Annual Report Work Group

Transcript
March 1, 2019
Virtual Meeting

SPEAKERS

Name	Organization	
Aaron Miri (Co-chair)	Imprivata	Co-Chair
Carolyn Petersen (Co-chair)	Individual	Co-Chair
Christina Caraballo	Get Real Health	Annual Report WG Member
Brett Oliver	Baptist Health	Annual Report WG Member
Chesley Richards	Centers for Disease Control and Prevention	Annual Report WG Member

Operator
Thank you. All lines are now bridged.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Good afternoon, everyone, and welcome to the HITCC annual report workgroup meeting for March 1. We will call the meeting to order starting with roll call. Carolyn Petersen?

Carolyn Petersen – Individual – Co-Chair
I'm here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Aaron Miri?

Aaron Miri – Imprivata – Co-Chair
I'm here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Christina Caraballo?

Christina Caraballo – Get Real Health – Annual Report WG Member
Hi, I'm here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Brett Oliver?

Brett Oliver – Baptist Health – Annual Report WG Member
Good afternoon, here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Chesley Richards? Maybe Chesley will join us later. With that, I know we are in the home stretch of our annual report. I know we are eager to get started. And I will turn it over to our co-chairs.

Carolyn Petersen – Individual – Co-Chair
Good afternoon, everyone. Thanks for coming to our latest meeting of the workgroup. It's great to see the progress we've made and to see how close we are to presenting what we hope will be the final draft to the full HITCC and getting approval. So, here is our agenda. Call to order and roll call, some opening remarks, and then, we'll get to look at the updates and feedback we've received from the HITCC members and do some planning for our next meeting. I'll pass the mic to Aaron for his comments.

Aaron Miri – Imprivata – Co-Chair
Yeah, no, I echo that. And I really want to thank this workgroup for this amazing output. And, again, I say this every meeting, but I think the proof is in the pudding. ONC team, you're amazing. And I think the overall meeting that we had with the HITCC the other week shows how much just general agreement there was. And we'll talk more about any feedback today. But overall, for the first go around for an annual report that's due to the Congress, just hats off. And so, I just thank the ONC, and I thank this committee, and I thank the team for the excellent work. Back to you, Carolyn.

Carolyn Petersen – Individual – Co-Chair
Ditto on the thanks to ONC. They've been stellar in helping us get this done. And I think it really shows. So, with that, let's go to the next slide. I think we've all seen this more times than we can remember. But we're just about at the point of completion. Go through the comments today and present this at the HITCC meeting in three weeks, not even three weeks, nineteen days. And then, hopefully, we'll have some break time before we get started on the fiscal year '19 version. Next slide, please. So, just a meeting left where we'll present the final to HITCC. And then, again, HITCC will move on and take that to HHS secretary and Congress. Next slide, please. Today, we want to go through a discussion about the comments and feedback that we received from HITCC members. There was some discussion at the full HITCC meeting last week. We also received quite a bit more via email.

And our intention today is to go through that and make some decisions about how to handle those comments with regard to changes to the report or listing things in an appendix or what we feel is the best way to address these comments. Next slide, please. So, again, here's our annual report structure. I think we're all pretty familiar with this, and we will work through the comments in a similar order. Next slide, please. Executive summary, we've covered this in depth, and we will ensure that what we do in one document is reflected in the other so there is consistency across the two documents. Next slide, please. Landscape analysis, background, some suggestions. So, here is where we start to get to the nitty-gritty. Do you want to work through these, Aaron? I think you handled the interactions.

Aaron Miri – Imprivata – Co-Chair
Yeah, sure. We'll do the same order that we did last time for the HITCC. So, from a background perspective, the suggestion around interoperability was to discuss if the primary problem was a lack of non-use of universal codes, label discreet observations like LOINK. And then, sort of the pace of the experience of the HIE. The suggestion was to add language supporting real-time, machine-readable, free of charge access to health information, including net price information. Our suggestion is to discuss the problem of destination for delivery of electronic health information and some possible solutions there, requiring the collection of destination information from the patient, stimulate availability in use of open source personal health record. This comes back to, and we can talk about these, do you want to talk about it individually, Carolyn? Or should we read them all and then come back?

Carolyn Petersen – Individual – Co-Chair
I think we might as well just talk about them individually and at least still like we're working through the slides and making progress.

Aaron Miri – Imprivata – Co-Chair
Yeah, okay.

Carolyn Petersen – Individual – Co-Chair
For these, we had a number of comments from a couple of the HITCC members that we should address.

Aaron Miri – Imprivata – Co-Chair
Yeah. So, what does this committee feel about our suggestion, the real-time machine-readable, free of charge access to health information? The net price comment that is something that when I look at it, I'm a little confused at that terminology. But maybe Christina or Brett or somebody could help educate me. What do you guys see with that? Does that wording make sense to you?

Brett Oliver – Baptist Health – Annual Report WG Member
This is Brett. I need a little more understanding myself. I don't know. It's not clear to me.

Aaron Miri – Imprivata – Co-Chair
When we look at this, I'm thinking the suggestion for that comment of net price may just be talking about the total charges of what your costs may be. And that's been the whole recent discussion with CMS. I know that's relatively recent. And even the non-enforceable rule of hospitals posting their prices to the

web and making it accessible, I think that's what this comment is referencing. But to the degree of the overall meat of the comment, the real-time machine-readable, free of charge access, it may be overkill. That's all I'm saying. I get the intent, but it may be a little bit of overkill.

Brett Oliver – Baptist Health – Annual Report WG Member
Yeah. And I don't know are we ready for real-time? Is that part of the legislation?

Aaron Miri – Imprivata – Co-Chair
I don't know. Good question.

Carolyn Petersen – Individual – Co-Chair
It seems to me that that's probably aspirational. I'm certainly not the expert on the legislation. Louise Anthony is.

Brett Oliver – Baptist Health – Annual Report WG Member
I just don't remember real time being a phrase that was used. But yeah, it's got a lot of detail that I'm sure I could have missed.

Carolyn Petersen – Individual – Co-Chair
I can't think of anything that recommends any timeframe that was tighter than the 30 days, to be honest.

Aaron Miri – Imprivata – Co-Chair
Yeah. So, we can maybe table that and investigate as we read the bill, which is ginormous. But I don't recall. I honestly don't recall. So, okay, maybe we can table that and just say do these terms appear in 21st Century Cures, and if so, how do we reference them. Or if not, what's the appropriate language to tie back appropriately? Is that kind of our suggestion on this one?

Brett Oliver – Baptist Health – Annual Report WG Member
I think so because there is language in there that talks about free of charge access to health information for patients. I'm assuming that's what they're referencing there. So, maybe it's just kind of an all-encompassing summary of a few things.

Aaron Miri – Imprivata – Co-Chair
Yeah. That's right. When I read this, it feels like rapid fire of several ideas put together. It's a great suggestion; I just want to make sure we're accurate. I don't want to overstate or understate the problem. Okay.

Carolyn Petersen – Individual – Co-Chair
I agree.

Aaron Miri – Imprivata – Co-Chair
All right. So, with that suggestion then, we will table it looking for language in the bill. If the law doesn't support that then, we'll make the relevant language as appropriate within the report. Okay. Then, for the next suggestion here. I'm sorry, was there a comment?

Christina Caraballo – Get Real Health – Annual Report WG Member
I'm sorry, Aaron. This is Christina. And I'm still kind of going through this. And I wanted to see it a little more in context. But I don't think it's necessarily that our recommendations have to support what's in the current proposed rule. I think our recommendations should be focused on what gaps we see in access to patient information and interoperability. So, I just want to make that distinction. I think we should align with what's in the rule and understand it. But if there are areas that we think need to be enhanced, I think we should take note of that as well.

Aaron Miri – Imprivata – Co-Chair
That's a fair comment. That's a fair comment. Absolutely. Okay. So, then, maybe with that lens on, take a second look at this from what's out there already in language and see if there is indeed a gap, then, we highlight that gap, whether it's in this report or maybe next year's report. Okay. For the sake of time though, let's go to the next suggestion here, which is to discuss the problem of destination for delivery of health information to patients with some possible solutions that require any collection of destination from the patient, stimulate availability and use of open source personal health record. What do we think about that? I think what this comment is getting at is patients still can't get their information in a timely way.

So, this is a way of enforcing or measuring our patients receiving that information, including the use of open source PHR, which I don't really know what that looks like or what that really is. What do you all think?

Carolyn Petersen – Individual – Co-Chair
I'm wondering if the PHR comment gets at the notion of data should be delivered in a format that is accessible to patients in some way. Or you wouldn't want it in some sort of proprietary format where it's like okay, fine, we sent you your record but when the person actually can't read it.

Aaron Miri – Imprivata – Co-Chair
That makes sense to me.

Carolyn Petersen – Individual – Co-Chair
I would think, certainly, we want to support the delivery of information in formats that are useful and useable by patients. But I'm a little concerned about stipulating open source personal health records because my sense is that most personal health records have kind of gone out of use because people wound up having to enter their own information a second time, or they weren't compatible with potentially many health records that people access through different providers and provider systems. It seems like it's pushing people to a technology they don't want to use.

Aaron Miri – Imprivata – Co-Chair
Yeah. That's interesting.

Brett Oliver – Baptist Health – Annual Report WG Member
What if you eliminated the word open source? Would that be – and just use of a personal health record? Whether that be using Apple or another third party outside of your normal healthcare provider.

Aaron Miri – Imprivata – Co-Chair
That's a good suggestion, although to be honest, we probably need to look into that and spend some time investigating where the market is going with that. And is the market moving away from that and going more to a distributed model and those sorts of things like Apple Records and those kinds of things? So, it could be something we put on the idea list for the next year's report to investigate PHRs.

Carolyn Petersen – Individual – Co-Chair
How about stimulating availability and use of patient-selected health records? How is that?

Aaron Miri – Imprivata – Co-Chair
But does that get at the meat of what this suggestion was from a HITCC member? I think so.

Carolyn Petersen – Individual – Co-Chair
I think part of the critical issue is that the patient is making the choice about where it should go and how they want to use it. It's not being forced into some standard or some tool that maybe isn't what is appropriate for that person.

Aaron Miri – Imprivata – Co-Chair
Christina, what do you think?

Christina Caraballo – Get Real Health – Annual Report WG Member
On this one, I think that this section is the landscape analysis. So, the first part of this sentence or the first part of this suggestion is really the analysis, which is the problem with the delivery of the information to patients. And I think that the second part is more just proposed solutions from the comments. That's what I would gather. So, I don't think the second part of the second bullet necessarily goes in the landscape analysis.

Aaron Miri – Imprivata – Co-Chair
Okay. So, it's maybe out of place then?

Christina Caraballo – Get Real Health – Annual Report WG Member
Yeah.

Aaron Miri – Imprivata – Co-Chair
Okay. So, then, Carolyn, if I'm understanding the comments from this committee right, and correct me if I'm wrong, then, that second half of this suggestion could go into a different part of the report. But we do need to go and research PHRs in general or change the verbiage, which I'm reluctant to do without understanding more from the member what they were going for with things. So, maybe it's worth taking that second half and tabling it for the next report and doing some investigation. What do you think?

Carolyn Petersen – Individual – Co-Chair
I think that's a fair way of approaching it. I definitely think we need to note the problem of destination. But I'm a bit hesitant, frankly, to even try to investigate this ourselves now and then, put some

recommendation in the draft that goes to HITCC on the 20th or 19th because that's asking them to think about and vote on a whole new issue that we haven't presented in the past.

Aaron Miri – Imprivata – Co-Chair
Agreed.

Carolyn Petersen – Individual – Co-Chair
That's kind of unfair to them, in a sense, especially with all of the NPRM stuff going on now.

Aaron Miri – Imprivata – Co-Chair
Fair point. Okay. Well, then, if this committee is good with that, then, we'll move on to the next slide, which is on the objection.

Michelle
Aaron, it's Michelle. I think we skipped the first bullet on this side, the background.

Aaron Miri – Imprivata – Co-Chair
Oh, did I?

Michelle
Yeah, you mentioned it, but we didn't pause for discussion.

Aaron Miri – Imprivata – Co-Chair
Oh, my bad. I'm sorry. It's been a Friday for me. So, on the very top there under the background area, the suggestion was to discuss if the primary problem is a lack of or non-use of universal codes to label discreet observations, e.g. LOINK. The word primary problem is an interesting concept because there is a disconnect depending on what solution or what data set and what they map back to. And I'll give you an example with things like patient-reported outcomes. A lot of that structure with PROs has not really been readily defined by the industry yet. Some have. Some map to LOINK. Some map to different structures, some don't, depending on the discipline. So, I can appreciate this comment. I don't know if that's the primary problem though when it comes to interoperability. What do you all think?

Carolyn Petersen – Individual – Co-Chair
I think you could say it is a problem. But I agree. I'm not sure if it's the primary problem. I think that's one individual framing it in a way that hasn't really been adapted as the approach by the full HITCC. So, I'm a bit nervous about framing it that way in the report.

Aaron Miri – Imprivata – Co-Chair
Because we do talk about standards in our interoperability section. We do talk about the need for even more defined standards and whatnot, which, of course, we're working on with the USCDI and other items. I don't know if I'm missing something with what this comment was going to that we already haven't addressed in the report. Brett or Christina?

Brett Oliver – Baptist Health – Annual Report WG Member

Yeah, I would list it as a problem, but I agree. It's not the primary problem, or I wouldn't want to list it as the primary problem.

Christina Caraballo – Get Real Health – Annual Report WG Member
I do agree with that. And I think it's very specific. And I don't think we got to that level in the report.

Aaron Miri – Imprivata – Co-Chair
Agreed.

Carolyn Petersen – Individual – Co-Chair
No, we didn't.

Aaron Miri – Imprivata – Co-Chair
Okay. So, I think we have the answer to that suggestion. All right. Next slide. Privacy and security, my favorite section. Patient matching and verification. The suggestion on this one was to discuss the use of the last four digits of social security numbers as a potential matching key and introduction of a Medicare medical records ID. So, I know we referenced the GAO report, and we do reference components of that report within the report already. I don't recall us even throwing out solutions like this already. And I'm reluctant to do that because I know the industry is still absorbing that report and still assessing. And there are a lot of things there that need to be worked through. Is that something that we want to use in this report? Or is that something for next year's report to talk about possible solutions, including this suggestion? What do you all think?

Carolyn Petersen – Individual – Co-Chair
I think I would feel most comfortable putting this on a list of ideas brought forth by members that could be discussed or addressed going forward in the next year. Just like another appendix that says other comments and thoughts that were not addressed in this report include. I know that, in the larger community, there is a significant movement against using social security numbers as identifiers and matchers.

Brett Oliver – Baptist Health – Annual Report WG Member
Yes.

Carolyn Petersen – Individual – Co-Chair
And so, I feel like there would be some people on the committee who would be uncomfortable with us sliding it in at the last minute when we didn't discuss it previously either within or without the context of the report.

Aaron Miri – Imprivata – Co-Chair
Good point.

Brett Oliver – Baptist Health – Annual Report WG Member
It's still such an elephant in the room that there's the national ID number that it will need to be addressed. But I'm not sure we want to get specific like this. And I would agree with Carolyn that social

security numbers are not going to go over well, at least in the community that I'm a part of. We're trying to do everything not to have to deliver those to different vendors, etc.

Aaron Miri – Imprivata – Co-Chair
Agreed, same here at UT. Same thing. Carolyn, what do you think? I'm sorry, not Carolyn, Christina, what do you think?

Christina Caraballo – Get Real Health – Annual Report WG Member
I agree. When I breezed through the slides really quickly before the meeting, I kind of stopped at that one and thought oh, okay. But I think that, for the landscape, the key here is that a patient identifier and if we want to do such as something, we can discuss that and list examples that have been identified as a way to work this in. But I think the main point is that the industry is really calling for a way to identify patients. And I think to put the social security number, I'm not sure if we're ready for that yet.

Aaron Miri – Imprivata – Co-Chair
Yeah. As an example, if you read the latest peer report on this, they even go into just how email address can give you a level of granularity that you didn't have before. So, there may be ways to accomplish this without using social to get the same level of resolution and granularity that this concept – not that this is a bad idea. I think all ideas are good ideas. But it may be something that we need to look at in more aggregate. And, again, I know in our report for this year, we do reference GAO, and I believe we reference the peer report as well. So, this would be a great topic for next year's report to really go into and get meaty about. So, I think that's our go forward plan. Is everybody in agreement with that?

Carolyn Petersen – Individual – Co-Chair
I'm good with it.

Brett Oliver – Baptist Health – Annual Report WG Member
Yes.

Christina Caraballo – Get Real Health – Annual Report WG Member
Sounds good.

Aaron Miri – Imprivata – Co-Chair
Good, all right. Next item on this, around patient access information, Carolyn, do you want to take this one?

Carolyn Petersen – Individual – Co-Chair
Sure. So, emerging platforms for data sharing by patients and caregivers, does the mention of unstructured data need any clarification? A member of HITCC pointed out that unstructured data is only mentioned once in the report and in proper context. So, this isn't a problem currently. But the individual also made the point that more precise language can be applied when talking about unstructured data. So, it sounds largely semantic, but how do we feel about that?

Brett Oliver – Baptist Health – Annual Report WG Member

I think Clem has brought that forward a couple of different times. There's no such thing as a totally unstructured report, just an unstructured payload, I believe, is the terminology he used.

Aaron Miri – Imprivata – Co-Chair
Yeah. And I can appreciate the essence of the comment. When I think of unstructured, I think of non-delineable. So, it's like a PDF document or something that doesn't have the resolution you need to be able to do something with the data and manipulate the actual data specifically. It's just data that's sitting out there with no reference that, again, it's not machine ready. So, I can appreciate the concept. And, again, I have no idea. Is the word unstructured, does that appear in any of 21st Century Cures or any of the recent rules? I don't know. Is that a common word, or do they use a different word?

Brett Oliver – Baptist Health – Annual Report WG Member
That's a good question.

Aaron Miri – Imprivata – Co-Chair
Yeah. I don't know. We may just need to research that so that we're using the right term. Again, I appreciate if it was Clem or whoever said this, I can appreciate the need to be specific about the language we use. So, I get the intent. I don't know what the right word is for that. I think it's meant to be in the spirit of data you can use and manipulate and use data intelligence around it or derive information from versus data that's just sort of I don't call it frivolous but just unusable. I think that's the intent.

Carolyn Petersen – Individual – Co-Chair
Yeah, I think so.

Aaron Miri – Imprivata – Co-Chair
Okay. So, we can research that word to find the right word. This is where we need a good thesaurus. See, there's a business idea. Someone come up with a thesaurus of words from bills or that are assigned as law. Okay. Next slide. Interoperability. Need to improve data quality, provenance, and usefulness. Suggestion, add discussion of clinical and operational workflow challenges faced when combining discreet, codified data with data from other sources. Add discussion of clinical and operational workflow challenges. Okay. I guess I understand the perspective here of the issues. But this is really generic. That's my concern with this.

Carolyn Petersen – Individual – Co-Chair
The specific comment from the member is to just add in a brief discussion of the challenges that clinicians, individuals, and other stakeholders faced when trying to make use of the data they received from various sources. So, like semantic and functional interoperability of electronic data is a barrier currently requiring manual mapping of data elements and other approaches to work around the problem. For interoperable data to be truly useful for stakeholders, more integration of electronic data is needed. It feels like it's something that we all sort of recognize as a problem. I'm not sure it rises to the level of discussion, but I could see adding a sentence or two that's well-crafted that makes these points without detouring into more text that might create a burden for HITCC people to review before approving.

Aaron Miri – Imprivata – Co-Chair

I agree in that I think we should comment towards the workflow challenges. I guess maybe I'm facing this because, obviously, being a healthcare CIO, I see it on the other side of that half the time when combining these data sets and data elements together, there's a workflow component to it that needs to be identified first upstream before you can even get to the point of trying to combine data and looking at output from that. So, I don't want to go down a rabbit's hole of oh, you have this problem because you didn't define this workflow upstream. It could just take us off track. But I appreciate the comment that it is difficult. It is difficult. But there are a lot of dimensions to this.

Carolyn Petersen – Individual – Co-Chair

Is it something that we want to put on the list of potential issues or discussions for fiscal year '19 instead? Is that a better way to deal with it?

Aaron Miri – Imprivata – Co-Chair

It may be just because I think the essence stands. I think it's important to explain this is not easy. It's not like just Legos, you're putting them together. It's a little bit more involved than that. Brett, I'm curious what you think. You deal with this as a practitioner. What do you think?

Brett Oliver – Baptist Health – Annual Report WG Member

Yeah. This one, to me, I'm listening to you guys because, for me, this really hits home if you're talking about med rec or I'm getting lab data outside of my system. It really does change; clog up, however, you want to say it, workflows on a clinical level. Now, my particular EHR vendor is working to sort of normalize some lab values with some of the bigger lab vendors. But it interrupts the clinical workflow because then, I can't necessarily normalize or compare lab data or report on lab data. It's coming from outside of my system. And then, when you talk about medicine reconciliation, I could pull it from two or three different spots. And now, I've got medicine that's triplicated, duplicated on my med list and then, try to figure out – for me, there are some real-world challenges with it.

But like I said, it may be covered through other areas if you're talking about standardizing data sets and being able to work through it that way. But there are clinical and operational workflow challenges for sure.

Aaron Miri – Imprivata – Co-Chair

Right.

Brett Oliver – Baptist Health – Annual Report WG Member

It is an awfully generic statement. I would agree with you all. I think I would like it to be – Carolyn mentioned just a sentence or two that it was well crafted rather than put it in the parking lot.

Aaron Miri – Imprivata – Co-Chair

Okay. Okay. So, maybe we could craft something for this report and then, put it also on the ideas to really dig into if we need to for next year's report. That way, we can really tease out the specifics as appropriate. Does that sound good?

Brett Oliver – Baptist Health – Annual Report WG Member
Yeah, that's right because it is a very general, open-ended statement there.

Aaron Miri – Imprivata – Co-Chair
It is. It is. And, again, I see it from both sides because, again, having put some of this stuff together, like you, it's just interesting. Like case and point, having a common dictionary for what the word outcome means. In any health institution, if you ask two people what the word outcome means, they'll define it differently for you. It's just interesting. Christina, what do you think?

Christina Caraballo – Get Real Health – Annual Report WG Member
Yeah. It was helpful to hear it in context. So, thank you, Carolyn. I think that we talked a lot about workflow challenges, in general, within our HITCC meetings. And I think that if we can provide any text or support on what some of those specific workflow challenges are, I think it would be extremely valuable. So, I think that we should look at this comment within the text of the report and just do kind of a double check and see if we don't need to expand this section. But I agree with the other comments that we should just have a high level, a couple of sentences to address it.

Aaron Miri – Imprivata – Co-Chair
Okay. Sounds good. Next slide. Back to privacy and security. Okay. So, under lack of user awareness and education on privacy and security protection, a suggestion came to us to discuss the federal role of supporting compliance with privacy and security regulations such as HIPAA for current users of HL7, Fyre, APIs. Sometimes, more patient data than necessary is being shared with business associates. We need formal guidance. Discuss the federal role for supporting compliance with privacy and security regulations. I'm a little lost as to is this suggestion related to APIs, in general, being adopted and what's going to happen with downstream applications ingesting that data and how are they governed? This is a little nebulous for me.

And, again, I may be too close to the subject and not seeing this right. Carolyn, how do you read this?

Carolyn Petersen – Individual – Co-Chair
Well, the initial comments from the member, there was an example of business associates receiving lab results, even when that's not necessary. And then, to further open it up, formal guidance should also be provided on compliance with relevant privacy and security regulations such as HIPAA of current uses of Fyre APIs such as in Smart on Fyre applications or CDS services that would be like sending full patient demographic details in all cases, the use of broadly scoped data access tokens. It kind of gets at sending more than people really need and circulating data unnecessarily.

Aaron Miri – Imprivata – Co-Chair
Yeah. So, what's interesting is, again, I was part of the API FACA a couple of years ago. And in that, we actually did a really good job of highlighting what falls under the purview of HIPAA, what doesn't fall under the purview of HIPAA, what falls under different jurisdictions. And OCR did a great job of trying to explain. It is a murky space, so I get the question. And we also referenced the output of that workgroup in our report. So, maybe we could comment to the continued need to keep pushing that information higher and distribute it more. I don't know. What do you all think? Brett or Christina, what do you think?

Brett Oliver – Baptist Health – Annual Report WG Member
Yeah. I just think referencing the previous statement that we had before, I think that more than covers it.

Aaron Miri – Imprivata – Co-Chair
Christina, comments? What do you think?

Christina Caraballo – Get Real Health – Annual Report WG Member
I don't have any comments right now.

Aaron Miri – Imprivata – Co-Chair
Okay. So, Carolyn, do you then agree that maybe we take this, and we just highlight, again, the output from that API workgroup? And I know there was also security task force or tiger team as they used to call it back in the day that was put together for anything around APIs. Because I think with the information blocking rule and a lot of API language there, there will be much more to dig into for next year as that rule is finalized and whatnot.

Carolyn Petersen – Individual – Co-Chair
Yeah, I agree. I think that's fine.

Aaron Miri – Imprivata – Co-Chair
Okay. Perfect.

Carolyn Petersen – Individual – Co-Chair
And that helps us keep a lot of repetitive stuff out of people's faces also.

Aaron Miri – Imprivata – Co-Chair
Great point. That's a great point. Okay. Next slide. Do you want to take this one, Carolyn?

Carolyn Petersen – Individual – Co-Chair
Sure. So, the suggestion in the section on lack of patient and caregiver access to patient data discussed adding terms like real-time, machine-readable, free of charge when discussing the gaps for patient access to health information and including net price information as a type of information to be shared with patients. We talked about this previously in a prior section. And I can add that I remain confused about net price information. And even if it's what you sort of think it is, which is like the final cost to you, the patient, after we've applied your insurance conditions and discounts and whatever, I think in a lot of cases that's just not necessarily knowable right down to the last dollar, even when you have some ballpark ideas.

So, I'm a bit hesitant to expect or to imply that we think that people should be able to get absolutely exacting bills before services are rendered. And one knows what will happen during the clinical engagement.

Aaron Miri – Imprivata – Co-Chair

Got it. So, I just had to pull up a business definition, and there's a reference here that I think is interesting. At the price at which a product or service is sold, after all of the taxes and other costs are added and discounts subtracted, the price might be referred to as sticker price. And after any additional charges are added to it, it becomes the net price. So, to your point, the net price is the final price after everything is said and done. what is the exact amount you're paying, which to your point may be confusing in the healthcare world because of how the price of a Big Mac is pretty much known in the business world as a way to look at economies and how healthy something is? It's not the same way in healthcare when you look at the price of what a hip replacement would be.

So, to the degree of it, it may be difficult to use the word net price. So, I agree with you on that. To me, I would recommend that we follow the same recommendation we did the first time this popped up. What do you all think?

Brett Oliver – Baptist Health – Annual Report WG Member
Yeah, Aaron, I would agree.

Aaron Miri – Imprivata – Co-Chair
Okay. Carolyn, if you're good, then, we'll go to the next slide.

Carolyn Petersen – Individual – Co-Chair
Yeah, I'm good.

Aaron Miri – Imprivata – Co-Chair
All right. Next slide. Interoperability. Address the reality gap between the perception of what has been certified and what is truly interoperable. A suggestion for this was to add another example of a range of codes for lab testing allowed in CCDA documents. What do we think about the suggestion?

Brett Oliver – Baptist Health – Annual Report WG Member
I like addressing the reality gap because I think that does exist. I'm not sure I'm following the suggestion in the example.

Christina Caraballo – Get Real Health – Annual Report WG Member
I think this is a very specific example. And I'd like to see it in context and to see what other examples we have. But this seems, once again, very, very specific.

Aaron Miri – Imprivata – Co-Chair
I guess, yeah, it is very specific. And I'm just trying to figure out does this get back to the intent and the overall nature of what our comment was with the reality gap because we as a group deliberately put that word in there because that's exactly how it feels. But what's allowed in a continuity of care document is just interesting. Carolyn, what do you think?

Carolyn Petersen – Individual – Co-Chair
I'm just pulling up the comment here from the member. Does the workgroup agree this is a good example and should be added to the section? The citation of the problem was from a 2014 survey. So,

there's a question of whether this is still as much of a problem now as it was when that reference came out. The individual also gave a more recent example of CMS removing a measure of compliance with standardization of lab testing. But Lab Corp sent a letter documenting that widespread standardization isn't yet the case. So, it feels really murky, to be honest. Is this may be, therefore, something that we should put on the list of things to look at for 2019?

Aaron Miri – Imprivata – Co-Chair
I think so. And thank you for reading the context. That's helpful to know. Okay. I think we look at this for 2019. Again, I get the intent but to your point, which they need to expand upon this.

Carolyn Petersen – Individual – Co-Chair
It feels like it deserves more of an in-depth research and discussion and really a more thoughtful, detailed, explication of the problem.

Aaron Miri – Imprivata – Co-Chair
Agreed. It is a problem. I can appreciate the comment of it. But there is a lot to this, right. There's a lot that feeds that and why and items that are being addressed also by the USCDI group. I think that will help this problem. But that could be part of the overall solution to this. Okay. Next item here. Recommended HITCC activity. Further measure whether systems are truly interoperable at both content and transport levels after implementation, especially among smaller practices and by patients. So, the suggestion here is to change measure to assess because 1) will there be sufficient data to measure. And 2) would the HITCC measure systems' interoperability or assess interoperability based on function?

Carolyn Petersen – Individual – Co-Chair
I think that's a fair point because for measure, typically, people do interpret that as you're counting something and then, perhaps relating it to other similar items or time periods. Or there's some sort of reference to some other standard or baseline. And assess, I think, is a little bit more leeway, particularly if something has progressed to a point where you can assess them qualitatively but not necessarily quantitatively.

Aaron Miri – Imprivata – Co-Chair
So, remember when we talked about this several months back when we first talked about measurement and whatnot and about the need to be as precise as possible because we didn't want to get into under whose judgment are you basing that this is good or bad? We wanted something with some sort of metric base, scorecard base, that sort of thing. I just worry that if we use the word assess, it may be too nebulous to really hone in on. Is that fair, or do you think I'm just overthinking it?

Carolyn Petersen – Individual – Co-Chair
No, I think that's a good point. Maybe there's an in-between word. Evaluate isn't stronger than assess. Maybe it's a bit stronger. Compare to baseline or –

Christina Caraballo – Get Real Health – Annual Report WG Member
Can we do just further assess and measure when possible?

Aaron Miri – Imprivata – Co-Chair

We could. But if HITCC does look at systems and says hey, is this really working or not, or is this snake oil, if we're not pointing to something specific that we're like the minimum floor is X, or you either hit X or you didn't, that's one thing. But if we say collectively, what this is doing is just not going to cut the mustard; there could be a lot of room in the community to say no. So, we could say we're able to measure, like you're saying, Christina. Or we could say evaluate and over next year's report, we can actually define what the criteria are.

Carolyn Petersen – Individual – Co-Chair

Yeah. I was just about to say maybe what we want to say is evaluate now and where measurements are currently possible, establish measures during fiscal year '19 so that measurement can occur in future years.

Aaron Miri – Imprivata – Co-Chair
That's fair.

Christina Caraballo – Get Real Health – Annual Report WG Member
I think that sounds good.

Carolyn Petersen – Individual – Co-Chair
Because it forces you to start addressing what is very vague right now.

Aaron Miri – Imprivata – Co-Chair
That's fair. That's very fair. Okay. Brett, are you good with that?

Brett Oliver – Baptist Health – Annual Report WG Member
Yes, sir.

Aaron Miri – Imprivata – Co-Chair
Okay. Perfect. Next item on here, other opportunities for further consideration. Again, this is a whole established metrics. Suggestion. Should the statement say metrics or best practices? Establish usability metrics for health information exchange. Should the statement say metrics or best practices? Again, this goes back to our point of wanting to actually measure health information exchange. And, again, trying to be specific. To me, it's metrics. But maybe it's a different word than metrics. What do you all think?

Carolyn Petersen – Individual – Co-Chair
I guess I kind of feel like we've had best practices forever. And either they haven't been implemented, or they aren't truly best practices or something because, clearly, issues still exist. So, I'm kind of more in the metrics camp, I think. Because with best practices, there's just not an impetus to meet a particular bar. It's kind of like well, you tried or you should try.

Christina Caraballo – Get Real Health – Annual Report WG Member
I agree with that statement.

Aaron Miri – Imprivata – Co-Chair

Yeah. Here's a well you tried cake. No. It's got to be something specific. Okay. I'll give a specific example here. I'm aware of major metropolitan cities where you have hospitals that refuse to share commercial pay information with each other. They'll share indigent care information with each other, but they refuse to share commercial information with each other for no other reason than they don't want to. So, to me, I would love to measure and say guess what, this metropolitan area is refusing to do this. Why? And let the question then be asked. And this is behavior that goes on across the country all of the time. People refuse to share. So, even when I mention information blocking rules are going to forbid some of this behavior, people just shrug and say deal with it. So, it's just interesting.

Carolyn Petersen – Individual – Co-Chair
Yeah. We're not wanting to award any medals for trying.

Aaron Miri – Imprivata – Co-Chair
Right.

Carolyn Petersen – Individual – Co-Chair
We're past that.

Aaron Miri – Imprivata – Co-Chair
Agreed. Brett, do you have any feelings about this? I'm sure you do.

Brett Oliver – Baptist Health – Annual Report WG Member
I would 100% agree with metrics. Yeah. Best practices don't move the needle in my world.

Aaron Miri – Imprivata – Co-Chair
Yeah. Okay. So, we have metrics then.

Brett Oliver – Baptist Health – Annual Report WG Member
Do you really get that attitude, Aaron?

Aaron Miri – Imprivata – Co-Chair
Oh, absolutely. Absolutely. I've got it now in two major metropolitan areas. And I have literally strongly resented those comments from folks. And they literally will not share commercial data, unless it's for treatment purposes. But they won't generally share via an HIE or anything. That's it. That's just the purpose of it. And it's very difficult. And that's common. And it's sad.

Brett Oliver – Baptist Health – Annual Report WG Member
I'm not surprised by the commonality. I'm surprised with the attitude that you've been faced with regarding it. So, now, I think I understand the new rules and fines a little bit better.

Aaron Miri – Imprivata – Co-Chair
Exactly. Exactly. I'm happy to share some war stories behind the scenes so you can hear the details of it because I'm sure you'll be as appalled as I was. Again, not for treatment purposes but just generally speaking, even for syndromic surveillance or whatnot. Having more data is better. And people refuse,

unless it's the indigent care, then, sure. You can have all of the indigent data you want. But when it comes to commercial, no, for the fear of you may take our paying patients. It's crazy. Okay. Before I go on a soapbox about that, next slide. Privacy and security. Recommended HITCC activity, consider federal and setting guidelines for the exchange of data. Yes. So, suggestion. Change the word consider to describe a more narrow activity. Okay. Is that really stating that they don't want us to like what we said before with the HIE, more or less be more definitive? What do you all think with the word consider?

Brett Oliver – Baptist Health – Annual Report WG Member
Was there anything more to that comment, Carolyn? Because it seems like if you're going to say you need to change a word, you'd give an idea of what you want it changed to.

Carolyn Petersen – Individual – Co-Chair
Yeah. At the 2/20 HITCC meeting, this individual said that the activity seems too broad as written. It affects two recommendations. And this is where I had said there are certain kinds of specific language that are used in legislation and also in the way that we have to respond. And "consider" is a way to cover a broad range of activities without, as a workgroup, trying to say HITCC needs to do this or that. The thought that comes to me is if we get more specific, are we then saying that we think HITCC should be, for example, advocating that OCR does such and such or FDA does such and such. As an advisory committee, there's a limit to what we can be pushing other agencies to do. And I'm not sure that you'd get a good agreement because the people on the HITCC represent such a wide range of stakeholders. I think you'd get a lot of pushback on different things no matter what you tried to present.

Aaron Miri – Imprivata – Co-Chair
Is there a different word than consider that means consider though? And so, maybe it looks like we're taking a stronger sense. So, I'm trying to play devil's advocate here. Could it be perhaps recommended options for the federal role or something to that effect?

Carolyn Petersen – Individual – Co-Chair
Review federal role, review and recommend?

Aaron Miri – Imprivata – Co-Chair
Review and recommend, yeah. I like that. That's a little bit more definitive. It's a little more narrow to the comment here.

Carolyn Petersen – Individual – Co-Chair
Yeah. Without saying that we think that we have –

Aaron Miri – Imprivata – Co-Chair
The right to, right.

Carolyn Petersen – Individual – Co-Chair
The right to be telling federal agencies what to do.

Aaron Miri – Imprivata – Co-Chair

Exactly. Or in this case, telling states what to do, right? We don't want to say thou shall. That's the last thing we want to get in the middle of.

Carolyn Petersen – Individual – Co-Chair
I agree. I want to hear from Brett and Christina before we make a decision about that.

Brett Oliver – Baptist Health – Annual Report WG Member
Go ahead, Christina.

Christina Caraballo – Get Real Health – Annual Report WG Member
I like the review and recommend. I think that sounds great.

Brett Oliver – Baptist Health – Annual Report WG Member
I do as well.

Aaron Miri – Imprivata – Co-Chair
Okay. That's settled. Next suggestion, discuss whether this recommendation covers any data collected by the states within the all-payer claims databases that currently are being sold by the states to third parties to maintain sustainability but goes beyond supporting research or public health. I really don't even know much –

Christina Caraballo – Get Real Health – Annual Report WG Member
Item for review.

Aaron Miri – Imprivata – Co-Chair
Pardon?

Carolyn Petersen – Individual – Co-Chair
Go ahead, Christina.

Christina Caraballo – Get Real Health – Annual Report WG Member
Oh, no, I was just going to say this seems specific as one of the items for review. And I think that this recommendation was generally broad, purposefully broad.

Carolyn Petersen – Individual – Co-Chair
The comment that goes with that is if mentioned in the report, this detailed point might better fit in the gap analysis in the section titled Variability of Information Sharing Policies Across States. When I think about it, I think it is a good fit in the gap analysis.

Christina Caraballo – Get Real Health – Annual Report WG Member
I agree.

Aaron Miri – Imprivata – Co-Chair
I would agree, but I'm going to caution that there are a few comments in here that I just don't know the supporting documentation. Example, are all of the states – because the way I read this is that all of the

states are selling data to third parties to maintain sustainability. Is that a true statement, yes or no? I don't know. And then, does that really go beyond supporting research or public health initiatives? I don't know. I also feel sort of like I'm lacking some knowledge on this from a state level and saying states just generally like that, all 50 states are doing this. Really? I don't know. So, I just worry about putting that in a report without the facts to back it up. And do we have the timeline to go research this to state that?

Carolyn Petersen – Individual – Co-Chair
Can we put it on the list of things we can investigate? Would that be more comfortable?

Aaron Miri – Imprivata – Co-Chair
Yeah. I think it's a fair comment. I don't want to lose sight of it. I don't feel comfortable myself saying that yeah, I agree with that. I don't know.

Carolyn Petersen – Individual – Co-Chair
That's a fair point. I don't know either, at least as specific as that gets like with all-payer claims databases. That's a good point. It's one of those things that feels like it's probably true on the surface of it, but you're right. We should be sure that we actually have evidence to support that before we include it.

Aaron Miri – Imprivata – Co-Chair
Is everybody in agreement with that, or is there some opposition?

Brett Oliver – Baptist Health – Annual Report WG Member
No, I'm in agreement.

Christina Caraballo – Get Real Health – Annual Report WG Member
Sounds good.

Aaron Miri – Imprivata – Co-Chair
Okay. Next item on here, consider the impact of the nationwide adoption of cybersecurity frameworks and delineate cybersecurity accountability for data by role. The suggestion was to change the word consider to describe a more narrow activity. I love this suggestion. I really do. Personally, I'm so passionate about frameworks and minimum floors and whatnot. But I think I have to go back to what we said for the first one on here. Review and propose or whatever. Something a little more narrow than considering beyond the mandate. Not as strong as a mandate but review and recommend or something like that.

Carolyn Petersen – Individual – Co-Chair
I'm comfortable with that if everyone else is.

Brett Oliver – Baptist Health – Annual Report WG Member
Yes.

Aaron Miri – Imprivata – Co-Chair
Christina, are you good with that?

Christina Caraballo – Get Real Health – Annual Report WG Member
I was just reading it over again. I'm reading the sentence do we want to do a review and provide guidance on the impact of.

Aaron Miri – Imprivata – Co-Chair
Yeah, right. Review and recommend or review and provide. Yeah, absolutely. I can appreciate their wanting there to be a more definitive stance.

Christina Caraballo – Get Real Health – Annual Report WG Member
Recommend is fine.

Aaron Miri – Imprivata – Co-Chair
Yeah.

Christina Caraballo – Get Real Health – Annual Report WG Member
I was thinking out loud when you called on me.

Aaron Miri – Imprivata – Co-Chair
I know. It's how I run meetings. Okay. Next slide. All right. Carolyn?

Carolyn Petersen – Individual – Co-Chair
Cool. So, recommended HITCC activity, measure impact of monetization of data exchange. The suggestion is to change "measure" to "assess" because will there be sufficient data to measure this. I guess, just thinking off the top of my head, I would kind of like the approach we mentioned from the other one about measure and assess in the sense of measure what we can and kind of look at identifying or developing some measurements for the future where we can't measure today.

Christina Caraballo – Get Real Health – Annual Report WG Member
I think that sounds good.

Aaron Miri – Imprivata – Co-Chair
Yeah. I agree with you.

Carolyn Petersen – Individual – Co-Chair
Any thoughts, Brett?

Brett Oliver – Baptist Health – Annual Report WG Member
No, I agree with you.

Carolyn Petersen – Individual – Co-Chair
Okay. And then, a similar point with regard to the recommended activity, measure amount, length of time, a portal has been online working properly. Patient engagement and/or patient understanding and use of data. Again, measure to assess. And I think I'm still comfortable with the same thought that we're going to use for the other two instances and measure to assess.

Brett Oliver – Baptist Health – Annual Report WG Member
Yeah, that makes sense.

Aaron Miri – Imprivata – Co-Chair
Agreed.

Christina Caraballo – Get Real Health – Annual Report WG Member
Agreed.

Carolyn Petersen – Individual – Co-Chair
Okay. Let's go to the next slide. So, this is the part where we talk about the presentation of the revised amended draft and how Aaron and I will offer it to the committee and approach getting approval. Ideally, we would get a vote at this March meeting and get it approved so that we can hand it off to the national coordinator. And ONC can go about the final tidying and neatening of the documents and then, take that to HHS and Congress. What are we thinking in terms of sort of the way we approach this? It occurs to me that it might be helpful what will go out to the members, I believe, will be probably two drafts of the annual report. One that has tracked changes so that people can easily see what we've changed and another with all of those tracked changes accepted so you can read it more easily and see the text.

Sometimes, when you have done a lot of work in tracked changes, it's hard to follow the flow of sentences because you get so much mark up in it. So, I think that's fair. In terms of addressing all of the changes that we have created, I'm wondering if it might be useful to have some slides with a three column chart. The first column being who presented the comments, the middle column is a basic summary or a brief gist of what the comment was like change measure to asses, and then, the third column being the action that we've taken where Aaron and I could talk through the things that we've talked through today and just, basically, say we made the change because X. We took this issue and decided that it's something that really needs a greater investigation and some research and discussion at the HITCC level.

So, we've put it on your possible to do list for the fiscal year 2019. In that sense, kind of showing people that we've actually taken their feedback to heart and worked through all of it. And also, not kind of burdening them with the number of comments we got that related to typos and things that aren't issues but are a discussion. But just housekeeping for the paper itself. How do you all feel about that?

Aaron Miri – Imprivata – Co-Chair
I think that makes sense to me.

Brett Oliver – Baptist Health – Annual Report WG Member
Yeah, it sounds great, Carolyn.

Carolyn Petersen – Individual – Co-Chair
I feel like if we're really transparent and try to show people how we've worked to address their concerns that we are then in the strongest position to say it's genuinely a full HITCC product. And we go forward with it as a full HITCC item that we've delivered and moved on to other business. And in showing people

the final draft, they can see the changes. It's all very transparent. They don't have to worry about us having slipped something in that they're not aware of that might later come back to haunt or come up in future work in ways they didn't expect.

Aaron Miri – Imprivata – Co-Chair
Right. And I guess also, it sets precedent. So, future report groups and report outs will follow the same type of format, which I am all about transparency and making sure everybody feels heard. We've had some great feedback and dialogue with HITCC members. So, I think it's a great idea, Carolyn.

Carolyn Petersen – Individual – Co-Chair
Cool. Yeah. And this way, people can see that their feedback was valued and the time that they spent reading the document actually meant something and was taken and used.

Aaron Miri – Imprivata – Co-Chair
Cool.

Carolyn Petersen – Individual – Co-Chair
Are there other thoughts about things that you all think would be helpful or presentation issues or situations that you would like to see reflected in what we bring forward to the full HITCC?

Christina Caraballo – Get Real Health – Annual Report WG Member
I think this sounds great. We've shown the draft, and I really liked the supporting materials with the one-page snapshot. I don't have any other suggestions.

Aaron Miri – Imprivata – Co-Chair
And Christina, because you've been such a huge stalwart on this and a really big help, did the flow of the report, as it's now finally put together, make sense?

Christina Caraballo – Get Real Health – Annual Report WG Member
Yeah, I think so. And this last round, I was kind of waiting to see what the rest of the committee input was. And now, once we get it all in, I'm looking forward to taking another read through. But I think it's looking great.

Aaron Miri – Imprivata – Co-Chair
Awesome. I agree. Okay.

Carolyn Petersen – Individual – Co-Chair
Well, what's next? Let's look at the next slide.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
I think that brings us to public comment. Yes. So, I know we're a little bit ahead of schedule. But before we open it up for public comment, are there any other discussion items that we should touch on before public comment?

Carolyn Petersen – Individual – Co-Chair
Maybe we should talk about when we want to get started with the next report for 2019. I know we've made this kind of passing a reference to it several times about spring. But today is March 1, and the equinox is coming up in 19 days. Maybe we should at least define for ourselves the break that we want to take so we kind of know what hopefully our headspace is before we get going on the next one.

Aaron Miri – Imprivata – Co-Chair
When is the April HITCC?

Carolyn Petersen – Individual – Co-Chair
April 10.

Aaron Miri – Imprivata – Co-Chair
April 10, all right. So, we have between the middle of March and April 10. Do we want to start right about the time of the next HITCC assuming that this HITCC adopts and accepts the report as is for FY '18?

Brett Oliver – Baptist Health – Annual Report WG Member
I would suggest that as soon as we're done with this new task force, these 60 days, because most of us I would assume are going to be on those, and it's going to require a lot of work.

Carolyn Petersen – Individual – Co-Chair
You're a mind reader, Brett.

Christina Caraballo – Get Real Health – Annual Report WG Member
Yeah, that was my understanding.

Aaron Miri – Imprivata – Co-Chair
That's a fair point. That is a fair point.

Carolyn Petersen – Individual – Co-Chair
That would get us out to like mid-May, which actually I think is a good break for us just head wise and feeling like we've had a break from all of this.

Aaron Miri – Imprivata – Co-Chair
At the end of the 60 days, I'm sure there will be a HITCC to discuss the feedback of 60 days and what's being finalized, right? So, the timing will be good going into a new report because we'll have that feedback to take into the next report and to sort of firm up our thoughts.

Christina Caraballo – Get Real Health – Annual Report WG Member
That's an excellent point, Aaron.

Aaron Miri – Imprivata – Co-Chair
Okay. So, we are then penciling in May-ish for mid-May or so, give or take. Okay.

Carolyn Petersen – Individual – Co-Chair

Yeah. And depending on how many meetings and how intense things get as HITCC wraps up the NPRM stuff, maybe that even slides into after Memorial Day. Technically, the 60 days would be up something like May 4 or 5. But if there's anything –

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
It's actually midnight on May 3.

Carolyn Petersen – Individual – Co-Chair
Okay.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Yeah. And then, we have our next full HITCC meeting on May 13.

Carolyn Petersen – Individual – Co-Chair
Okay. So, depending on if there's any activity that we still need to wrap up after the 13th, maybe we look at I'd say the first week of June or at least after Memorial Day. So, we get through the holiday.

Aaron Miri – Imprivata – Co-Chair
Yeah. That's a great thought. All right. So, we'll do post Memorial Day. We'll reconvene to the start of the next chapter. I love it.

Carolyn Petersen – Individual – Co-Chair
Okay. That should be good. And then, we'll be fresh, too.

Aaron Miri – Imprivata – Co-Chair
Okay.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Anything else, especially in preparation for the March 19 meeting? Are we good there?

Aaron Miri – Imprivata – Co-Chair
I think I feel good for it. I don't know. Carolyn, what do you think?

Carolyn Petersen – Individual – Co-Chair
I think so. Will we be presenting on the 19th or the 20th? Do we know yet?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
It will be the 19th.

Carolyn Petersen – Individual – Co-Chair
Okay. So, will everybody be there for both of those days?

Aaron Miri – Imprivata – Co-Chair
Oh, yeah.

Brett Oliver – Baptist Health – Annual Report WG Member
I will.

Christina Caraballo – Get Real Health – Annual Report WG Member
Yes, I'll be there.

Carolyn Petersen – Individual – Co-Chair
Okay. So, if we get some sort of asteroid request or comment from outer space, potentially, we could huddle for half an hour at the end of the meeting on the 19th. And if it's something that we can immediately address, perhaps we could return it to the HITCC the next day. Maybe we can find a way to carve out a few minutes, Lauren, and see if we can present that and get agreement and get approval.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Sure.

Carolyn Petersen – Individual – Co-Chair
Obviously, if it's a massive issue then, we shouldn't be thinking that way. But if it's a small shift, maybe we can still find a way to resolve the business on the 20th.

Aaron Miri – Imprivata – Co-Chair
Yeah, if we need it. That's a good thought.

Carolyn Petersen – Individual – Co-Chair
Looking at this and thinking about the comments, it's hard for me to envision that happening. I don't even know what that would be. But you never know.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Yeah. Michelle and I were just discussing that very same point earlier. If it gets to that point, maybe we could just spend the first part of the meeting on the 20th resolving any outstanding issues. But, of course, we'll just kind of play it by ear.

Carolyn Petersen – Individual – Co-Chair
Okay.

Aaron Miri – Imprivata – Co-Chair
Sounds good, exciting. Love it.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Okay. Why don't we just break for public comment now, since it sounds like we are kind of wrapping up? Operator, can you open the line for public comments?

Operator
If you would like to make a public comment, please press star 1 on your telephone keypad. A confirmation tone will indicate your line is in the cue. You may press star 2 if you would like to remove your comment from the cue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay. I know we have a relatively light audience today. But, operator, do we have anyone in the cue?

Operator
There is no one in the cue at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay. Well, I'll hand it back to Aaron and Carolyn for any outstanding items or last-minute remarks.

Carolyn Petersen – Individual – Co-Chair
I just want to thank everyone for hanging in there and attending all of these meetings and working with us on the first ever annual report. I think we have a really great work product to bring forward. And I'm proud to have worked with you all and am really looking for some good resolution.

Aaron Miri – Imprivata – Co-Chair
And I absolutely agree with that. And I think it's a fantastic precedence making. And I'm really proud of what this committee is going to be able to turn around to Dr. Rucker and to the secretary and beyond. I think it really meets the letter of the spirit of what 21st Century Cures is all about. And it's just a really great moment. So, thank you all.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
And thanks for your leadership in this workgroup. So, we're looking forward to later this month when we present the final draft. Michelle, anything else?

Michelle
No, we covered everything I need. Thank you.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay, great. Well, we will adjourn here a few minutes early and have a great weekend, everyone.

>> [Event Concluded]