ASTP | Health IT Advisory Committee

Health Information Technology Advisory Committee

Annual Report Workgroup Virtual Meeting

Transcript | October 7, 2024, 11 AM – 12:30 PM ET

Attendance

Members

Medell Briggs-Malonson, UCLA Health, 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
Anna McCollister, Individual
Kikelomo Oshunkentan, Pegasystems
Rochelle Prosser, Orchid Healthcare Solutions

Members Not in Attendance

Sarah DeSilvey, Gravity Project
Jim Jirjis, Centers for Disease Control and Prevention
Eliel Oliveira, Harvard Medical School & Harvard Pilgrim Health Care Institute, Co-Chair

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. 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 (ASTP), and I will be serving as your designated federal officer for today's call. Just as a reminder to the workgroup members, all of our meetings are open to the public, and public feedback is welcome throughout. Members of the public can type in their comments through the Zoom chat feature throughout the meeting and will also have the opportunity to make verbal comments at the end of our agenda today. We will have a designated public comment period. I am going to start off with a rollcall, so, when I call your name, please indicate that you are present. I am going to start with our cochair. Medell Briggs-Malonson?

Medell Briggs-Malonson
Present. Good morning, everyone.

Seth Pazinski
Thank you. I did get a message that Eliel Oliveira would not be able to join us today. Hans Buitendijk?

Hans Buitendijk
Good morning and afternoon.

Seth Pazinski
Good morning, thank you. Hannah Galvin?

Hannah Galvin
Good morning.

Seth Pazinski
Good morning. Jim Jirjis? Anna McCollister? Shila Blend? Sarah DeSilvey? Steve Eichner?

Steven Eichner
Good morning.

Seth Pazinski
Good morning. Hi, Steve. Kikelomo Oshunkentan?

Kikelomo Oshunkentan
Good morning.

Seth Pazinski
Good morning. Rochelle Prosser?

Rochelle Prosser
Good morning.

Seth Pazinski
All right. Thank you, everyone, and now I am going to turn it over to Medell for her opening remarks.

Opening Remarks, Update on Workgroup Plans, & Discussion of Draft Annual Report for FY24

(00:01:46)

Medell Briggs-Malonson
Great. Thank you so much, Seth. I just want to say thank you to the entire Annual Report Workgroup. I really appreciate all of the comments that came directly into ASTP about the illustrative stories, as well as any other revisions, and today, we are going to have a great day actually going over the draft report. This is going to be the time for all of us to provide our input, and also any additional revisions before we meet with the committee as a whole next week in Washington, DC. So, with that, let's go ahead and get started.

In addition to what I just mentioned, we are going to quickly go over the update on our workgroup plans. We are going to discuss the draft Health Information Technology Advisory Committee (HITAC) Annual Report for fiscal year '24, then we will open it up for public comment, and then adjourn. Next slide, Accel. So, this is our overall meeting schedule. You see that we are almost three fourths done with all of our meetings. It is amazing how time goes by so quickly. And so, today, we are really going to focus on reviewing the first draft of the Annual Report, and then, after next week's HITAC meeting, we will come back and also update that draft in order to prepare it for HITAC final review and approval in preparation for the November-December 2024 transmittal process. Next slide.

This is the meeting schedule for the full HITAC committee. The majority of us will be in Washington, DC next week, and some of us will be there virtually, where we are going to present this draft Annual Report to the larger committee in order to receive their feedback, and then, on November 7th, during our HITAC committee meeting, we will review it one last time and also vote for its approval, so this meeting today is incredibly critical in order to gain everyone's perspectives and thoughts about this report. Next slide.

In terms of the development, we as the workgroup are going to complete the illustrative story ideas and discuss the draft report today. As I mentioned, we will present this draft report to HITAC next week when we are all in DC. After any additional edits, the HITAC will vote to approve the report, and it will be transmitted to the national coordinator in November 2024. After that point in time, ASTP is going to forward the final report to the HHS secretary and Congress, and also post it on HealthIT.gov. I am going to drop a little pearl right now. Given all the amazing work that the Annual Report Workgroup has done to prepare this report, the draft of which you will see in a moment, this is also a time for us to use our own channels to advertise this Annual Report, so we will speak more about that later on in the next week or so. Next slide.

For our discussion of the draft HITAC Annual Report, is there a next slide to talk about the division, our new target area? Okay, Accel, let's bring up the HITAC Annual Report draft for us to start to review. We have some incredibly exciting news, and this all came directly from the recommendations and the expertise. The Portable Document Format (PDF) is just fine, whichever one is best to view. Could we make it a little bit larger? Thank you. So, what we are going to do is go over the draft, and you all will see that this is already a preformatted draft of the final report. As was mentioned earlier in some of our initial meetings, one of the things that ASTP has really been focused on, especially with Michelle's guidance and leadership with the rest of the team that works with her, is to make this Annual Report more visual and concise so that it can truly help to inform people of all levels, whether that is inside or outside Congress and the government, and to modernize it to 2024, so you will see some of those changes right now. Next slide.

This is the initial table of contents, and this is the first official page of the Annual Report, which goes over all the various different sections that are going to be included in the Annual Report. So, there is a foreword about HITAC, HITAC target areas, the Cures Act, and the health IT infrastructure landscape, and you may notice that there is a new target area that we are going to discuss in a moment, which is the use of artificial intelligence that improves health and healthcare. Once again, that came directly from all of your feedback and recommendations that, given the emerging landscape of artificial intelligence, we really need to bring it out as its own target area, so you will see

some of those changes in the Annual Report. This thing goes over the next five target areas. Also, it summarizes all of the HITAC progress in fiscal year 2024, and then it concludes with the appendix. Next page.

So, this is a bit of the foreword, which is the introduction to the Annual Report, which gives a high-level overview of all that HITAC has been doing in terms of our activities, as well as our many recommendations. Next slide. This also goes and provides more information about HITAC, and you will see that, again, the layout here is much cleaner, more streamlined, has a lot of various different visuals for those that like to read, but also those that like to look at images, and this gives an overview of our history as HITAC since its initiation, and also from this year. Next slide.

Now, these are the primary HITAC target areas in the Cures Act. And so, the Cures Act initially started with four different target areas. Earlier, maybe last year or the year before, we added the design and use of technologies that advance health equity, and now we are adding the new target area officially to HITAC, which is the use of artificial intelligence that improves health and healthcare. The summary of this target area is applying this emerging health IT by providers, patients, and other interested parties safely, securely, and fairly to achieve better health outcomes. This is because we know that artificial intelligence (AI) is now part of all that we do in health IT, and it is really important that we have a focus on this, so, thank you to all the Annual Report Workgroup members who highlighted and amplified that this really needed to be its own separate target area. ASTP, as well as Micky Tripathi, agreed with that, so that is why we have it as our new target area. You will see the rest of the format as we move on. Congratulations to us on having six target areas. All right, next slide.

So, this just gives a bit of the health IT infrastructure landscape, which goes over some of the different aspects that have been occurring this past year, and also some of the history, once again, of HITAC, and what we are trying to obtain not only in fiscal year ’24, but also going into fiscal year ’25. Next slide.

This is the first area where I will stop to see if there are any questions because after this slide, we are going to get more into each one of the different target areas. Once again, this is a summary of all the various different target areas and topics, and what I feel is really nice about this page is that you have the target areas, and it highlights each one of the topics we are going to go into in terms of the next portion of the crosswalk. For instance, for use of artificial intelligence that improves health and healthcare, we have the use of AI in health and healthcare, provider use of AI in health and healthcare, and impact on patients by the use of AI in health and healthcare, so it really helps to define those areas.

When it comes to design and use of technologies that enhance health equity, implementing health equity by design, use of technologies that support public health, optimizing public health data exchange and infrastructure, interoperability, which is a huge area with many different topics this year, as well as privacy and security, where it says “privacy and security of health data,” lack of disclosure accountability, transparency in use of deidentified data, and patient access to information, patient generated health data (PGHD), as well as reducing patient burden.

I want to pause here to see if there are any thoughts or comments so far because we are then going to get into each one of the target areas, the illustrative stories, as well as the crosswalk and the writeup. Any comments so far on this new design or our new target area?

Rochelle Prosser
I am driving, so I am limited in my ability to raise my hand. I think it is beautiful. It is very well laid out. **[Inaudible] [00:11:34]** so congratulations. I really love it.

Medell Briggs-Malonson

Thank you so much, Rochelle. I appreciate your comments. Yes, I agree. I think the team did an amazing job. Wonderful. There is one other comment that came in from Ike that just shows the progress that we have made as well regarding the infrastructure. It is really nice that we can clearly show how to continue to expand some of our recommendations and some of the areas that we think are also very pertinent to the current and future state of health IT in this country, so thank you all for that.

Anna McCollister
Medell, this is Anna. I do not know if you can see my hand raised.

Medell Briggs-Malonson
Now I can see it. Yes, Anna?

Anna McCollister
I thought I would follow the rules this time.

Medell Briggs-Malonson
I can actually now see everyone's hand. Sorry, I was on a different view, so, thank you. Go ahead.

Anna McCollister
I have one question, and this slide helps, but when you first listed the target areas from the Cures Act, you noted that we had added artificial intelligence. Was that part of the Cures Act, or are we now just adding things? Is it the Cures Act plus things that we think are important? If that is the case, one of the areas that I want to ask that we highlight is reducing patient burden, and I can see in this slide that you have actually added that as a sub-bullet, but as a procedural matter, I am just curious.

Medell Briggs-Malonson
That is a great question, and I will also have Seth chime in. The Cures Act originally had four. It started off with use of technologies that support public health interoperability… Actually, it may have had three, right, Seth? Was it three initially?

Seth Pazinski
Correct. Interoperability, privacy and security, and patient access to information were the original three priority target areas.

Medell Briggs-Malonson
Thank you, Seth. But what occurs is that, in the Cures Act, it states that, as HITAC, in collaboration, of course, with ASTP/ONC, if there are new areas that emerge that we think are critical to this work, they can be recommended. So, as HITAC, over the years, we have added three additional target areas and topics based off of what is going on in our country in terms of thinking about what is best for HITAC to focus on and provide recommendations. Seth, I would love for you to give any other comments about that.

Seth Pazinski
So, in the Cures Act, as you mentioned, Congress laid out three target areas to start with, which were interoperability, privacy and security, and patient access to information, and they allowed for the HITAC, in consultation with ASTP, to identify additional target areas, and so, in past years, HITAC has added the health equity and public health target areas, and this would be the latest addition, ultimately depending on HITAC approving the report at the November HITAC meeting.

Anna McCollister

Thank you. I think that is helpful. The two sub-bullets that you have added to patient access to information are my two really important areas, though not the only ones, so, thank you for that. I really appreciate your calling those out. I really like the graphics, too. Again, when we go, remember that those two topics under patient access to information are already part of our report and our full crosswalk. This is just trying to provide a high-level summary for people reading the report, so it is very important. Ike, I see your hand. I am sorry I missed it initially. I was on a single view versus the gallery view.

Steven Eichner
No worries at all. My question about the progress of infrastructure was more along the lines that we called attention to progress in that location, but we did not identify progress toward what about infrastructure, so that may be something we want to provide a little clarity on. Secondly, the graphics are terribly impressive. I do hope that there is going to be a similar effort in helping improve navigability of information for individuals that cannot see the beautiful graphics and are using screen readers or other technology to help navigate and understand the Annual Report.

Medell Briggs-Malonson
Yes. Let me answer your most recent question, and then we will go back to what you are referring to in terms of infrastructure. Yes, absolutely. This will be transformed to make sure that it meets all the 508 requirements. That has already been discussed because we want to make sure this is a report that is highly inclusive of absolutely everyone and that everyone can take in all of the information. So, that has already been discussed and is in progress, so thank you for bringing that up. And now, Ike, when you were talking about infrastructure, was that on a previous page?

Steven Eichner
Go back up to that first slide on infrastructure, about three slides up. It was mostly text. It was that one. In the left-hand column, it says “assessment of progress.” We did not say what it was progress towards within this system. There should be some kind of goal.

Medell Briggs-Malonson
Absolutely. I clearly see what you are referring to. Are there any thoughts about that? I do not want to put you on the spot.

Steven Eichner
I do not have an immediate answer, but there should be some kind of target.

Medell Briggs-Malonson
Agreed. Maybe all of us, especially after going through the draft report, can circle back to this. This is a really good callout, because what is it progress towards? You are absolutely right. Right now, that is a little too empty. We should say “progress towards greater interoperability which is accessible to all” or whatever it may be.

Steven Eichner
Right, or assessment of the infrastructure. Either way works, but from my perspective, if you are going to say “progress,” you need to say what you are working toward, or you will never know when you are there.

Medell Briggs-Malonson
One hundred percent. We also have a recommendation of progress towards achieving the goals in each one of our target areas, just to wrap that in, so we will work on that. That is a very good callout. Thank you so much for that. Okay, any other comments? I can see everyone’s hands now. All right. Well, if there are no other comments, let’s keep on going through the report. The very next page is an overview of all the federal activities across the

target areas. Now, this is actually a special page which is, once again, in response to our conversation during our last Annual Report Workgroup meeting. One of the discussions we were having was the fact that with some of the recommendations we are providing as the Annual Report Group/HITAC, we know there are other federal activities going on in these various different target areas, so we really wanted to make sure to call that out to say that while we as HITAC are providing these recommendations, we know that this is also a priority in several other areas as well.

So, other agencies are doing this, ASTP is also working on something similar, so we want this work to be complementary. What the team did was create this, which gave a high-level overview of many of the other activities that are going on throughout HHS agencies and beyond that do complement some of our recommendations, so therefore, there is an asterisk when we go into the various different topics in each target areas, and that asterisk, as you can see at the bottom of the left column, says, "The HITAC recognizes that it is important to align its work with significant initiatives already under way at HHS that address certain topics to some degree. These topics are indicated with an asterisk in the following pages." And so, these will also be hyperlinked so that people can actually click directly on any of these federal activities to learn more about them. You will see how this plays out and is formatted in the upcoming pages. Ike, I see your hand.

Steven Eichner
Really quickly, I think it would be good to include, at least in the text block on the left, if not in any of the descriptors for any of the activities, a recognition that federal activities are implemented in conjunction with state, local, territorial, etc. and the private sector, and that they are not operating in a vacuum. It is really a collaborative effort across the board.

Medell Briggs-Malonson
Great addition there, absolutely. It is within the agencies, but there are lots of partnerships under way. Great, thank you for that, Ike. Any other thoughts about this? Okay, let's keep on going. The very first section is use of artificial intelligence that improves health and healthcare. And so, in each one of the various different initial target areas, you will see a list of the key topics that it is going to review, as well as the introduction to that topic. And so, there is a lot in this report. We cannot read it all during this meeting, but I at least want to walk you all through it so you can see the format, but also, if anything comes out at you or you have any comments from doing your prereading, we can also discuss that, and if you have not had a chance to go through this draft report yet, I really urge you to do so ASAP, and we will talk about when the revisions are needed because we do want to incorporate your feedback and thoughts before the report goes to HITAC in a couple of days, so that is one thing that is really critical, and we will speak a little bit more about those steps. Ike, you have a question.

Steven Eichner
In the topics, we have talked about provider use of AI impact on patients. How do we change the language here so that patients are a little more engaged and centered as actors from a driving perspective, not a being-driven perspective?

Medell Briggs-Malonson
I understand what you are saying in terms of the impact on patients, but it is really more about patient use. It is kind of bidirectional because we have patients' use of AI and how they interact with the technology, as well as clinical decision support and other types of technology that are being used in various different clinical settings. So, maybe once we get there, let's think about how we can potentially word that when we get to that section. This is unidirectional, but I also think that our recommendations for this were thinking a little bit more about the safety, ethics, and equitable use of AI in the clinical decision arena, but let's take a look at that.

Steven Eichner

Absolutely. My point is that if we are talking more broadly about being patient-centered and patient-driven and want patients engaged in their healthcare, if we start using language that reflects all the way through with patient engagement as actors and drivers, we talk about things being done for patients rather than things being done to them.

Medell Briggs-Malonson
I agree with you. I fully understand your point in every single way, and that is why I want us to take a look at that section, so that we can make sure to align it with the right framing and wording that may be needed.

Steven Eichner
Thank you.

Medell Briggs-Malonson
Absolutely. Anna?

Anna McCollister
I just wanted to concur with Ike, and thank you, Ike, for raising that. I was not quite sure where to raise it, but yes, there is a whole movement of patients using AI that I am part of, though I am not the leader of it, but a lot of us are using AI, especially Chat generative pre-trained transformer (GPT), to iterate our way through different questions and things that are very difficult to get answered in a traditional healthcare setting. That is outside of the clinical setting, but it certainly interacts with the clinical setting. In addition, in the diabetes community, there is a lot of use of AI, or at least algorithm-based support, as well as the use of the customized large language model (LLM) drawing from specific databases that have validated, peer-reviewed information about diabetes that are being driven and developed by patients, but certainly could be integrated within the clinical setting.

So, I just wanted to say that it is an important point, and thank you, Ike, for raising it. I am never quite sure how this works with ASTP because I feel like the focus of the agency is just what is happening in the clinical setting with providers. Patients in the Type 1 community are hacking our way through the system to do things that are completely outside of the healthcare system, but kind of adjacent to it and integrated in different ways, so I am never quite sure how that fits within the remit of ONC/ASTP.

Medell Briggs-Malonson
Those are all very important points, and remember, this is our report, so this topic has actually been here for several weeks and almost months, so if this is not landing right, let's take a look at it and try to see because this is our report as the Annual Report Group as well as HITAC, and so, while it is done in collaboration, of course, with ASTP, these are topics that we have decided upon, so if we feel that there is something that needs to be modified or changed, this is the last time that we need to do it because this is moving forward. So, let's move to that section so we can see and just remind ourselves a bit about this because I think that this is a very important piece, and I know we have had a lot of different discussions. Can we go to the next page? We are going to go through the next two pages.

First, I want to just pause here as well, and this is just what some of the first illustrative story actually shows. For the ASTP team, I have recommendations to change this picture. It would be nice to have a little bit more of a warmer interdisciplinary-type picture, so I have some thoughts about changing this picture. I want to put that out there right now, just because this seems a little bit sterile, and it almost makes an image that it is only physicians, all the computers, and it does not seem as patient-centered as what we are trying to do as well. But this is the new story that emerged out for the AI, and I do not know you all have seen this, and I am looking at time, but we can go through this. I do want to get to the patient aspects of AI in the rest of the report.

Very quickly, I am not going to read it word for word, but a network of real Federally Qualified Health Centers (FQHC) all use the same electronic health record system. They designed their electronic record system to incorporate best practices to collect and analyze their patients' demographics, medical conditions, and health-related social needs. They also invested in new data dashboards and analytic tools to identify and address inequities in clinical care and healthcare outcomes among their patient groups. The electronic health record (EHR) design allows the FQHCs to enhance their support of individuals and sub-populations most in need of targeted medical or social health. Building on the data infrastructure and patients' insight, the FQHC network can assess AI clinical tools more effectively to discern which solutions are matched best to their patients and clinicians.

In particular, the FQs desire a new AI clinical decision support tool to identify worsening heart failure to enable quick access early intervention and potential referral to the regional cardiac specialty center. They select a tool that is transparent and includes health equity principles in the design, such as incorporating data from historically marginalized populations that are similar to those served by the FQ network. They deploy the tool with staff training to properly assess for and mitigate potential bias. They also implement analytics to monitor for standardized tool use and equitable outcomes across the diverse populations.

The new AI tool FQ network processes demonstrate successful application across all populations. The use of the AI tool leads to improved early heart failure interventions and an increase in specialty referrals, especially among patients of underrepresented ethnic or racial groups, patients with limited English proficiency, and patients living with disabilities. The FQHC network submits its findings and data to the developers, who enhance their model and transparency documentation. So, that was just the first story. That is introducing the aspiration or the potential for AI across various different populations. I just want to see if there are any thoughts about that. Yes, Ike?

Steven Eichner
Can we insert a paragraph or sentence that uses less complex terminology that puts patients in the center? Patients are our focus here, but from the patient engagement/patient impact side of it, is there a way of modifying the text in that space?

Medell Briggs-Malonson
Yes. Are you thinking about it in terms of the readability level?

Steven Eichner
Both from a readability and engagement perspective. From a patient perspective, how does this thing benefit them?

Medell Briggs-Malonson
Absolutely. So, maybe something along the lines of, for instance, "These tools also provide patient education and engagement opportunities."

Steven Eichner
I thoroughly recognize that the benefit of this thing is for the patient. I am not discounting that, but clearly communicating it is important. From the patient's perspective, how does it benefit them? In other words, put in a statement like "By using this tool, doctors will be able to care more efficiently for patients, introduce duplicative testing, etc." Make the patient's life easier.

Medell Briggs-Malonson
Absolutely. That is a great comment. So, yes, I think there may be something in the outcomes of that down here that can actually demonstrate because of the improved interventions. Thank you for that recommendation.

Anna McCollister
Since we are going with the FQHC care setting, one of the things that is happening is those who can afford to spend $20.00 a month for a ChatGPT 4 subscription have access to it, and people who cannot afford that do not have access to it. There are other tools out there, but maybe we can put a future case scenario where the FQHC has an institutional subscription to one of these LLMs that has whatever appropriate restriction in terms of making the data valid or come from valid sources, as opposed to a snake oil salesman or whatever, where the patient would be able to query the LLM ahead of their doctor's appointment and further refine their questions to understand their symptoms and issues and have a better-informed discussion with their physician.

Medell Briggs-Malonson
Absolutely. Those are all great points. I do caution us, though. While we see the future of LLMs and I agree with some of the other comments that have been stated that we still have a large amount of work to do with them, this is aspirational, and in thinking about how we can do so, that is also a great point and potential to add. Thank you so much, Anna. Hans?

Hans Buitendijk
Thank you, Medell. The comment that I have is really related to the references to the EHRs, and I did not catch that earlier. As this is aspirational, it is attempting to identify where we can be. It seems to focus more on how you can do it with the same EHRs across all the institutions, but potentially not when you use different EHRs. There are actually ways to do it either way. There are pros and cons around it, so I am wondering whether there is any opportunity to not lead the reader to the conclusion that the only way you can apply AI and achieve these are by using the same EHR because we have many, many configurations across the board where it is done across diverse EHRs and in a variety of different ways. Obviously, I am doing a little bit of potential markup to say change "same" to "different EHRs" and then adjust the analytics tools that cut across all the EHRs, but that might then imply to some that you can only do it with different EHRs. So, I am trying to figure out how to state that because this is a universal capability, and there are a variety of ways to achieve that.

Medell Briggs-Malonson
That is a really great point because we do want to have that full interoperability that is agnostic to any of the EHRs, and yes, we have that. In the FQ setting and more resource-limited settings, it is a little bit more challenging until they fully get onto some of the various different platforms, but I love the idea of where that is going in the future, so I would love your thoughts about how that can actually be revised in order to demonstrate where we should be, especially when it comes to our FQHCs. Thank you for that, Hans. Anna, I see your hand again, and then we are going to move on to the next, because we have five more target areas to get through.

Anna McCollister
Okay, I will be quick. One other additional thing that could be interesting to add into this, just to meld some of our topic areas together, is the incorporation of patient-generated health data into the EHR and being able to have AI that operates based off of home-based data, home-collected data, and sensor-collected data as well as EHR data and patient-reported outcomes. I have serious concerns about what on earth AI is going to produce based off of EHR data, just because I feel like a lot of those data points are kind of crude or very blunt. At least in the case of diabetes and high blood pressure monitoring, among other things, we have sensor-based/home-based data collection methods that would be far more granular and lend themselves to much better algorithmic data input and output.

Medell Briggs-Malonson
I think your idea is very well taken because especially with conditions such as heart failure, there is a large amount of remote monitoring that can be deployed and patient-generated health data that can be used, so that is a great suggestion. Thank you so much. I know the team is capturing everyone's ideas. All right, we are going to move on

to the next page because I want to make sure we get through this report. So, this is the standard crosswalk that we have had, and you will see also at the very top that we have the immediate opportunities, in which we did categorize the vast majority of these topics into immediate, and we do have a few that are longer-term, which means from the year 2025 on. This is the same information that we have seen over the past several weeks to months. Next page.

Again, I want to make sure that we are clear in this area, provider use of AI and impact on patients. This is also the same information. However, given the comments from both Ike and Anna, thinking about how we can be more patient-centered, that is why I wanted us to take a look at what the gaps were, as well as the key challenges and opportunities that we had discussed. Is there a better framing of that topic name based off of what we as a workgroup worked on for this topic? Once again, we identified that the key gaps were AI data models used for algorithms and predictive analytics may not be representative of diverse populations, nor of high-quality data, raising the risk of harm to patients, so that was the primary key gap that we were addressing, with the key opportunities of assuring 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 only should not be used for a pediatric patient. So, that is what this topic is focused on right now, specifically looking at those AI data models and clinical algorithms that are used for the delivery of clinical care, and so, while we absolutely do not have time to add on more just because we are literally in the final stretch of this report, is there something that we do want to do in terms of rephrasing the topic name so it is a little bit more patient-centered based off of the topics that we have lined out here?

Again, if we do not know for sure yet and we need to have more time to think through this, because I think there may be some other changes to this, what I can say is you all can provide your revisions and recommendations, and the team can work on trying to make sure that the language aligns also with our intentions as much as possible. Ike, I see your hand.

Steven Eichner
I am just brainstorming. “Patient involvement in the use of AI in health and healthcare.” I am trying to come up with a shorthand way of getting to the bidirectional concepts that we are really talking about.

Anna McCollister
“AI that empowers patients for self-care and integration of clinical care.”

Medell Briggs-Malonson
Let’s capture those, but what I do urge everyone to do is read through the key gaps, challenges, opportunities, and recommended HITAC activities, because my only concern that I will mention is that a lot of what we have discussed and moved forward so far, even though the larger HITAC committee, really focuses more on the data models and the clinical algorithms, and something which I think is an opportunity is that we did not emphasize the bidirectionality and patient perspective and voice of the use of AI. So, let’s capture what the two of you said, but I want us to think a little bit more, and I just urge us to take a look at this in its entirety to try to figure out how we stay true to what the Annual Report workgroup already decided upon and the HITAC committee already moved forward, but how we bring in that thread that technology should not just be done to patients. It should be a partnership as well.

Steven Eichner
I do not want to divert us for too long, and I do not remember if this was the Annual Report Workgroup or another place in HITAC, but something that was in the context of interoperability standards was looking at patients being

informed of what AI models were in use and the factors being used in any of those models as they applied to the patient. The patient was in a position to evaluate whether the model was actually applicable to their situation.

Medell Briggs-Malonson
Agreed.

Anna McCollister
That actually came up a lot during the Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing (HTI-1) Final Rule workgroups. That might be what you are thinking of, Ike. Medell, I think you have a fair point. What would be the best way to review this and apply comments?

Medell Briggs-Malonson
Yes. Anna, all of the materials were sent to the entire workgroup, and I definitely highly recommend providing the comments and the revisions specifically for this topic, and I will take a deeper look at it as well. We are only on one of six, so we have to move. I highly recommend we all take a look at this and try to see what additional revisions we can provide.

Anna McCollister
Got it.

Medell Briggs-Malonson
Great. Thank you all so much. All right, Accel, let's move on to the next target area. This next one is design and use of technologies that advance health equity. Now that we took out the AI portion that was really focused on representation in our clinical algorithms and clinical decision support tools and ensuring that we have safety and equitable and ethical uses of AI, this is the remaining topic, which is really focused on ASTP's efforts in terms of health equity by design. And so, we will go on to the next piece. This is the story that was advanced, and this was a combination of some of various different aspects of what many actually recommended, and due to time, I just want to make sure that we get through everything because we only have about 40 minutes left, but I am going to do this illustrative story really quickly so that everyone can think about how our topics go directly into these stories.

So, this is recommended HITAC activities that can advance. It says a regional health network is looking to adopt a new health IT system utilizing informational resources from ASTP. The health network evaluates how to implement health equity principles in the design of the health IT system. Searching the ASTP/ONC certified health IT product list, the network identifies a certified health IT module that supports health equity data standards and the capability to display information in multiple languages. The area the network serves has high rates of pediatric asthma due to environmental factors such as high rates of emissions from factories and older multifamily dwellings, leading to high usage of emergency department services. After implementing the new health IT module, the network is better able to collect social drivers of health information and identify pediatric patients with asthma during routine visits.

For patients who show up at the Emergency Department (ED), clinicians record the asthma diagnosis, treatment, and social determinants of health (SDOH) information using standardized diagnosis codes. Pediatric patients with an ED visit for asthma and relevant social risk codes are added to a list of health network community health workers who conduct outreach to ensure that the patients can access medications, specialists, and air purifiers, and can address social needs like transportation. The network additionally uses demographic data elements and clinical and social risk outcomes data to monitor equitable population performance. Six months after implementing the health IT module, the health network is better able to reduce inequities for its pediatric patients with asthma and monitor their outcomes. Any thoughts on the story? Okay, I am not seeing any hands, so it sounds like we are all in agreement. Yes, Rochelle?

Rochelle Prosser
Can you add one word? Proximity **[inaudible] [00:47:14]** and that is often a driver in asthma **[inaudible]** certain populations that are exposed to environmental toxins in the air. I do not know if we are able to do that. If not, I am fine with it as it is.

Medell Briggs-Malonson
Rochelle, I am sorry, you were breaking up. You said proximity to…?

Rochelle Prosser
Highways or transportation hubs. The emissions from cars are often dragged into air conditioning vents, and that is what drives a lot of the asthma in **[inaudible] [00:47:57]** populations because they are proximal to highways or infrastructure transportation.

Medell Briggs-Malonson
Yes, absolutely. I completely hear you and agree. And so, there already in the story, it says "high rates of emissions from factories," but I think that adding "high rates of emissions from factories and freeways" is key.

Rochelle Prosser
There we go. One word.

Medell Briggs-Malonson
One hundred percent. We know that all these different carbon and toxic emissions from all these fuel-based entities are significant drivers, especially in urban areas, so, thank you for that recommendation. Just so it is not too wordy, maybe we can figure out a way to refine that sentence. Thank you, Rochelle. Any other comments or additions? All right. And so, let's move on to the next, and once again, Michelle, the images are lovely, but maybe we should take a look at some of the images as well. This actually goes back to patient-centeredness. While we have a lot of clinicians inside the images, it may be nice to even just show families or something along those lines, just trying to show our aspirations of trying to get both individuals and families to their highest level of health.

So, here is the topic for implementing health equity by design. This is the standard crosswalk that we had before. Again, previously, we had two, but now we moved that second topic into the new AI target area, so nothing has changed here, and this is really amplifying all of our various different work in terms of supporting ASTP with their mission to really continue to build out health equity by design across the nation in all of our health IT infrastructure, programs, and policies. All right, we will keep on going to the third target area, which is use of technologies that support public health. There is one primary topic, which is optimizing public health data exchange and infrastructure. This is the intro here. Please take a look at this, read it, revise it, and add any additions, but we are going to go on to the illustrative. I sometimes say "ill-LUST-tra-tive" and sometimes "ill-us-TRAY-tive." It is like "to-may-to" and "to-mah-to." But, we will go in here.

The next piece here is the story of what we are trying to push forward in terms of the use of technologies that support public health. I will read this very quickly as well to get everyone's thoughts. Maria and her young children make brunch together using organic ingredients, but they feel unwell the next day, with abdominal pain, vomiting, and diarrhea. Concerned about their symptoms, the family visits a nearby urgent care clinic, which orders laboratory tests. During the care, the Trusted Exchange Framework and Common Agreement (TEFCA) and the North Star architecture enable seamless data exchange across providers, ensuring that each family member's health information is updated in real time. These updates inform their immediate care and contribute to a larger data set that can be used for public health monitoring and future care decisions. Meanwhile, unknown to Maria, 64

people visiting three different hospitals and two urgent care clinics in her town have also complained about abdominal pain and gastrointestinal issues within the past three weeks.

Each hospital and clinic participates in the state syndromic surveillance program, which notifies the state's public health epidemiologist about the large number of similar cases. Laboratory tests gathered from several providers confirm that there are cases of salmonella infection. An outbreak team is established by the state public health authority. The team works with staff from the hospitals and clinics, including those who support their health IT systems, to reach each person and ask them about what and where they had eaten, as well as where they purchased groceries before getting sick.

The team analyzes the data using geographic information systems (GIS) technology and identifies eggs from a local farm stand as a likely source. Inspectors visit the farm stand to collect samples. Tests confirm that salmonella is present at the farm stand and in the chicken coop on the property. Maria is contacted by the outbreak team and informed of their findings. She takes additional steps to implement stricter food safety measures at home. That is our public health story. So, that was a combination, I believe, of several different stories as well. Any comments or thoughts about this story? Thank you, Ike, because we took many of your elements, so I want to make sure we have some of your thoughts on this. Yes, Ike?

Steven Eichner
It looks really good. I have a couple of really minor tweaks, like just changing it from "public health epidemiologist" to something that allows for states that have more than one public health epidemiologist. And then, looking at the follow-on, it might be "public health also provides information about what she can do for better food safety going forward."

Medell Briggs-Malonson
Great, thank you. Thank you so much, and thank you for the idea of this story as well. Great. Any other comments on the public health story? All right, let's keep on going through. So, we are going next to the crosswalk here, and this is the crosswalk of what we have taken a look at. Nothing has been changed at all with this crosswalk with the topic, and this is an immediate opportunity for this upcoming year as well. Let's keep on going to the fourth target area. Now we are getting into interoperability, and this was one of the areas where we had several more topics, which was interesting, because in past Annual Reports, we have had a few less topics, so it just shows that we have ebbs and flows, and while we have some topics that are highly complex in which there may only be one or two topics, then we have other areas, such as interoperability, where they all kind of mingle together to create a much larger recommendation. So, this is showing all seven topics underneath interoperability, including some of the most recent ones of further improving data quality in sharing, supporting data standards in maternal health, and supporting data standards for diverse abilities.

So, let's go to the story so we can show how all of these seven topics were intermingled in the story. So, this is a story of interoperability, and it says an 82-year-old woman falls in her assisted living community and breaks her hip. She is transferred to the hospital for surgery. The hospital recently adopted a certified health IT module that supports bidirectional exchange with other providers, enabling the patient's care team to easily access her health records, lab tests, medications, and care summaries from her primary care provider and the assisted living community. Even though he is over 1,000 miles away, her son is a caregiver for her with permission to access her medical record. After she is discharged from the hospital, the assisted living community's physical therapist starts rehabilitation and implements a care plan with her orthopedist's input.

Due to the improvement of image standards and exchange, the pre- and post-operative radiologic images are available to the physical therapist and her primary care provider. The assisted living community shares timely progress reports with her orthopedist and primary care physician (PCP) through their onsite resident information

system, so the recovery data is available for follow-up appointments. The son can monitor his mother's progress through automated feeds to an app on his phone that informs him that she has been attending all her appointments and offers timely updates about her medical status. The assisted living community system also tracks her nutrition and activity, allowing her son to know that she is active, eating healthy, and being monitored for additional fall risks. All right, any thoughts about the interoperability story? Yes, Ike?

Steven Eichner
Very quickly, can we modify the story so that it is clear that the son has permission to receive information about his mother's health status, and on the previous slide, can we include patient access to data as also being an interoperability challenge, not just the provider environment?

Medell Briggs-Malonson
Yes. Let's take each one at a time. So, in the last sentence of the first paragraph, it says her son is a caregiver for her with permission to access…

Steven Eichner
Okay, I missed yes.

Medell Briggs-Malonson
That is a really good point. We wanted to make sure in terms of consent.

Steven Eichner
It might be good to move that to the first part of that sentence so that other people do not make the same mistake I did.

Medell Briggs-Malonson
Okay, got it. We can rearrange that sentence. Maybe we can put the distance at the very end. "Her son is a caregiver for her with permission; however, he lives 1,000 miles away."

Steven Eichner
Exactly.

Medell Briggs-Malonson
So, that is very clear. Okay, great. And then, in your second comment, you were saying in terms of…

Steven Eichner
If we look at "data exchange amongst healthcare providers, patients, and other groups has been challenging," patient access to data has also been challenging.

Medell Briggs-Malonson
Got it, so we should add "patient" into that area of the intro.

Steven Eichner
Right. It may not be exchange, but it may be access. It cannot be exchange because right now, there really is not much opportunity for patients to contribute data to their EHR. That is a related issue, but I do not want to make it overly complex.

Medell Briggs-Malonson
Thank you, Ike. Yes, Anna?

Anna McCollister
I concur with Ike's perspective, but like in the personal comments I submitted to the HTI-2 thing, we need to be able to have patient-mediated image exchange. If you go to an ophthalmologist and they get imaging done, but you want to get another ophthalmologist to look at it because you are not sure that what you are getting from the first one is the right thing, it is kind of awkward to go to the doctor and say, "Hey, can you make sure this other doctor, your direct competitor down the street, can also see it?" So, I as a patient should be able to directly access… In the HTI-2 stuff, they were proposing link-based, which I think is great, but it is the kind of thing where patients should be a mediator who can access the image, not just the physicians.

Medell Briggs-Malonson
I completely agree with you in every way. As you all remember, we do have a target area for patient access, and so, when we get to that one, let's see if it encompasses to what you all are referring to because I think with the target areas, it has been historically just trying to put things in various different categories. I am not saying that one is not as important as the other, but they all have their place. Once we get to that patient area, let's see if we also feel like we need to come back to the interoperability to add something here to the interoperability section as well. I think historically, the interoperability, whether right or wrong, has been interoperability between, for instance, clinical settings, public health settings, tribal settings, etc., more of the public health and clinical delivery system, while the patient access has also been dovetailing off of that, but fully focused on the patient and trying to reduce that burden. Let's look when we get there, and if we feel like we need to come back to this interoperability and add some items, let's definitely discuss that as well.

Anna McCollister
Okay.

Medell Briggs-Malonson
Great, so we will put a pin in that, but do not forget. All right, let's continue on. We went through the story, so the story looks good, and then, these are all the various different topics, and this is the standard crosswalk that we have all looked at and reviewed numerous times. Let's continue going on to the next page. These are immediate opportunities because we felt that everything in terms of this target area is immediate, which it is. And then, there is a next page for it, and here were some of the longer-term opportunities. That was really with pharmacies because we felt like there needed to be some fundamental blocks laid before we could actually provide that full recommendation for interoperability along with pharmaceutical data. Okay, let's go on to the next target area.

So, this target area is privacy and security. I love how the color is red, by the way, Michelle. So, there are three topics in this target area: Privacy of sensitive health data, lack of disclosure accountability, transparency, and use of deidentified data. This is the intro. Please take a look at the intro. Let's make sure all the introductions really do comprise all of the details and the sentiments that we would like. Your feedback is so incredibly important. Yes, Hans?

Hans Buitendijk
On that topic, I am going to be providing a couple of added suggestions that make a clarified distinction between the discrete sensitive data and the ability to recognize discrete data inside documents, narratives, free texts, data sets, and things like that because it is, at times, unclear when we talk about that that we actually need to address both sets of data and that we need to be able to manage the document that contains sensitive data as easily as recognizing the data itself, as it will be exchanged and shared in both ways. We are not only exchanging documents, but we are also exchanging discrete data, and we need to catch them all and decide, according to the rules, which ones we can share or not. So, there are a couple of edits that I will provide to clarify the distinction and complete the scope.

Medell Briggs-Malonson
Excellent. Thank you so much, Hans. We greatly appreciate those additions to this. Those are really important pieces and points. Great. Any other comments here before we go on to the story? Okay, Accel, let's go on to the next slide. So, this is the story that is supporting privacy and security. A patient with hypertension, bunions, depression, and opioid use disorder is seen by a PCP and psychiatrist at Good Health System and a podiatrist at Neighborhood Health System. He is concerned about his privacy and wishes not to disclose information about his depression or opiate use disorder to his podiatrist. Good Health Systems recently implemented a new patient portal feature that allows the patient to interact with a consent management tool to request restrictions on disclosures under Health Insurance Portability and Accountability Act (HIPAA). The patient logs into the portal and is provided information consent at a 6th-grade reading level regarding the risks and benefits of restricting certain data from being shared among his providers.

After reviewing the information, he decides to request a restriction on the disclosure of his depression and opioid use disorder diagnoses to the podiatrist. Good Health System reviews the request and grants it. The health IT system tags structured and unstructured data according to nationally developed value set authority center terminology standards for different types of sensitive data as defined by federal and state law. Depending on the requesting provider, the tagged data may or may not be shared in accordance with the patient's consent directives. This capability is developed through a public-private partnership between the federal government, healthcare industry, medical providers, and patient advocates to simplify the data segmentation and consent management process. So, that is our story that focuses on privacy and security, and Hannah, thank you so much for all of your great contributions to this story. Any additional thoughts about this story or additions to it? Great. Everyone seems satisfied with the story and the lock picture. Thanks, Michelle.

All right, well then, let's keep on going through. We are in our last target area, and then we can have a little bit more discussion. Here is the crosswalk for privacy of sensitive data, and then, this is the immediate opportunity that we defined. Let's keep on going to the next page. These are the additional two longer-term opportunities of lack of disclosure accountability and transparency in the use of deidentified data. Great, let's go on to the next page.

The last, but definitely not least, topic is patient access to information, where we have two topics, patient-generated health data and reducing patient burden. Once again, here is the introduction. I ask everyone to read through the introduction and make sure that it aligns with what we want to convey regarding this target area and what some of the various different opportunities are as well. We will move directly on into the story aspect. And so, this is a story to support patient access to information, so I will read it as well. A Japanese-speaking woman sees multiple healthcare providers across different networks for several health conditions. Before her primary care doctor implemented new patient portal software, she would spend an inordinate amount of time requesting her records from the various specialists.

As a result of the new patient portal functionality and the TEFCA, she can consolidate her health information from multiple providers across several health networks and platforms into a single dashboard and spend less time coordinating her care. By incorporating health equity into the design of the health IT systems, developers implement features such as support for multiple languages, instructions in plain language written at a 6th-grade reading level, and both digital and health tutorials. Since her doctor has a small population of Japanese-speaking patients, he is now able to update the portal with a module in Japanese. A tutorial built into the EHR allows the patient to learn about the portal and its functionality in her preferred language. The online tutorial also enables her to increase her digital literacy and learn more about her health issues at times that are convenient for her without needing to find childcare or taking time away from her job. Okay, that is the story. Any thoughts? Ike, I see your hand.

Steven Eichner
We talked about patient access to information, but the modules include patient-generated health data. The story does not include anything about passing data in the other direction. I am not interested as a patient in having to use my Personal Preference Program (PPP) portal. I want to use whatever portal I want to use to access my data. Looking at a provider getting a new EHR does not mean that they are receiving data or they are performing as an individual access service provider to get any of my health data from any other providers in the first place. That is another gap that is missing in this space because there are three challenges that we need to address.

Medell Briggs-Malonson
Great, thank you. You were breaking up slightly at the very beginning, and please fill in the gaps, but what I gathered was that 1). This does not include any patient-generated health data, 2). It is discussing using the patient portal, but as a patient, you may not want to use your patient portal, you may want to use your own technology, but everything flows into your own platform that you feel most comfortable with, and I am sorry, Ike, I missed the third one.

Steven Eichner
The third part is that just because a provider has a new EHR does not mean that they are engaged as an individual access service provider in terms of getting any of my health data from any other healthcare provider.

Medell Briggs-Malonson
Got it, yes. And so, even though that patient portal is there, that does not mean they are actively bringing information in. Thank you for that, Ike. We will see if there is some way that the team can take a look at the story and see how to incorporate some of those important elements.

Steven Eichner
I really do think that it is important for patients to have a choice about what technology they want to use to aggregate their data and make it available to whomever they want, and that is often not necessarily easily done if you are using a particular provider's portal. You cannot generally then say, "Oh, I want this other healthcare provider to have all my data in that portal."

Medell Briggs-Malonson
Very good points, and very similar to what Anna was mentioning. Anna, I see your hand, but I am going to go to Hans first, and then we will go to you as well.

Hans Buitendijk
Thank you. I agree and support the intent of Steve's comments. Just as a clarification, Medell, I like the way you phrased it as a patient having a choice of platforms, and to clarify, typically, a provider only has one portal. That may or may not be part of the same EHR. It might be another one or any kind of combination. But the choice is not that the patient can choose their own portal, it is more that they can choose their own apps that they interact with. I think the terminology of "choice of platform" makes it a little bit neutral because I do not think we can set an expectation that a provider is going to have multiple different portals plugged into their environment. It is their portal, but there are other technologies that can be used to share data with the patients in whatever format they want to.

Medell Briggs-Malonson
Yes, I absolutely agree with that as well. I really agree with what you and Ike are mentioning. Anna, I know you are going to bring it home as well.

Anna McCollister
Oh, Medell, you are so kind. I feel like the case study that I submitted got to Ike's points more directly, and I understand that it looks like the team has attempted to meld the original use case with the stuff that I did, which is great. I like the language part too, which I did not include, but the way that I meant to write it, and perhaps I did not articulate this particularly well, was that the patient had a EHR that pulled all of the data from all of the sources into one thing so that she could use it and access it when and where she wanted without having to go into the portals. You can kind of read what the team has got here to maybe mean that, but I do not think it is as clear as it could be, and again, maybe I just did not articulate it particularly well in what I sent through, but what I intended to write would have incorporated all the stuff that Ike had mentioned.

Medell Briggs-Malonson
That is great, Anna, and thank you so much for submitting those various different ideas for the story. I think that exactly what you are saying and what others are saying is that the vision is that patients do not have to rely on these EHR patient portals, but they have their own technology that is able to access and bring in information from across all of their various different providers and patient-generated health data. So, from what the three of you all have mentioned, and also what you submitted, Anna, maybe this story can just be revised a bit more to have that additional step of that autonomy and that full ownership over the data that also allows for PGHD to flow into it as well. Thank you so much, Michelle and team. If we are able to add in some of those different comments, then that should meet all the various different thoughts about patient access to information and the future of patient access to information. Great. Any other thoughts or comments about this one?

Steven Eichner
I will be really fast. It might be useful to talk about building on the foundation of Blue Button and other technologies, not that it is the be-all end-all, but it would indicate that there has been previous work done.

Medell Briggs-Malonson
Great suggestion. Thank you so much, Ike. All right. Well, that was the last story for our six target areas, so let's go directly to the crosswalk.

Anna McCollister
What about the patient-generated health data one?

Medell Briggs-Malonson
This was patient access. So, there is one story for each one of the target areas. So, the topics are right here, where we have reducing patient burden, and I believe we will go to the next slide, where we see patient-generated health data. So, the idea is that we incorporate the PGHD into that story so that it is reflective of the two topics that the report is discussing underneath the target area of patient access to information.

Steven Eichner
With patient-generated data, the category label "patient access to information" really is not reflective of that as a function because we have introduced bidirectional exchange here.

Medell Briggs-Malonson
Yes. So, let me make sure that I fully understand, Ike. Are you asking if patient-generated health data should be underneath patient access to information or underneath a different target area? Is that what you are asking?

Steven Eichner

Yes, or to change the target area. In the context of interoperability, patient-generated health data would seem to be a natural in that space. Under the category of patient access, patient-generated is about providing information a little more than accessing information.

Medell Briggs-Malonson
Right. You bring up a really important point. I know that patient-generated health data has been underneath this target area, patient access to information, for many years. That does not mean that it necessarily is the right location for it to be, but one of the things that I think is really important, just because we are where we are right now, at the final course of this, is to put this in the parking lot for us to re-look at it in the next Annual Report. Your point is very valid. If it is patient-generated health data, patients do not need to have access to it. They already have it. But even if you look here, we have been discussing more interoperability when it comes to incorporating PGHD into all of our other health IT systems. So, I think your point is very, very well taken. I am pausing because I am not quite sure how ASTP wants to handle thinking about moving this topic out of this target area into another one at this stage, but I absolutely do feel that we need to discuss that for our upcoming Annual Report on where the best place is for PGHD. Also, as we know PGHD has been on our list and in the Annual Report for at least three reports, how do we ensure that we are making the right amount of progress in this space as well?

Anna McCollister
I would argue that you can incorporate it into each of the areas in one way or another. You could make the case that patients have access to this information. In this case, the patients have access to it, and the physicians and healthcare systems do not, so I think you could torture it enough to make it work in this category. I think Ike's point is valid, but perhaps PGHD should just be integrated in different ways into the sections on interoperability and public health because temperature data could be super helpful for public health. We saw that some in the pandemic.

Steven Eichner
To a certain extent, we might be able to address some of it by going back to the interoperability tab and saying, "See also patient access to information," as there may be a particularly strong tie between those two groupings, and that might help address a number of issues.

Medell Briggs-Malonson
Yes, thank you. Thank you all for those ideas. It is really important. So, this is really something for us to think about: What we need to do with PGHD and where best it needs to be situated in the Annual Report and in terms of our work as well, because it is very important, as we all know. Excellent.

Anna McCollister
I would definitely like to see it called out more, and if there is not a use case specifically looking at PGHD, then I would like to see that called out a bit more in the patient access to information use case.

Medell Briggs-Malonson
Yes, absolutely, and I think that is a relatively important and straightforward addition to add. Great. All right, this is the last topic underneath patient access to information, and let's keep on going through the report. Seth, please let me know when it is time for public comment. This is the HITAC progress in fiscal year 2024. It goes over all of our different HITAC accomplishments as well as the different subcommittees that engage and also provide recommendations during the year. Next slide.

This is what our accomplishments as the Annual Report Workgroup have been over the past several years and what our overall charge is, which is also just a great reminder of why we are all here as the Annual Report Workgroup, what our products are, where they tend to go, and how they do make an impact. Next slide. This is a

bit of what we did from HTI-2. As you can see, it is just breaking down all the various different accomplishments and the charges, as well as our Interoperability Standards Workgroup, which convened in the early part of this year. Next slide.

And then, the Pharmacy Interoperability and Emerging Therapeutics Taskforce of 2023. This was a little bit of an overlap into 2024, so that is why that is there. Next slide. And then, we have the appendix. Can we just click through these pretty quickly? I think that is where we are, and it has some other items. You can keep on going, Accel, because I know we are at public comment. This last bit is just acknowledgments, and we will do some modifications there. That is the report. So, please provide your comments, and then, Seth, I will turn it on over to you for public comment.

Public Comment (01:22:03)

Seth Pazinski
Thank you so much, Medell. We are going to open up the meeting for public comment. If you are on Zoom and would like to make a comment, please use the hand raise function, which is located in the Zoom toolbar at the bottom of your screen. If you are participating by phone only today, you can press *9 to raise your hand, and once called upon, press *6 to mute and unmute your lines. I have a couple updates while we give folks an opportunity to raise their hands. One is that the final Annual Report Workgroup meeting for the fiscal 2024 cycle is scheduled for October 29th from 12:00 to 1:30 p.m. Eastern Time. I also wanted to highlight for the Annual Report Workgroup members that this was included in the materials that were distributed in today's call, but we are asking if you could provide any written feedback on the draft report to the HITAC email address by close of business on Tuesday, October 8th. With that, I see no comments on the phone at this time, and I see no hands raised, so, Medell, I will send it back to you to close us out.

Next Steps and Adjourn (01:23:19)

Medell Briggs-Malonson
Thank you so much, Seth, and again, thank you to the workgroup for all of your perspectives and insights. I was just informed that if anyone has any additional comments, revisions, or recommendations, the ASTP team needs them by the end of the day tomorrow, which is Tuesday, so, again, if you have any revisions, comments, or additions, please take a look at all of these materials and please do your best to submit them by the end of the day tomorrow, which is Tuesday, October 8th. That will allow the team to incorporate the comments and make the revisions because they have to get all of the materials out to the full HITAC committee before the end of this week. Once again, thank you so much. I really do appreciate all of the thought and revisions, and I look forward to seeing all of you all in Washington, DC next Wednesday and Thursday. Have a great day, everyone.

Hans Buitendijk
Take care. Thank you.

Anna McCollister
Thank you.

Medell Briggs-Malonson
Bye-bye.

Questions and Comments Received Via Zoom Webinar Chat

Anna McCollister: Anna McCollister has joined. My apologies for joining late!

Shila Blend: Shila Blend present

Steven Eichner: My comment on "progress" in infrastructure was that the statement didn't include any goal.

Steven Eichner: The graphical layout is impressive. Will similar effort go into materials that meet 508 requirements to improve navigability for individuals using screen readers and other technologies?

Hannah K. Galvin: I really like the new format - it is much more consumable.

Steven Eichner: And we might include public health as a collaborator or convener to support model development and partner engagement.

Hans Buitendijk: Adding to Steven, that it be FHIR-based APIs, of which CARIN for Blue Button and FHIR US Core based APIs are all examples of.

Questions and Comments Received Via Email

No comments were received via email.

Resources

AR WG Webpage
AR WG - October 7, 2024, Meeting Webpage

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