Health Information Technology Advisory Committee

Annual Report Workgroup Virtual Meeting

Transcript | September 23, 2024, 11 AM – 12:30 PM ET

Attendance

Members

Medell Briggs-Malonson, UCLA Health, Co-Chair
Eliel Oliveira, Harvard Medical School & Harvard Pilgrim Health Care Institute, Co-Chair
Shila Blend, North Dakota Health Information Network
Hans Buitendijk, Oracle Health
Steven (Ike) Eichner, Texas Department of State Health Services
Hannah Galvin, Cambridge Health Alliance
Jim Jirjis, Centers for Disease Control and Prevention
Anna McCollister, Individual
Rochelle Prosser, Orchid Healthcare Solutions

Members Not in Attendance

Sarah DeSilvey, Gravity Project
Kikelomo Oshunkentan, Pegasystems

ASTP Staff

Seth Pazinski, Designated Federal Officer
Michelle Murray, Senior Health Policy Analyst, ONC

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

Seth Pazinski
All right, good morning, everyone, and welcome to the Annual Report Workgroup meeting for the fiscal year 2024 cycle. I am Seth Pazinski with the United States Department of Health and Human Services (HHS) Assistant Secretary for Technology Policy and Office of the National Coordinator for Health Information Technology (ASTP), and I will be serving as the designated federal officer for today's Health Information Technology Advisory Committee (HITAC) workgroup call. As a reminder, all our workgroup meetings are open to the public, and public feedback is welcome and encouraged throughout. Members of the public can type comments in the Zoom chat feature throughout the meeting or make verbal comments during the public comment period that is scheduled towards the end of our agenda today. I am going to start off the meeting with a roll call, so when I call your name, please indicate that you are present, and I will start with our co-chairs. Medell Briggs-Malonson?

Medell Briggs-Malonson
Good morning.

Seth Pazinski
Good morning. Eliel Oliveira?

Eliel Oliveira
Good morning.

Seth Pazinski
Good morning. Hans Buitendijk? Hannah Galvin?

Hannah Galvin
Good morning.

Seth Pazinski
Good morning. Jim Jirjis? I saw that Jim was on, but it looks like he has dropped off, so we will see if he joins. Anna McCollister? Shila Blend?

Shila Blend
Good morning.

Seth Pazinski
Good morning. Sarah DeSilvey? Steve Eichner?

Steven Eichner
Good morning.

Seth Pazinski
Good morning. Kikelomo Oshunkentan? Rochelle Prosser? All right, thank you. Rochelle, I just called your name, if you want to announce yourself.

Rochelle Prosser
Present.

Seth Pazinski

All right, thank you. Is there anyone else who I missed or who just joined? Okay, I am going to turn it over to Medell and Eliel for their opening remarks and to get us into our agenda.

Opening Remarks (00:01:53)

Medell Briggs-Malonson
Excellent. Well, thank you so much, Seth, and good morning, everyone. Happy Monday. We are entering into the last portion of September, and it is so amazing how time is flying by. So, today's meeting is going to be another great meeting. We are really going to wrap up some of our prioritization and go deeper into some of our story ideas, so we are really looking forward to everyone's thoughts and insights as we start to move into the final phases of the annual report. Eliel, I will turn it on over to you also for your opening remarks.

Eliel Oliveira
Thanks, Medell, and thanks, everyone, for joining. Yes, we are getting close to the finish line. As you are going to see today, we are going to polish a few things and start getting prepared for feedback and views from the whole HITAC group and prepare ourselves for the final submission in December. Thank you for all the contributions you have provided so far. We are looking forward to the discussion today. Back to you, Seth. Thanks.

Update on Workgroup Plans (00:03:00)

Seth Pazinski
All right, thank you. We can go to the next slide, and the next one. This just has the dates coming up for the workgroup meetings, so there are two more workgroup meetings after today. Go to the next slide. And then, as Eliel mentioned, at the October 17th meeting of the HITAC, which will be in person, we will be going through a draft of the FY '24 annual report and getting the full committee's feedback. Go to the next slide. This just lays out the next steps, preparing us for finalizing the report and delivering it to Congress in the November timeframe. Next slide. All right, I am going to turn it back to Medell and Eliel to get into finishing up our prioritization discussion.

Medell Briggs-Malonson
Great, thank you so much, Seth. Actually, can we go back to the prior slide for just one moment as well? Thank you, Seth, for walking through some of those administrative items. I want to focus on this slide for just one moment, especially with the Annual Report Workgroup. We are very quickly nearing the end of this process, and there are some really important steps where we are. Today, we are going to finalize the prioritization of all the various different draft topics, but we are also going to go into the stories. Now, what is really important and what I want to make sure everyone sees is that the workgroup is going to review the entire draft report on October 7th, which means our very next meeting. I want to emphasize that this is the last time that we as a workgroup will be meeting and discussing any changes, revisions, or additions prior to this report going to the full committee on October 17th, when we will all be in DC together.

The reason why I am emphasizing this is if you have any ideas, revisions, or tweaks, we want everyone to really review these items in detail and submit their comments directly to Michelle and team so that we can incorporate all these various different ideas that you have before the ASTP team finalizes the draft report, and then it is presented to the full committee. The reason why is that this is a very short timeframe, and we do not want any last-minute thoughts or last-minute additions, so I am actually asking very clearly, and Eliel and I have had some chats about this, for everyone to take the time up front to go through this report in detail so that when we get to presenting the draft report to the full committee in person, at least we as a workgroup have finalized or come as close as possible to finalizing our various different comments and revisions to allow the rest of our HITAC colleagues to then provide their insight.

So, we really want everyone to invest some time between now and all the way up to, for instance, October 7th to go line by line through everything so that we can ensure that all of your thoughts, comments, and wonderful recommendations are incorporated before this draft report is finalized to go forward to the full committee of HITAC on the 17th. I just wanted to make sure that we were very clear about some of those different items. Okay, let's go on to the next slide. Eliel, if you like I can go through the last prioritization, and maybe you can pick up on the illustrative stories.

Eliel Oliveira
That sounds great.

Discussion of Draft Crosswalk of Topics for the HITAC Annual Report for FY24 (00:07:03)

Medell Briggs-Malonson
Wonderful. So, of course, we have been discussing the draft crosswalk of topics for the HITAC annual report, and our task today is to finish going through the crosswalk of draft topics in order to propose the tier, whether it is an immediate task, meaning calendar years 2025 to 2026, meaning this upcoming calendar year, or if it is a longer-term topic, which means anywhere from 2027 to 2030 and/or beyond. Normally, these longer-term topics are assigned to those areas where we may need to have a little bit more exploration before we can implement those recommendations or we may need to build a foundation of first of saying we have to go through Phase 1 and Phase 2 before we get to some of these other topics.

So, I just want to remind everyone of our two different tiers that we can assign to each topic, immediate, which means we have to execute this next year, versus long-term, saying this is very important, but we have to probably put in place some of the building blocks or have some other initiatives before we assign it for execution. So, now that we have an idea and we are reminded what our two proposed tiers are, let's move into the draft crosswalk of topics. We have a little bit of a skinnied-down version that does not include all the details so that we as a workgroup can go pretty quickly through them. We are going to continue to go through.

This is just as a reminder and we are not going to discuss it, but as you can see, we have a lot of immediate, there are some long-term, and now we are here on patient access to information, and we need to assign either immediate or longer-term to each one of these topics. The very first topic for us to consider is the patient-generated health data, and of course, the opportunities around PGHD were in terms of improving interoperability standards and metadata to support incorporation and personal access and control of clinically relevant PGHD. And so, there are a few other items there as well, but we really focus on our patient and the data they are generating. I want to open it up for discussion. Do we believe that this is an immediate or longer-term topic? Any thoughts? Yes, Rochelle?

Rochelle Prosser
I think it is both because we need to start talking about it now to get it started. Patients need to be able to have the ability to upload, and we are currently doing some of this now, but there need to be some longer discussions on how the data is showing and the quality aspects of that data, so I would say it is both.

Medell Briggs-Malonson
Great, thank you. If it is both, that means we need to actually start something this calendar year. So, when we start something this upcoming calendar year as an immediate, that does not mean it is one and done, that means we just have to start the work. What you are saying is that this is an immediate need, an immediate topic, which, of course, will most likely continue on for several years after that.

Rochelle Prosser

That is correct.

Medell Briggs-Malonson
Great, thank you. Anna?

Anna McCollister
I definitely say this is immediate. It has been put on the back burner for two decades now. There is no reason why it should not be immediate. There is no reason why it should not be done now. Some of the standards work has been done. It still needs to be completed, but it definitely is immediate.

Medell Briggs-Malonson
Great. Thank you so much for that, Anna, and yes, this has been a recurrent topic, and it is very important because we have to support our patients, their needs, and their data, so, thank you for that. Any other thoughts? There are two votes right now for immediate.

Steven Eichner
I think it is immediate as well, and the context is if we are really talking about patient-centered healthcare, then patients need to be at the center. I would be tempted to make that reference throughout this piece because otherwise, we are not doing real justice to that term.

Medell Briggs-Malonson
Excellent. I agree with that as well, Ike. Very good points. So, are there any objections to it being immediate? Okay, not seeing or hearing any, we will make PGHD an immediate proposed tier. All right, let's move on to the next one: Reducing patient burden. Just as a reminder again, the reducing patient burden aspect was creating health IT that is more accessible and inclusive for the patient concerning health and digital literacy, multiple languages, and optimal modes of data transport. Consider patient burden implications, priorities for use of health IT, and other related **[inaudible] [00:12:20]** to advance efforts that ease burden for patients. So, I see that there is already one vote from Rochelle for immediate. Any other thoughts? Immediate or long-term?

Hannah Galvin
This is Hannah.

Medell Briggs-Malonson
I see Anna, and then Hannah.

Anna McCollister
I think this is absolutely immediate. Patient burden and the impact of all this stuff on patients reducing the burden on patients has been neglected for too long. It needs to be considered a priority.

Medell Briggs-Malonson
Yes, thank you, Anna. And then we have Hannah. I saw Hannah right before Ike, so, Hannah, we will go to you next.

Hannah Galvin
Thanks, Medell. Sorry, I am driving and am not as able to use the hand function. I also agree with immediate, and I do think this also may be not entirely a prerequisite to the patient-generated health data piece, but it needs to go hand in hand with it at least, and I know that we have been saying many of these topics are immediate, and if we are going to set them in some context for ASTP, if we put everything as immediate, then it may not be quite as helpful because we need to do everything in the next year, and I would actually emphasize that both this and

patient-generated health data are very important for us to deal with in the next calendar year, but for me, this even needs to come first as we are thinking about patient-generated health data because we have to achieve a floor here before we can enable better technologies for patients.

Medell Briggs-Malonson
Thank you so much for those important comments, Hannah. Because you are driving, just go ahead and speak out because I want to make sure you are safe. Thank you for letting us know that, so if you want to say something, just come off of mute, and I will recognize you. I have some thoughts about what you said, but I want to get to Ike's comment for reducing patient burden.

Steven Eichner
This piece is really fast. Looking at patient literacy pieces needs to be called attention to separately, but also prioritized with respect to all the other elements because it is literacy in the context of other things that we are prioritizing that really becomes important, and if you do not pursue that as up-front as we are looking at new things, you will forever be playing catch-up. Secondly, I think it is first providing global emphasis on patients with complex conditions or complex healthcare specifically, so we are not talking necessarily about patients in general, but maybe giving special attention to those folks that have more complex things, more complex needs, and more complex opportunities to participate, if that makes any sense.

Medell Briggs-Malonson
Both items make a lot of sense, Ike, in every single way because we know that, No. 1, this all just has to be highlighted and amplified in every single way, but especially as you are saying with our patients with complex needs and complex conditions, that is the root of health equity and justice. We have to focus on what those needs are, and we have to address them. It cannot just be universal. We have to be able to adapt and make sure that those that have the greatest needs are the ones that we are also thinking about this for. So, yes, it would be great to see where we can highlight complex needs and, I would say, complex conditions because we know that that has been a focus of even what we have mentioned here on HITAC, and we do not want to lose that in all of the work, so, thank you for those points. Rochelle, I saw your hand. I was just going to say one thing.

I absolutely vote for this to be immediate in so many different ways, one, because from all the different things that all of you all have already said in which we have to make sure that our technology is rooted in being very patient-centric, and right now, oftentimes, our technology is not, not only our technology that we are collecting from the patient, but our technology that we are using to provide clinical services to, and the reason why I feel that this is also incredibly top priority is because we have additional regulations that are now in effect, especially as I mentioned last time, with Section 1557 of the Affordable Care Act. It is exactly this. And so, there is no putting all of these things on the back burner because even other agencies within HHS are saying that we have to address these different items and we have to ensure that everyone is actually benefiting from health information technology in an equitable and just way, so I also agree with all the amazing things you all have said. Any objections to making this immediate? Welcome, Jim. We are happy to have you. Great. Thank you so much. It seems like there are no objections to this.

The very last one is impact on patients by the use of artificial intelligence (AI) in health and healthcare, and once again, this is the impact on patients. We have another topic, which is really focused on the clinicians using AI, but this is specifically impact on patients by the use of AI in health and healthcare. And so, the opportunity, of course, is to ensure the quality, relevance, safety, and usability of AI data models and algorithms. For example, AI training models could be flagged in health IT systems to indicate that a model trained on adults should not be used for a pediatric population, so this is trying to add more visibility and more transparency to the patients in terms of the various different AI models or AI algorithms that have been used in their overall health and healthcare. Any

thoughts about the proposed tier, whether it is immediate or longer-term? Hannah, you are not supposed to be raising your emoji hand.

Hannah Galvin
Sorry, yes. I do think that this is immediate. I think that some of this work is already happening, which is a very good thing. Especially around some of the generative AI note-writing tools, there is work that is starting to look at the impact of those AI-generated notes on patients and how patients are perceiving those notes, and patient-friendly notes, and so, a lot of that is already under way, and so, I think it is important for ASTP to be taking a look at patient understanding of the tools that are impacting them and that are part of the co-generated medical record or impacting their care. And so, since this is moving quickly and impacting care, I think that it is important to be a priority for the next year.

Medell Briggs-Malonson
Thank you, Hannah. It is definitely moving very, very fast. Rochelle?

Rochelle Prosser
Thank you. First of all, I want to thank you for your courage to just write this line here. As we look to AI and how it will improve workplaces, enhance diagnostics, and really just foster better care and outcomes in general, or at least that is the intentionality, we must be mindful that the pediatric population is of varying age, first of all, and so, one-size-fits-all modeling does not bode well, and even then, there is a limitation on linguistics itself that is really unique to the pediatric population, and so, this is why we really have to be laser focused to make sure that we are only using AI in the right contexts and for the right purposes, so I vote for this to be immediate.

Medell Briggs-Malonson
Thank you so much, Rochelle. That is the idea of this in general, and whether it is due to pediatric populations, adult populations, adolescents, or to various different medical conditions, age groups, or whatever it may be, the idea behind this is that whatever the model is trained on, it is transparent and face-up for patients and their providers and clinicians to see if that actually is applicable to them or not, and that is going to make a huge difference in terms of artificial intelligence and many of these other algorithms, decision support interventions, and other items that are coming out. Anna?

Anna McCollister
I just wanted to add that I definitely think this is immediate. This stuff is moving too quickly. I do not think we should do anything to necessarily muck up the use of it or slow things down because it is essential that we allow innovation to move forward. However, we have to be able to very visually and persistently declare what type of data was used to train the model and make sure that is apparent throughout the use of these tools, not just a one-time installation.

Medell Briggs-Malonson
Agreed, absolutely. I hope that that is what this is getting towards, especially for it to be a complement, at least with certified health IT modules with Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing (HTI-1) Final Rule, but just across the industry in general, of making sure that this is visible, to your point, Anna, throughout the entire life course of all this various different AI that is emerging. I hear lots of immediates because we know how fast this space is moving and we already know many of the efforts that are already under way. Are there any objections to making this immediate? Okay, I do not see any. There are no objections to making this immediate, so we will make this last one immediate as well, and no, we cannot, Anna. Yes, it sounds nice and quiet. Let's move forward.

I want to go up to the top really quickly because I want everyone to see what we have now organized or categorized each topic as, and now that we have gone through everything, I will say that the vast majority of items are immediate, and we have already had the conversation that, yes, there is a lot of work that needs to be done, and there is a lot of work that we think is critical. However, if everything is immediate, it almost seems like nothing is immediate. It may stay the same, but I just want us to go one last time as a workgroup through all the various different topics and see if we as a workgroup are recommending immediate action or if any of the immediate actions, now that we have gone through the entire crosswalk, can potentially be recategorized as longer-term. So, we will start at the top and go through this very quickly, and I am not going to ask for another vote, but if someone feels that maybe they have an idea or an opinion that we should change it to longer-term, please speak up, but I am just going to reread through these to make sure that the workgroup is, once again, fully aware of what our decisions are.

So, the very first topic is use of artificial intelligence (AI) in health and healthcare. This is really about just continuing to look at the governance standards as well as approaching some of the healthcare challenges that we have with research regulations and clinical care. We have coined that as immediate. We also have implementing health equity by design, and this is really to move forward with promoting health equity by design consistently throughout various different health IT initiatives. We are looking at the methods, strategies, and standards used to implement health equity by design. We have coined that as immediate. Rochelle, I see your hand. Was that a leftover hand?

Rochelle Prosser
No, sorry, I was speaking on mute. My apologies. I just have a thought. Where our government partners are already acting, it behooves us to move forward with those. Is there a way of being able to tell on each one of these where our government partners are already moving forward and where we must act to make it a little easier for the group? Like you said, if we are boiling the ocean, it does not work, but where we are already moving forward in other agencies and lagging behind just to be brought up to speed with the rest of them, is there a way to be able to tell that at a glance to make it easier for us?

Medell Briggs-Malonson
That is a really good point. There is a lot of work that is already taking place in some of these areas, but I do believe that we as HITAC have an additional voice that we can lend, especially in support of ASTP, and especially as ASTP's scope has broadened significantly, but one thing that may be very interesting to do, because I was thinking of this when I was looking at this crosswalk, is even some type of indicator that there are some other agencies that are working on this or there are new regulations that are working on this. So, for instance, I would say even right now with implementing health equity by design, do we put something like an asterisk by it because we already know that this is a priority for ASTP, or the same thing with AI in health and healthcare? We know that there are several agencies that are working on it, so we put an asterisk by it. So, that may be something that we can note.

What I really want us to think about is that this is still comprised by us if we still say it is immediate, like we need to focus on this, or if it is long-term, but I do think identifying in some way that other agencies are really invested, whether it is ASTP or others, and/or if there is other regulation that is requiring it, that may be something to think of. Great point. All right, I am going to keep us going because we want to get to the story so I can turn it over to Eliel. So, use of technologies that support public health, once again, optimizing public health data exchange and infrastructure. This is really about furthering the interoperability between healthcare providers and public health authorities, especially with all of the new emergence of items such as Trusted Exchange Framework and Common Agreement (TEFCA) and also bringing in our public health authorities' experience with data exchange. We have actually determined this to be immediate. Let's keep on going. I am watching for hands if anybody feels otherwise.

All right, interoperability, supporting interoperability standards, especially when it comes to laboratories and pharmacies. The opportunity was to explore available adoption levers to require commercial and public laboratories to meet appropriate standards. We have stated that that needs to be immediate. However, when it comes to increasing pharmacy data transparency regarding drug shortages and availability, we have saved for that to be longer-term after we improve the interoperability. In terms of supporting image interoperability, we stated that the opportunity was to identify the current landscape of imaging data standards and implementing recommendations to access that data. That has been determined to be immediate. While also improving long-term and post-acute care interoperability and examining those opportunities to increase the availability, we have also stated that that should be immediate.

When looking at the topic of improving behavioral health interoperability, examining opportunities to increase the availability of behavioral-health-focused certified health IT modules that support interoperability, we have also stated that that should be immediate. We do not really need to explain further improvement of data quality and sharing. We have also determined that to be immediate. With supporting data standards for maternal health, identifying the current state of maternal health data to ensure better care during the provision of high-quality maternal care, we have stated for that to be immediate.

Hannah Galvin
Excuse me, Medell?

Medell Briggs-Malonson
Yes, I see your hand, Hannah.

Hannah Galvin
Thanks. There are a couple things that have struck me about behavioral health and public health. As we read through them, all of us think that of course we need that to be immediate. All of those are reasons we need to exchange data immediately. But the one thing that strikes me is that we are now implementing TEFCA, and just to the point of nothing being immediate if everything is immediate, is there a case to be made that in considering some of these areas that are planned TEFCA Standard Operating Procedures (SOPs), or part of TEFCA SOPs, or that should be expansions of current TEFCA SOPs, maybe our recommendation is that they are potentially not separate and immediate, but should be a little bit longer-term and built out as part of TEFCA, just in order to think about this strategically and, again, giving ASTP some direction and not seeing everything as immediate. I just wanted to bring that up.

Medell Briggs-Malonson
Thank you, Hannah. That is a really important piece, and it kind of goes along with what Rochelle was saying as well. When we know that there is work that is currently going on, how do we plug into that work? That is a really, really good piece. I see your hand, Jim.

Jim Jirjis
To her point around TEFCA, in your mission to not make everything immediate, I remember the days when every chest X-ray was ordered stat because you thought that if it was not, everything would take 10 hours, so nothing was stat. Particularly with the example of the data standards for TEFCA, which I see here, we are saying that is immediate. Further improvement of data quality and sharing, right? It is interesting because right now, TEFCA is a Clinical Document Architecture (CDA) push, so there is this gigantic amount of information that is often more than you need, but we are moving to Fast Healthcare Interoperability Resources (FHIR), and in some ways, FHIR will allow more precision for the requester, so what is driving the need for immediacy is that we have to define how much data people send in the CDA. Once FHIR starts to become the method, that becomes less important, so

how do we deal with that tradeoff? If we do not focus on it, then we lose our window where it is really needed if we do not make it immediate, but ultimately, it should be addressed with FHIR, but it just may take a few years.

Medell Briggs-Malonson
That is incredibly important as well. I think that is what everyone is trying to get at. We know that, most likely, this is all going to solve itself, but we do not want these important pieces to be pushed to the side or not thought about very clearly as the standard processes are moving through their journey. And so, it does bring up a really good point, and Jim, what you were saying goes directly along with what Hannah was saying. We know that these cycles or these wheels are already in motion, and right now, it is an issue, but hopefully, two or three years from now, it is not going to be an issue, but how do we ensure that we amplify it to say that as we are going through this, let's make sure that we are not losing this really critical information about the need for all of these different areas to be incorporated?

Let's think through that because we have this standard structure of immediate longer-term, but is there a different category? And now I am rocking the boat with Michelle and the rest of the ASTP group, but is there something else? This goes back to Rochelle's point and even what I was thinking, when we know things are in motion but we want to ensure that people understand how high of a priority it is as the different items are still being created or still being improved. Eliel, I see your hand as well.

Eliel Oliveira
I just want to put a plug here, Medell, on the Long-Term and Post-Acute Care (LTPAC) and behavioral health as the key example I use. I think there is immediacy here for HTI-3, if I am imagining the next round of an enforcement activity for those two types of electronic health record systems to also be required to be certified. I think you saw in Health Data, Technology, and Interoperability: Patient Engagement, Information Sharing, and Public Health Interoperability (HTI-2) Proposed Rule how public health and payers are now required, but that is not going to happen until 2028, I think, so even if the rule is written for next year for something like this for LTPAC and behavioral health, it still takes several years until vendors are required to comply, so I think that might be one thing for us to keep in mind in our recommendations here, considering some enforcement for those types of electronic health records (EHR).

Medell Briggs-Malonson
Absolutely, and you are absolutely right. Even if we start getting the motion forward, the implementation and the accountability takes a while, yes. Good point, Eliel. Ike?

Steven Eichner
One of the balance points in looking at TEFCA and public health is that use of TEFCA is optional. There is no requirement included in any of the federal regulations about using TEFCA. What that means that for public health on receiving data is that there is not necessarily a way of having all data coming through TEFCA, which puts public health in a position of having to support two different interfaces simultaneously because we still need the data from all entities that are reporting. That is another factor as you look at how you shift to using TEFCA as a primary way, but also manage the folks that are late adopters, and, from a public health perspective, looking at maintaining technology. In that situation, I would say adopting TEFCA is not necessarily the highest priority across the board, at least without the context of continuing to support slower adopters.

Jim Jirjis
Can I comment on that?

Medell Briggs-Malonson
Yes, please.

Jim Jirjis
Just to add color to support Ike's comments and fine-tune them, too, what he is saying is not hypothetical. One of our big public health priorities was to get a viewer to use the query use case with TEFCA for case investigators and public health to be able to understand where the patient has been and get access to the data to do their job. Because it is optional, we did all this work of having three jurisdictions get access to a viewer sitting on top of a Qualified Health Information Networks (QHIN), and they are logging in today, and there is zero data in there. Isn't that crazy? Because no provider has opted in on public health. So, then we start this campaign to slowly get providers to do it, but then, to Ike's point, we end up with 10% of the cases, so now they are doing their old method, and we have layered on a new method. It is worth. So, we should double down on healthcare working with Centers for Medicare & Medicaid Services (CMS) to provide incentives for healthcare to adopt so that we do not have this middle ground that is even more complex.

The other thing I would say is that TEFCA can also be used for public-health-to-public-health use cases. That is where we control the source and the requester, and we can get past some of the low adoption if jurisdictions use it, but it is primarily in the healthcare-to-public-health space that adoption needs to be enhanced, where it could get worse before it gets better.

Medell Briggs-Malonson
Well, thank you both for those comments about that. It shows, once again, the immediacy of this, while also thinking about how we do the additional reinforcement as well as adoption later on down the line. Ike, I see your hand. Do you have another comment? Feel free to come off whenever you want.

Steven Eichner
No, I do not.

Medell Briggs-Malonson
Thanks, Ike. So, this has been an amazing conversation. What I am hearing, and you all correct me to see if I am hearing this appropriately, is that there are several different items that we all believe are immediate, and we have to continue to push it forward because it truly does impact overall health, public health, and the delivery of healthcare services, as well as reinforcing the interoperability of all our systems throughout the entire ecosystem, but while we are listing immediate, there may be another way where we list immediate, like we have to continue to move forward with this, but recognize and acknowledge that there are other processes, agencies, or work that is currently under way or contingencies related to this as well.

I am wondering, once again, if there is a way that we can almost do an immediate, but then put something like an asterisk or star which clearly indicates that, of these various different topics that we believe are immediate, either there is work currently under way that this should align with and/or enhance, or it might be that because of where the rest of our systems are, whether it is through accountability, adoption, or whatever it may be, we still have to push this forward until all of the other entities come into play and coalesce for us to have the overall interoperability that we would all hope for. So, what are some thoughts about that? Was that correct as a summary?

Hannah Galvin
I think these categories are somewhat specified for us, but it is possible to have an "in progress" category, which is sort of like your immediate star?

Medell Briggs-Malonson
That is an idea, absolutely. The only small revision I would add to that, Hannah, is that if you see "in progress," you may ask why it is part of this annual report.

Hannah Galvin
I like the immediate star idea, but we just have to explain the star somewhere.

Medell Briggs-Malonson
Yes, because I still want to add the urgency to it. Yes, it is in progress, but we need to push it even more.

Hannah Galvin
I agree. I totally agree with the immediate star as long as we explain it somewhere.

Medell Briggs-Malonson
Okay, that sounds good. I saw somebody else come off, but thank you for that, Hannah. I absolutely like the idea of seeing "in progress," and whatever that means, having some descriptions there. Rochelle?

Rochelle Prosser
Yes, it was me that had my hand up. I was just saying we could say "in progress by other agency" just to add that clarifying context to show the immediacy. I am not sure if that would be a solution, but I am just offering something forward.

Medell Briggs-Malonson
Absolutely, thank you so much. If there are any other ideas, please let us know. We will take this back to ASTP as the co-chairs to try and figure it out because we do want to represent your thoughts on this, and I do think that it is not just binary, it is not just immediate versus longer-term. There is something in the middle, just based off our current climate, that is occurring, which is exciting because of all the work that ASTP has been doing, as well as other agencies, so it seems like we do have to underscore the rationale of why we are saying we have to push this because we have to push it not only because it is important, but because others are already pushing this as well. Okay, you all. Let's get back to this because we have to move to the illustrative stories.

The next one we were talking about was supporting data standards for diverse abilities as well as provider use of AI. Supporting data standards for diverse abilities is really focused on identifying the current state of patient disabilities and accessibility data to ensure better care during provision of healthcare or in emergency situations. Any thoughts about that in terms of immediate or long-term? All right, not seeing or hearing any, I would say this is another immediate star or immediate in progress because there are already clear regulations that we have to continue to do this. In addition, provider use of AI in health and health care is going back to the provider, and we had already spoken about the patient. So, assist in identifying best practices and safeguards for appropriate uses of AI and safeguards in the use of AI by healthcare providers, including clinical, administrative research, and patient engagement purposes. We have currently categorized this as immediate. Any thoughts on if we need to change this to a different area? I am not seeing or hearing any either. Let's keep on scrolling down, please, Accel, to the last one, privacy of sensitive health data.

Clarify the set of sensitive health data protected by privacy rules and consent directives more consistently across various contexts and types of technology. We have categorized this as immediate, and then we have lack of disclosure accountability, define a long-term roadmap to implement accounting of disclosures. We also categorized that as longer-term. In addition, transparency in use of deidentified data, learning more about patient preferences for disclosures about the sharing of their deidentified health data. We also categorized that as longer-term. As we know, we just went over patient access to information. Any additional thoughts, or do we think that this is reflective of what our insights and recommendations are at this time? Okay, excellent, workgroup. I do not see any additional items, so we will go back and try to figure out how we can tease out the immediate and immediate

star/in progress and try to get that wording a little clearer, and it seems like we are ready to go with our draft crosswalk as well as our proposed tiers, so, thank you, everyone, for all of your input. It is exciting.

Jim Jirjis
Can I ask a quick question?

Medell Briggs-Malonson
Yes, please.

Jim Jirjis
In the past, and even this year, we have talked about whether the role of HITAC to advise beyond what ONC is really working on in the here and now, and we have always talked about it, but, truth be told, there is so much that ONC is doing that we tend to focus on the things that are near and present. And so, the comment about nothing being immediate when everything is immediate may not be true because when we come to this work, we are actually responding to issues that are very near-term. We are not doing a lot of "three or five years from now, you ought to," so is it really true that, if 80% of these are immediate, then nothing is immediate, or is all of this helpful because it is right where ONC is already working? That is just another perspective. It may not actually be a bad thing to have a lot of immediates.

Medell Briggs-Malonson
Jim, I would say I agree with you, and it actually settles me that we would have immediate star or some other type of category, and the reason why is because in my mind, that will help ASTP as well as other agencies or others that are looking at this, whether it is Congressional members or whomever, to see that our recommendations are not only aligning with ASTP's massive amount of work that has really been cranked up over the years, but also that it is aligning with the rest of what is going on in HHS as well as other agencies outside of HHS by clearly demonstrating that we understand what is occurring and we think these are immediate for us to act on, and that we are not the only ones that think this is immediate to act on. I feel much more settled now that we are going to explore a way of demonstrating that our work is directly aligning with the priorities of ASTP or any of our other agencies, and we have to act on it. Those are just some of my own personal thoughts. Any other thoughts about that from the workgroup? Okay, you all are fantastic. I love this. At this moment, I will turn it on over to Eliel so we can go through the illustrative stories.

Discussion of Illustrative Story Ideas for the HITAC Annual Report for FY24 (00:48:58)

Eliel Oliveira
Thank you, Medell, and thank you, everyone. Could we bring the deck back up on the screen, Accel team? So, we are going to talk about the illustrative stories, and we went over some of that last week. If we can go to the next slide, what I am going to do here, as you see, is that this is supposed to be aspirational, demonstrating what can happen in the future. It is not describing the current state. We have five bullet points here, just describing what those stories are. Like in the last meeting, I am going to go through all five, and then we will open it up for comments because I think that may be more productive. Otherwise, we may never get to No. 5.

So, first, in health equity, addressing bias in AI models for clinical care, what would be a good story to illustrate the future of health? A health system dermatology department uses an AI tool trained on diverse data, including minority group representation. Clinicians can then better diagnose skin conditions on darker skin tones with a user-friendly, transparent AI tool. Staff training and bias mitigation have improved diagnosis speed and reduced disparity in treatment of cancer, psoriasis, and eczema. That is the story for health equity on AI models. Let's go to the next one, and keep in mind what we are trying to convey.

For public health leveraging the TEFCA for a viral outbreak, imagine a situation where a female patient visits an urgent care clinic in the evening, complaining of a cough and fever. Health data updated in real time through TEFCA during her urgent care visit, and the public health authorities then use deidentified data to identify and monitor a viral outbreak in her town. TEFCA then enables collaboration among state, tribal, local, and territorial authorities, ensuring resources are deployed efficiently to outbreak hotspots. So, this is definitely an advancement that we envision here in real time for surveillance of infectious diseases.

The next one is under interoperability, envisioning a case of enhancing postsurgical care coordination. We just touched a little bit on long-term, post-acute care, so here is an example. A senior patient is transferred from the hospital to a post-acute care facility after a hip replacement surgery. The post-acute care facility uses a certified health IT module for seamless data exchange with providers. Radiological images and progress reports are shared with surgeons and primary care providers, ensuring coordinated care, and the availability of post-surgery recovery data aids follow-up care with imaging updates added to the patient's longitudinal record. Next.

Here is one story on our privacy security addressing Electronic Health Information (EHI) disclosures. Imagine a patient with sickle cell anemia has been seeing hematologists for five years and participated in a sickle cell study at her doctor's suggestion, but then she is concerned about her privacy and curious about where her protected health information has been disclosed. A new patient portal feature of the hematologist's EHR system allows patients to request an account of Protected Health Information (PHI) disclosures for the last six years in accordance with recently enacted Health Insurance Portability and Accountability Act (HIPAA) regulations. The feature was developed through a public/private partnership between the federal government and medical providers to simplify the disclosure tracking process, and the system tagged PHI disclosures, presenting information in laypersons' terms at a 6th-grade reading level. That is a great case complexion. Next slide.

This is our last one, patient access, reducing patient burden. So, imagine the situation of a woman that speaks English as a second language seeing multiple healthcare providers in different networks for several health conditions, resulting in extra effort to gather her health data from various specialists. Health IT developers have implemented features such as multiple languages and instructions in plain language written at a 6th-grade level in both digital literacy and health information tutorials. As a result of the new patient portal functionality and the TEFCA, she is able to consolidate her health information across multiple providers and spend less time coordinating her care, which I think is a great example of how maybe AI can help in translation and tutorials with more information. I think that ends our list of stories, so I want to go back and hear from anyone if anyone has any thoughts, concerns, or comments here as well.

Hannah Galvin
Eliel, unfortunately, I have to jump off in a second for another call. Can I just make a comment on the privacy one? Can you bring that back? Since what we are saying is immediate is not actually an accounting of disclosures, but is coming to consensus on sensitive data elements and terminologies around sensitive data elements, I would rethink the illustrative story and have it be something a little more like the patient has sickle cell anemia, but also has Human immunodeficiency virus (HIV), a behavioral health condition, or substance use disorder, and she needs to send information about her sickle cell disease, but does not want to share information about her substance use disorder, behavioral health condition, or whatever we decide, like history of abortion, though that is complicated with sickle cell because usually, they want to treat something else.

We need to talk about tagging the sensitive data element to control sharing and consent around that data element but sharing the other health information because that is what we have said is the immediate versus the long-term in our priorities, and I am happy to help work with you around that, I actually have a use case around that that Shift is using, and I cannot remember if you have sent these out already, and if not, will you send them out again after the meeting? I am happy to work around that, but I wonder what others think about that.

Eliel Oliveira
That is an excellent point, Hannah. Thanks for picking up on that. I agree, if we are not saying that PHI disclosures are not a priority long-term one, maybe we should use a different case. We did send this deck to everyone here, and we would love to get the use case that you guys at Shift are using to take a look at. That could be good content for the group here to consider and add, but overall, I do not know if others have any thoughts. Medell, I see your hand, but I tend to agree with your comments, Hannah.

Hannah Galvin
I am happy to put in a strawman, and then others can comment on it, since we already have one that we are working with, but I am happy to take a look at it.

Medell Briggs-Malonson
Thanks, Eliel. I did not have any comments, but I think Hannah brings up an incredibly important point if we want to have the story ideas focus on all of the immediate aspects, or at least immediate that then flows into long-term, if anything, so I am happy that folks are taking a look at that. Eliel, my comments were actually on the health equity case, and I am happy to also provide some additional input on this, but one of the things that we want to have with the illustrative stories is that they be very aspirational in the future, and I even think that Jim mentioned this during the last one. This scenario is already here and present, and there are a lot of tools that have already been deployed. While it is not consistent or standardized with all health systems, there are a lot of tools that have already been deployed in order to ensure that we are identifying various different dermatologic conditions on skin color, and especially the skin color of patients of color, and making sure that we have those appropriate diagnoses.

And so, if we want to push this and really give a picture of the future, while I think that this is incredibly important to start to standardize across the country, one idea is to really highlight where we want to go, and where I really think we want to go when it comes to artificial intelligence and mitigating bias in our model sand clinical care is for our models to be designed from the very beginning to mitigate and/or eliminate any bias as well as in order to set up new tools and solutions where, as different outcomes are coming out, those outcomes are also being assessed to ensure that we are not having any variance in outcomes between patient populations, geographies, or whatever that may be.

So, I would recommend that we change this health equity story to be even more forward-facing and maybe incorporate the AI and health equity by design topics into one story to talk about a future where, because of the intentional design, transparency, and testing, we now have created new forms of technology that produce equitable outcomes, but then have additional layers of that technology to assess once these tools are deployed that we are not having variations in outcomes between subpopulations, and I think we can do this in a way of using various different conditions or something else to demonstrate this. So, I am happy to work on it, but I would want us to be a little more forward-facing with this health equity story that incorporates both AI and health equity by design.

Eliel Oliveira
Thanks, Medell. If I am hearing you correctly, I totally agree. There is nothing wrong with the story, but there is the fact that we do not have a framework by which these technologies are being developed, validated, approved, and utilized. I think this is pretty much open and out there. Nobody is necessarily putting a check mark and saying, “Yes, this is good, this works and does the job, and the outcomes are validated.” I think that is an important aspect, and Jim has a note here as well about the expenses of some of those tools, and I think that if there is a process for validation/certification of some of these algorithms and tools that are complete and address the real problem and then a few reach the market, then those few can maybe expand to a larger set of implementations, which then reduce the cost of use. Otherwise, we have so many solutions doing the same thing that everybody is asking a

different price point as well. It is hard for providers to decide which one is doing the best out there because nobody has actually ever made that determination.

Medell Briggs-Malonson
Yes, and this is all important, but I am actually going probably five steps ahead of that. I am not talking about an individual model, I am talking about the new standard for how we develop, deploy, and monitor health technology in our country. There is a little bit of a different nuance here that I am trying to relay that is truly probably about three to five years out, if that, but that we have to start working on. And so, there are the current tools used by clinicians. Yes, we have to work on that, but I am talking about how we ensure that we are creating the new standards and frameworks, but also additional systems, to ensure nondiscrimination and nonbias in all of our health technologies. I am happy to write it up. I will work with the team to write a case for that.

Eliel Oliveira
That sounds good.

Steven Eichner
Medell, I see where you are going, and I would love to help you flesh out those pieces a little bit.

Medell Briggs-Malonson
Absolutely. That would be great, Ike.

Eliel Oliveira
Rochelle?

Rochelle Prosser
Under looking at health equity in rural health, we have populations that have no pediatrician for 200 miles or more, and so, that becomes a health equity issue, and I was wondering how we might be able to show a forward-thinking use case where, as long as we are not using language learning models in AI, we could technically use technology to provide healthcare and reduce health equity in the future for the pediatric population and rural health, where we are closing hospitals or clinics that are more proximal to this patient population, as an additional case, if we are able to weave that in.

Eliel Oliveira
At least where we are right now, where we are addressing bias in AI models, I am not saying that what you are raising is not as important, Rochelle, but are you saying that there is a possibility there for a use case's explanation related to AI models for rural populations as well?

Rochelle Prosser
Yes, for pediatric patients, as long as we remove language learning models from the use of the AI tool, because that population does not have the language literacy. So, if we remove the language learning, meaning that AI would learn it on its own, I think we might be able to bring that population in, saying that five years from now, we foresee pediatric populations in rural health providing telehealth or technology advancements in the areas where a pediatrician does not exist within 200 miles or more, since this is now a goal of Paradigm and Advanced Research Projects Agency for Health (ARPA-H), which is one of our partners. I am just trying to tie that in.

Eliel Oliveira
That makes sense. I believe that with all that we talked about in these areas here, we have quite a bit of reframing on this language, so between what Medell was saying in terms of how this feeds into a national process by which

models are created, validated, certified, and used, maybe we should keep that in mind as well, Rochelle, in terms of pediatric rural patients as we are rewriting this.

Rochelle Prosser
Yes, thank you, because we currently have the Broadband Equity, Access, and Deployment (BEAD) Program, where we are bringing broadband to these communities, but there is no healthcare infrastructure available to catch these rural populations. I am just trying to see where we can get the most bang for our buck if we focus on a health equity perspective and really just show it for the true health inequity that it is, and that would be just showing that there is no pediatrician for more than 200 miles in most rural health communities.

Eliel Oliveira
That makes sense. How do we identify and react to those areas intelligently? That might be a way to weave that into the language here.

Rochelle Prosser
Yes, correct. Thank you.

Eliel Oliveira
Great. Steve, I see your hand up.

Steven Eichner
Yes. I shared several other potential stories with Medell on Friday that take a slightly different approach to looking at identifying hypothetical people, so it is really a different approach that is a little more engaging, focusing on some of the same pieces, but from an engagement perspective, the stories that are written here have more bullet points highlighting technological features and are not necessarily told from the patient's perspective or experience. Again, if we are going to be about patient-centered health and put the patient at the center, we might want to think about how to make that happen a little bit more. There are also some problems with the public health example about things being anonymous in case investigation, but that is a matter of cleaning up the stories that are there, and we might get together with Jim and other folks, blend stories, and come up with a better solution.

Medell Briggs-Malonson
Ike, I did absolutely forward your stories directly to Michelle for us to discuss and talk about, so if you want to share some of those stories with us, especially that second one that was focused on public health, which really incorporated a lot of the different things, that is completely up to you. Maybe that is one thing that we can incorporate into alternative stories when we send this out to the workgroup, and the workgroup can also comment on it. That is your choice there.

Steven Eichner
Sure, I am happy to sit down and do that work and am more than happy to see that come out. I put together a couple of stories. One was a mother who relocated from one state to another with two young children. One had some health issues and needed an Individualized Education Program (IEP) update as they were getting into a new school, so we were really looking at the ability to collect historical information in a new space. Another story was looking at a disease investigation dealing with salmonella, because people across a number of fairly decent countywide areas have all gone to several different organizations with intestinal issues, and syndromic surveillance picked up the incidents and public health worked in conjunction with the individuals and healthcare providers to identify the source. Those are the directions we were headed in.

Eliel Oliveira

Thanks, Steve. That is a great point. All these stories should be patient-centered, and maybe Michelle can correct me on a couple of my thoughts here, but one is that the bullet list here is kind of high-level, trying to describe what this story is about, but it is going to be written as a more reader-friendly story itself, and then that aspect of the patient perspective can be added and enhanced. The second one, on which Michelle can help as well, is I think we are running against our timeline here to also make adjustments and compile these to be inserted in the report that we are going to review next time. Those are the two thoughts that I have on how we structure these for review. Michelle, I do not know if you are available and can confirm some of the thoughts that I shared here.

Michelle Murray
Sure. You are correct that, at the high level right now on our team, we have a couple written-out draft ideas, but they are not very developed yet, so we paused on that. Some years, we have gone first and put a fully drafted story out for you to edit, but then, over time, we have learned that it is better that we pause at this stage and get the workgroup's input sooner so we do not have to shift gears at the last minute. We are collecting ideas. Currently, we are right on target for that. Because we have a condensed schedule, we are meeting biweekly. The HITAC meeting is coming really soon, and we need to leave time for review of various ASTP staff as well as all of you, and then, eventually, the HITAC members get it a week ahead of their review on the 17th of October, so we are very crunched for time. By the end of this month, I am trying to collect all the pieces so we can turn around a draft report for you in time for your next meeting. Hopefully that answers your question, Eliel.

Eliel Oliveira
Yes, thank you, Michelle. Ike, I guess we will share that with Michelle, and I think we are going to be waiting for Hannah, and I know she is not on the call as well, but it sounds like she has a story to share. We will probably have a lot of content to cover there to make adjustments. With that said, I know we had public comment coming up, but I wanted to give another few minutes here to see if there are any other comments on these stories. Medell?

Medell Briggs-Malonson
I have no comments on other stories, Eliel, and we will talk about this again, but as we are all recommending revisions to these stories, we all have to make sure we get the stories in so that Michelle and team can take a look at them, try to format them, and then float them back to the workgroup for our comment. And so, we will be making sure to put out a very clear timeline, like a true deadline, for when we need the stories so that we can ensure all of the appropriate work is able to occur in the back end.

Eliel Oliveira
Thanks, Medell. Anna, I see your hand up.

Anna McCollister
Sorry, I was talking on mute. I had to step away for a second, so please forgive me if I missed something, but last year, for these stories, for a number of the issues, we had several bullet points. I remember writing a couple of different bullet points. Is it possible this year to have more than bullet point to illustrate? Some of these issues are complex, though they pretty much all are complex, but I just wanted to ask.

Eliel Oliveira
Sorry, Anna. I think I missed your question, but what I am understanding from the comment that I was asking for Michelle earlier was that the bullet list here is giving a high-level idea of what the story really is, but it is going to be written in a way that is more descriptive. Was that your question?

Anna McCollister

No. Last year, in the stories for each of the issues, in some cases, we had two or three different anecdotes to illustrate the importance of it, rather than just one. Are we going to do that again this year, or are we limiting ourselves to one little anecdote for illustrative stories?

Eliel Oliveira
I think the answer is that we are going to have one story per topic area, but Michelle, I do not know if that is correct.

Michelle Murray
That is speaking to the point that we had a longer process in past years, so, in the schedule, we just went with one option for you that seemed more promising out of a couple that we had dreamed up, so we are open to switching gears on that. Anna is right that there were two for each target area last year, and we chose one early on to go further with. Because of the schedule, we skipped ahead to try to put one out there, but we can switch it out for something else. Eliel is right, there is only space for one story. Especially if we are going to the slide format, there is really just one paragraph that we have space for. You can add more slides if you want, but then the report gets longer. We are aiming for one story for each target area.

Anna McCollister
Thank you.

Eliel Oliveira
You are welcome. Any other comments, questions, or thoughts on these stories?

Medell Briggs-Malonson
Eliel, I have one quick thing. Anna, going back to your point and your comment, especially because you may not have heard the discussion before, ASTP and Michelle have done a great job of putting forth these story ideas, but if we feel like there is an additional story idea or topic that may highlight what we are trying to convey, please offer up that idea, because we are already offering up ideas in health equity, as well as public health and privacy of data, and so, it seems like we did have a few more items to discuss, but if there is something where you say, “Gosh, I do not know if this is really highlighting our aspirational future or what we are trying to convey in the annual report,” we want to hear your thoughts and your voice. We just have to have everyone’s thoughts by a certain deadline that we are going to solidify.

Anna McCollister
Got it. Thank you, Medell.

Eliel Oliveira
Thanks, Anna. Any other comments, thoughts, questions, or concerns? All right, hearing none, like Medell just described, we are hoping to hear from any and all of you with any additional story ideas where we can make adjustments here, and we are going to start working on that timeline and share it back later for the deadline that we will have to be able to incorporate anything else into the report. With that said, I think we are close. I do not think we have a next step here, except to turn it back to Seth for public comment.

Public Comment (01:18:18)

Seth Pazinski
All right, thank you. So, we are going to transition into the public comment part of our agenda. If you would like to make a public comment, you can use the Zoom chat feature by raising your hand, which is located in the Zoom toolbar at the bottom of your screen, to be called upon for public comment. If you are participating via phone only

today, you can press *9 to raise your hand, and then, once called upon, press *6 to mute and unmute your line. While we give folks a few seconds to raise their hand, I just want to note that our next Annual Report Workgroup meeting is scheduled for October 7th from 11:00 a.m. to 12:30 p.m. Eastern Time. I am checking, and I do not see any hands raised in the Zoom chat, and we have no comments on the line, so that concludes our public comment, and I will turn it back to you, Medell and Eliel, for next steps and to close out our meeting.

Next Steps and Adjourn (01:19:23)

Medell Briggs-Malonson
Thank you, Seth, and thank you to the entire workgroup for an amazing meeting. So, we were able to get through a fair amount of content as well as thinking through our stories. Once again, we are going to send out homework, and it is going to be very explicit. I know we all receive a large number of emails, but we are really getting up to crunch time, and this is the time where, if you feel additions or any type of significant revisions need to be made, we want those items in by the date, so we will send that, and then Eliel and I will be sending another reminder. Please submit your information because we do have to make sure we are getting all the reports ready to go because we are on a more abbreviated timeline than we have been in past years. We just love the energy and ideas. Thank you so much, everyone. We really do appreciate you joining us, as always, for all of this important work. Eliel, I will pass the ball to you.

Eliel Oliveira
Yes, and thanks, everybody. Again, this was great. I think we continue to make great progress. We are close to the finish line, but like Medell was saying, watch your email for some deadlines and some final submissions or homework from you. We would love to get those details to be able to make adjustments now that we are at the end. With that said, thank you so much. Enjoy your seven minutes back to your schedule.

Medell Briggs-Malonson
Bye, everyone. See you soon.

Questions and Comments Received Via Zoom Webinar Chat

Jim Jirjis: Jim Jirjis Joined late

Steven Eichner: (How) do we keep pace with other acticities out of ASTP and other actors?

Hannah K. Galvin: I am going to have to jump off for another call, but Eliel, I would be glad to help with the privacy story - I have thoughts on this one. Do you mind sending these (if you haven't already) and I will make comments on this one?

Rochelle Prosser: Happy to help you on case update.

Hannah K. Galvin: I have to drop. I will take a look at this offline thanks!

Jim Jirjis: tools are out there like this skin example, but it comes with significant expense at a time when providers are experiencing financial pressures

Questions and Comments Received Via Email

No comments were received via email.

Resources

AR WG Webpage
AR WG - September 23, 2024, Meeting Webpage

Transcript approved by Seth Pazinski, HITAC DFO, on 10/18/24.