presenting with PGHD. More and more clinicians are being put on the spot on how to interpret and use that information. Is it clinically relevant to make an interpretation there? How do we begin to coalesce the industry?

Next, is the safety and impact of mobile health apps. The gap is the use of apps that are built without using sound clinical knowledge can produce incorrect conclusions or can produce readings that impact patient safety. There is a lack of meaningful analysis of global health app data and efficacy as well as guidance on data security for clinicians and patients. We want to explore the ecosystem of vetting efficacy and security of mobile health apps, including recent industry research and federal regulatory efforts. We do note that

there is a lot of work going on in a lot of industries, like FDA, FDC, and others. How do we learn from that and how do we incorporate those findings into what we are doing?

Second, there is considerably increasing use of digital therapeutics, or digiceuticals, in clinical treatment. You will remember that we have mentioned this several times in the Annual Report Work Group, that this is an emerging industry that is accelerating rapidly. How do you do that? What is this going to look like for digiceuticals? How do we treat that with the same level of efficacy as say prescribing a Schedule II substance or something similar? How do we make sure we know what is happening here?

Next, but not least, price cost transparency. Lovely topic that we always talk about here in the industry. The gap is low compliance among hospitals with price cost transparency rules, as well as non-user-friendly methods assuring complex data, hinder patient access in the use of price related information. What do we want to do? We want to hold a listening session to learn about best practices for implementing price cost transparency rules that enhance the patient's experience in accessing this data. The bottom line is that it is way too complicated and it should not be, so how can HITAC jump in here and help continue to push best practice and educate the right way to get this done so that patients have the information they need to make appropriate decisions? Next slide.

All right. Thank you. I will help facilitate any Q&As. Mr. Steven Eichner. Ike, you are up first.

Steven Eichner
Thank you so much. I have about, I guess, three or four points and I'll go backwards in order.

Aaron Miri
Sure.

Steven Eichner
Thinking about the patient access data and looking at safety of overlaps, I think privacy is also an element that needs to be included in that element. Thinking about helping patients understand if they are using a mobile app, who is providing that mobile app to them, where is that data actually being stored, and who else has access to that data are really critical pieces of information, whether it is going to straight to my PCP or my healthcare team or to a third party or other uses is really unclear to the patient.

Secondly, I think we need to look at public health and provider collaborative activities across a wide variety of spaces. This might be another key topic area. Listening to the presentation earlier today and looking at the data that was presented about things like the number of hospitals participating in ECR and ELR and the like, I think we need to do an additional focus to ensure we are actually looking at good comprehensive numbers and using standardized definitions of ECR and ELR across spaces because I am not sure that there is adequate reporting across that. If you are looking even at a subsample, or a sample, you are not necessarily looking at the data picture as a whole and understanding what that looks like both on the hospital side and the public health end in terms of what public health is receiving and where they are actually receiving data from. On the public health side, it is critically important to understand and reflect things like the ability of throwing the ball and catching the ball from the idea of the certification standards and improvements that were discussed about earlier, if that makes any kind of sense.

A third component of that structure could also be looking at sharing information between public health and healthcare providers on the return and essentially looking at services or recommendations that public health might be able to use its data resources and expand services like computer decisions to support utilizing public health data resources to provide good information and good recommendations back to the provider community and what might be done about evolving standards in that space. Those are three components and a fourth element. I do think that public health should be that fourth ongoing effort because public health is part of the healthcare system and collaborating with healthcare providers is critical for everybody's benefit. Providers, public health, patients, the entire community. Thank you.

Aaron Miri
Thanks, Ike. Medell, do you want to comment real quick?

Medell Briggs-Malonson
No, just a lot of great comments that you made there. Without a doubt, that was part of what we discussed as well, the critical impact of ELR and ECRs, so yes, public health is definitely and should be part of our priorities in all that we do.

Aaron Miri
Absolutely. I would also add equitable public health. Ike, I am sure you were referring to that as well, to make sure it is truly ubiquitous care in that partnership in totality. Next up, Abby Sears. You are next.

Abby Sears
Thank you very much. Beautiful job on this. I love to see the direction. Just one request in consideration and one comment for you to put in the back of your minds as you are moving forward on this important work. The first one is would you consider thinking about how the lack of broadband and connectivity across the country could be impacted by some of the work that you are thinking doing, from an equity standpoint, both for critical access hospitals, but also as we think about telehealth and as we think about the use of mobile devices and patients, we have seen significant equity issues related to not having broadband access and needing to use telephonic visits versus video visits. I think that is something to keep an eye on because it will continue to hinder access. That was the one for consideration.

My second comment is this. You probably already know this, but in case you do not, last year the NIH funded a project called AIM-AHEAD. That particular project is 100 percent focused on looking at how to design AI related to equity and the use of large sets of data that are specifically focused and have a large amount of uninsured and underinsured patients and then looking at the algorithms that will dramatically impact care based off of that. They might be a place for you to gather some additional information as you look at the AI pieces of your work.

Aaron Miri
Great points, Abby. I love the broadband comment. I completely agree with that, giving what I am seeing here in the rural parts of Florida and Southern Georgia. I appreciate that. Medell?

Medell Briggs-Malonson
Yeah. I also agree with that. Abby, I was going to mention in terms of broadband, when we look at what has been traditionally defined as the digital divide, it is not only just, as you mentioned, broadband, but it is

also just the even the infrastructure when you do have Wi-Fi in the areas the devices that people do have access to. That is why when we are looking at overall accessibility to not only the infrastructure for IT, including broadband and the reliability of Wi-Fi when it does exist, but also the devices that people have in order to connect. All very important points and all items that we definitely plan to expand upon. Thank you also for the additional recommendations.

Aaron Miri
I would also put a plug in for multilingual devices. Being of Hispanic descent, it is very important, especially for folks who hare primarily secondary language speaking, such as Hispanic or others, to be able to understand how to use those devices and if they are in a broadband deficient area, how does that work. Great **[inaudible - crosstalk] [03:06:13]** –

Steven Eichner
Aaron, I am just going to **[inaudible]** also accessibility factors come into play, too. That is something that we need to prioritize as well that we are probably not doing as good of a job as we might. There may be guidance on the books, but there is not necessarily great adherence to that.

Aaron Miri
Totally agree.

Medell Briggs-Malonson
[Inaudible – crosstalk] Inclusivity in every single way, and inclusivity in all aspects.

Aaron Miri
There is the word. Now, we had a hand race and it just went down, I think. Les Lenert? Was that you?

Les Lenert
Yeah, it was. I was just going to plus-one the suggestion of working on data segmentation and privacy in women's health. The data blocking statutes in particular do need to be reexamined in view of that, or rules have to be examined because when routine care in one state is a crime in another, we need to think about the unrestricted requirement to release the data on demand and that people need to know that there are risks with doing that when there are requests from a state where the law is different than the one they had the procedure performed in. I think that looking at this issue in reviewing different approaches for labeling data as confidential in the electronic record beyond break the glass of functionality, where you will label a whole record a whole event as confidential, is really important.

Aaron Miri
Got it. I agree with you and that is interesting. I had not actually considered that, so that is a very good point about that review. Medell, anything you want to add?

Medell Briggs-Malonson
No. Thank you for that.

Aaron Miri
No problem. Hung Luu, you are next.

Hung Luu
I will also echo that and add on the pediatric population as well because I think with the data blocking legislation, I do not think the pediatric population was considered in the fact that we all hope that everybody is raised in a healthy family that has their best interests at heart, but as we all know abuse can take place and sometimes certain tests or radiologic findings can expose that and could actually place the patient in danger if the person who lives in the same household has access to their medical record. I think that as we explore data blocking, we should take into account that one size does not necessarily fit all and that we need to think about particular populations, such as pediatric populations.

Aaron Miri
Hung, that is a great point. I will say that Steve Posnack did a great blog that talks about some of the exceptions to information blocking and how to use the exceptions and the need for those. To your point, I think we should look at those and continue to expand upon it and see if there is opportunity there or applicability of those exceptions in a certain way. Again, I will give a plug for some of those blogs that are out there by the ONC that tried to explain some of this and how could we do this without running afoul of the information block, but keep patient safety paramount and first and foremost. Medell, anything you wan to add?

Medell Briggs-Malonson
Yeah. I was just going to add that our pediatric population tends to be one of our most vulnerable populations in multiple ways and, Hung, I think you are mentioning and hitting on some of these different pieces. I also agree that as we are thinking about these recommendations and these processes, how do we ensure the safety and the protection but also knowing that they are minors. This is something we run into in so many different ways when trying to make sure we are providing the best and most appropriate care to our pediatric population. I want to amplify that this is a very important population that we sometimes do not put as much attention into when thinking about what some of their needs are when it comes to health IT when we absolutely should. Thank you for that.

Aaron Miri
Yeah. Good points. Good questions. Good conversation, you all. Other comments, other thoughts, or other questions? All right. I would please ask you to look at these in your spare time, marinate on the m some more. If things come to the top of your mind or relevant activities that you want to ask about – oh, we have another question that popped up. I will not conclude just yet. We have a few minutes. Ike, go for it.

Steven Eichner
I am sorry. One last question. Do we need to differentiate between Medicaid and public health in looking at the discussions because they are both government involved. They are different programs with different purposes and different arrays, although we collaborate well together on many different projects. I was wondering if you need to make sure somewhere in the framework that we are addressing the differences between the two. It is not so much the differences, it is the separation of involvement or the separation of exchange, exchanging data with government as public health. They serve different purposes and different functions and other different sets of regulations than looking at exchange of data with Medicaid in the Medicaid framework as a payer or other programs. Figuring out what that fits in is something to think about, and not necessarily to undertake as a task but just to account for as we are looking at exchange.

Aaron Miri
That is a good point. That is a good follow-up.

Medell Briggs-Malonson
Yeah. I think this is very intriguing because in my mind there is a distinct difference between public health and when we are developing all of our strategies to impact the good of our people as a country and especially focus on making sure that we are achieving equity, especially with those communities and populations that have had worst public health outcomes versus Medicaid, which is strictly focused on normally the provision of healthcare services. Of course, we bring in all of the other social drivers, but they do tend to be two different entities. I think what you are mentioning is very important to make sure there we are not conflating the two but yet also knowing that we are putting in place all of these various exchanges and other forms of our IT processes to help to elevate and support the overall best healthcare outcomes for everyone. I do agree that is a very important piece not to conflate and also due to the various reporting requirements as well. Thank you for bringing that up. It seems like that is something that we should dive into a bit more as well.

Aaron Miri
Yeah. I agree with that totally. Other questions or comments here? All right. While seeing the non, again please marinate on this after hours. Think about it in your sleep like we do and let us know any topics that come to top of mind. I see that Steve Posnack put a shameless plug in for his blog. Check it out if you have not. It is a really good blog. There are several of them out there and some written by Elise as well. They really try to delve into some of these nuances, but it is nuanced. Again, let us bring those questions back here and we can always go through them. Good job, Medell. Anything you want to say to close out this item?

Medell Briggs-Malonson
No. Thank you, also, Aaron. Great job, as well. Thank you all for your input.

Aaron Miri
Wonderful. All right. With that, Denise, if you are in agreement, we can ask Seth to go to public comment here?

Denise Webb
Yes.

Aaron Miri
All right.

Public Comment (03:14:45)

Seth Pazinski
All right. Thank you. We are going to open the meeting for public comment at this point. 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 and then once called upon press *6 to mute and unmute your line. We will just pause here and give folks a few

seconds to queue up. Okay, I am not seeing any comments at this point. I will turn it back to Aaron and Denise.

Aaron Miri
Let me ask for clarification on process. I apologize. I see folks with their hands raised in the attendees, which is the public, I believe.

Denise Webb
Oh. Yeah.

Seth Pazinski
I am sorry. I am not seeing it on my end. Maybe, Medell, if you can call out the folks who have their hand raised?

Aaron Miri
Yeah, first we have Shelly Spiro. I will just go ahead and do it. Shelley?

Seth Pazinski
Okay.

Shelly Spiro
Good afternoon. My name is Shelley Spiro. I am the Executive Director of the Pharmacy HIT Collaborative, representing over 250,000 members of the majority national pharmacy associations including pharmacy education and accreditation in 14 associate member organizations. Regarding Dr. Rolle's presentation about the 2023 planning related to pharmacy interoperability and emerging therapeutics, the pharmacy profession agrees with the plan and the formation of the Pharmacy Interoperability Task Force. Pharmacists are on the cutting edge of documenting and sharing clinical services using FHIR and in many cases are ready and willing to expand these interoperable exchanges.

Over the past seven years, the pharmacy profession stepped up and adopted FHIR Release 4 Enabled Pharmacist Electronic Care Plan implementation guide, validated and published at NCPDP and HL7. The e-Care plan is highly adopted by 19 system vendors with millions of electronic care plans being shared nationally. The e-Care plan applications are being taught in 97 colleges of pharmacy and in another initiative through a joint effort with NCPDP and HL7, we are working on a FHIR resource for a standardized medication profile to help exchange medication related data during transitions of care. The Pharmacy HIT Collaborative are the stewards of over 120 value sets within the National Library of Medicine's Value Set Authority Center to follow USCDI rules including codes to document such as determinants of health issues identified by pharmacists during patient care encounters. We are in support and applaud ONC forming a 2023 Pharmacy Interoperability Task Force. Thank you.

Aaron Miri
Thank you, Shelly. Next up, I believe we have Pooja. I apologize if I pronounced your name wrong. Pooja, you are next.

Pooja Babbrah

Great. Can you hear me Okay?

Aaron Miri
Yes.

Pooja Babbrah
Fantastic. Thank you so much. Good afternoon. My name is Pooja Babbrah. I am currently the Pharmacy and PBM Practice Lead for Point-of-Care Partners. We are a health IT consulting company. I am also currently on the chair of the board of NCPDP. Frist of all, I would also like to thank Tricia Lee for bringing forward the pharmacy use case for the 2023 work plan. I am excited about it and thrilled to see the support and discussion in the chat.

I want to quickly make two points. The first is through the lens of my role with Point-of-Care Partners. Over the past year, we have done several client projects with pharmacies and health plans and there is definitely this growing interest for health plans and pharmacies towards more closely together to improve patient outcomes. Of course, we have the medication therapy management services but what we are seeing now is health plans wanting to work with pharmacists to help close gaps in care with patients. Also, there are several health plans who are looking to pharmacists to support their health equity initiatives around medication adherence.

The one thing that has been identified both by health plans and pharmacists in kind of moving this work forward specifically has been around interoperability, so very excited to see that we are thinking about doing this. Just related to the work we are doing it NCPDP, Tricia Lee mentioned the initiative we have around the national facilitator model. We are using existing standards to allow for the real time data access for pharmacists to support public health reporting. We just actually announced a pilot around that to show how pharmacists can access and report on COVID vaccinations, essentially using existing standards, so no matter where you received your COVID vaccine, whether it was in a different pharmacy or even a different state, when you go to get your booster or additional vaccinations, the pharmacist would be able to access that information. That is kind of a tie-in to both the pharmacy and the public health.

Just one last point on NCPDP. We are in the middle of updating our strategic plan and one of the main initiatives that have come out of our research and what we have heard for membership is that we need to be able to support our member organizations and the pharmacy industry in helping advance the pharmacist practice and care coordination. To me that means improving interoperability but also a lot of what Tricia Lee touched on in terms of visual therapeutics, emerging therapies, and standardization around exchange of data. I am also, like Shelley, fully in support of this committee adding pharmacy interoperability to the 2023 work plan. I know there are quite a few of us on the call today that I think are in support of that. I appreciate the committee's efforts and time on taking that into consideration. Thank you.

Aaron Miri
Thank you very much for your comments. I appreciate that. Next up, Pam Schweitzer, I believe?

Pam Schweitzer
Can you hear me okay?

Aaron Miri
Yes, ma'am.

Pam Schweitzer
Okay. Thank you for the opportunity to be able to speak. My peers have already said a lot of it so I will just say it from my perspective here. I am a former federal employee, a pharmacist. In fact, I was a former US Public Health Service Chief Pharmacist. I am also NCPDP, on the Board of Trustees, and also on the foundation board for the National Community Pharmacist Association, and I live in rural South Dakota. The reason why I mention all of this is, first of all, I am very impressed with being able to listen in to the committee and the discussion. They are so spot-on with the direction our country needs to move, so I was very impressed with that, and also their 2023 plans that I strongly support Tricia Lee's comments and her focus on pharmacy interoperability.

There is a lot of opportunities that have come up with COVID just traveling around the country. I see these pockets all over the country of people doing things on paper and spreadsheets with pharmacy working with social services and working with community resources. There is just this wide-open opportunity, and to be able focus in on this for 2023 and hear all of this I think is going to be very valuable and it is going to help consumers be able to connect to the needed services that they need in our community. I agree also with all of the very thoughtful discussion on privacy security, information blocking, and data segmentation. Those are all real important parts to be included in there. Overall, I am very supportive of this committee and Tricia Lee's comments. Thank you for the opportunity to share.

Aaron Miri
Thank you very much. I appreciate the comments. Seth, keep me honest. I believe that is all the comments we have on Accel Team?

Denise Webb
Yes, that is correct.

Seth Pazinski
Yes. That is all I see online. All right. Thank you, Accel. Just a couple of updates for us to get back to Aaron and Denise to close us out. Reminding everyone our next HITAC meeting is going to be held in January 2023. We do anticipate the full schedule of HITAC meetings for next year coming out relatively soon, so folks can be on the lookout for that. I just want to remind everyone that all of the HITAC meeting materials are publicly available on healthit.gov. With that, I will transition back to Aaron and Denise.

Final Remarks and Adjourn (03:24:35)

Aaron Miri
Perfect. Let me go first here and then I want to turn it over to Denise. First, I want to read into the record, just so that we have a comment from one of our HITAC members who was not able to get off of mute quick enough here. This is from Sheryl Turney. Her comment is, "We need to consider caregivers and children in TEFCA as well when payers have notifications of protected orders or that do not share requests. This needs to be addressed properly in the operating procedures for TEFCA related to information blocking. There should be some way for patient caregivers to notify TEFCA and QHINS that information in whole or in part should not be shared at their request." I believe what Sheryl is alluding to is that privacy conversation we had earlier and being able to opt in and opt out with that informed consent and of course informed assent.

Another one for privacy and we are definitely hearing that loud and clear. Thank you, Sheryl and I appreciate that being part of the minutes here. As we close out here, I want to think all of you for today. It was a wonderful session, very productive, and very lively, which is exactly what the HITAC is. I want to say again my public thanks to all of you rolling off the committee. You are all family. You will always be family and you are always part of the HITAC community forever, and ever, and ever, and your work and efforts will live forever in the work that has been accomplished that is driving this country forward.

For those of you listening, we appreciate your participation today. Thank you to my brand-new co-chair Medell, as well as thank you very much to our existing co-chair Denise, who has been a phenomenal partner in crime to me this past year in making things happen as we continue to drive forward our progress around this country. Also, with that, I want to wish you Happy Holidays and to be well. We will definitely see you in January to kick off another bright year on the HITAC. Denise, over to yo9u to close us out.

Denise Webb
Thank you, Aaron. Again, I want to say how much I appreciate being able to serve the last five years with all of you. It has been an absolute pleasure and a great experience. I hope that we will cross paths again. I certainly will have some time to serve on some task forces or other groups in the next year, if that opportunity occurs. Hopefully, I will get to see many of you again within that capacity. Again, thank you, and thank you, ONC. I appreciate it. Farewell to my other colleagues that are also leaving the committee with me. Farewell to all and I hope you all have a wonderful rest of the year and Happy Holidays.

Aaron Miri
Happy Holidays. Thank you all. Have a good one.