The Office of the National Coordinator for Health Information Technology

Transcript

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

July 22, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Co-Chair
Carolyn Petersen	Individual	Co-Chair
Christina Caraballo	Audacious Inquiry	Member
Brett Oliver	Baptist Health	Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Michelle Murray	Office of the National Coordinator	Staff Lead
Cassandra Hadley	Office of the National Coordinator	HITAC Back Up/ Support

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

Operator
Thank you. All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Happy Wednesday to you, and welcome to the HITAC annual report workgroup meeting. We have our small but mighty team of Carolyn Petersen and Aaron Miri, our cochairs, and Christina Caraballo and Brett Oliver, and with that, I'm going to turn it over to our cochairs to get us started.

Opening Remarks and Meeting Schedules (00:00:27)

Carolyn Petersen
Hey, everyone. Good afternoon, and thanks again for making some time in your busy day for our workgroup and make some more progress on the next version of the annual report. I hope everyone is feeling healthy and safe as we work through the summer heat, and I look forward to our work today.

Aaron Miri
Hello to everybody listening. I appreciate you joining the call. Again, I echo what Carolyn said in terms of I hope everybody's being safe and taking care of themselves, their loved ones, their family, and their friends. It is definitely a trying time, but together, we'll get there, and these topics, these concepts – I keep saying at every report workgroup where we talk about this, but they are so germane and playing out right now in the public discourse in terms of interoperability and other challenges, so these reports to congress become even more important, and I have leveraged multiple iterations of these reports, even in discussions with the CDC and others in our local health systems and local health authorities. So, I look forward to talking, and let's get our show started. Carolyn, do you want to kick it off?

Discussion of Potential Topics for HITAC Annual Report for FY20 (00:01:37)

Carolyn Petersen
Sure. So, where we left off was midway through a Word doc that had some potential topics for the annual report that we're working on, and we thought we would go back to that document and see if we can hopefully wrap that up today. We will have a public comment period as well, and then briefly discuss our next steps for the next meeting, which will be in early August – not nearly as far away as the last one was. So, if we could have the next slide, please.

This is our meeting schedule. Today is July 22, and our next meeting is in just a couple of weeks, where we start thinking about the crosswalks and topics. That may carry us into September, and then, of course, we'll have the outline, the drafts, and all the stuff we're really familiar with at this point. Next slide, please. So, we will present in September at the HITAC meeting, which will be virtual, and what we present will depend on how far we get today and at the August meeting, but so far, we're on schedule, so, good for us. Next slide, please.

And so, now we'll get into the discussion of potential topics. Go ahead. Let's see. I can't read that, but I can pull up – there we go. I'll pull up my own copy on my computer, as perhaps you will choose to do also.

Lauren Richie
Michelle, if you're able to zoom in…

Michelle Murray
I don't have access myself. Somebody else might have access.

Carolyn Petersen
If it turns out to be a problem, Aaron and I can just read them out loud and work through it that way. I don't want anybody to go blind before you get into the summer swimming and stuff.

Michelle Murray
Is there a wider landscape view of this document? It's a landscape document.

Carolyn Petersen
There we go. That's pretty good, because the far-right column is empty for everything going forward. So, where we left off in our last meeting was on these two items in the top section related to the health IT response to the COVID-19 pandemic, and the first issue is the patient-matching challenges due to gaps in information, and particularly demographics shared from commercial laboratories and from contact tracing records, and the lack of unique patient identifiers. We see this as landing in the public health and interoperability target areas. It's something new. We didn't have that in the 2019 report, and Aaron was the person who suggested this, so I'm going to give him the mic and he can talk about what he has in mind.

Aaron Miri

Yes, let's talk about real-world issues here, and I'm sure Brett also has a number of them, being a practitioner on the front lines. So, as a degree of it, we've had numerous challenges as we've been doing contact tracing here across Austin and on behalf of Austin Public Health, and really make sure that as we are developing clusters or noticing clusters of COVID-19 patients or whatever it be, making sure that parents – let's say there's a contact or a suspected person called Aaron. How is one Aaron not another Aaron or is not a duplicate in the record – so on and so forth.

These issues compound themselves. Given the fact that I'm in Texas and there are a number of demographic statuses where people have similar-sounding names or the same names, it becomes very complicated without a unique patient identifier, and I think we've seen these gaps of care that are obviously playing out in the public health domain, but are not exclusive to public health. I think this is across the entire continuum of care. I'd invite Brett to give us his position perspective on this as well. I'm sure he's seen firsthand about how there can be major ramifications from this.

Brett Oliver
Yeah, absolutely. I would just echo what you said, Aaron. It's a challenge. We UDI processes when the data are found to be in the wrong chart, but I just wonder how long it goes undetected if it's close to or not exactly the same. It's interesting. I think it's gaining some momentum. We just recently had some of our HIM folks reaching out to our senior leadership asking them to politically back UDI – not necessarily to back how it's done, but just the concept – and it needs to be brought out more. I think it's still at an executive level, not at the provider level or HIT level of leadership. I think it's pretty clear that it's at the executive leadership level of hospitals and clinics and things. I don't think there's as much awareness as there should be in the complexities, especially as we go down all this extra information exchange that's going to be forced – for good reason, but it's going to be forced. Without that, I think we will run into some unintended consequences.

Aaron Miri
I'll give you another real-world aspect or issue: Labs. There has been a lot of news media about timeliness of COVID-19 lab testing and whatnot, and there's a big issue – a big gap. If you go to, say, a commercial lab, a drive-through lab, or a common drugstore convenience that's providing COVID-19 testing, that data is not shared as rapidly or readily as if you go to a provider or institution and get that data there back with the public health authorities. So, it's very common for people to get tested multiple times when they shouldn't be or they fall through the cracks. It's difficult because you don't know that this patient Aaron is really Aaron, and so, this compounds the lab testing issue and the density and saturation rate that we have right now in this country, and it's causing a big hang-up simply because we don't have some strategy or some way of correctly identifying uniquely if Aaron is Aaron. I'd invite Carolyn or Christina to give their comments as well.

Carolyn Petersen
I think that as important as it is to tease out all of these aspects of the situation, which is real, we can't lose sight of some of the privacy considerations that have kept UDI from going further in the future. It's not for nothing that we haven't gotten it yet, and it would be useful to focus on how we can resolve some of those concerns so that it might be something meaningful and implementable going forward.

Aaron Miri

Good point.

Brett Oliver
I would just add another caveat to it – I'm sorry, Christina, I don't mean to take any time from you. To your point about the labs, what ends up happening when you have that matching challenge is that you just end up sending the results to the patient, which is fine – they need their results – but then it doesn't go anywhere in terms of making decisions about going to work or being quarantined. That's been a real challenge, especially as you've had to rapidly stand up multiple labs to help with the volumes that are necessary. You're not going to have an interface and have all these patient-matching issues. You're going to end up sending the results to the patient and have them triage their own results.

Aaron Miri
Christina, any thoughts?

Christina Caraballo
I think this is a great topic. I have a few things. I wonder if we should pull out the unique patient identifier as a standalone topic in the report. I feel like it's come up multiple times during our HITAC discussions. It's been one of those topics that's been off limits, but we always bring it up, so I think it's starting to draw more attention. Again, it might be worthwhile for it to have its own section. I can't recall if it already has its own section. Carolyn or Aaron, do you know?

Aaron Miri
That's an interesting thought. I will say I participated in a Virtual Updates Capitol Hill about two weeks ago with a congressman from Illinois – I forget his name, but a brilliant guy who has a PhD – and he very articulately spoke to where the House is looking at this, and their position on it, and the need especially around COVID, so, to your point, Christina, about people being aware of the issue and it being talked about with various lawmakers, it's a main narrative, if not already its own standalone thing. Carolyn, what do you think?

Carolyn Petersen
I'm definitely not as dialed into all the legislation coming up as you are, but I do think that it's something that will be revisited again and again as we deal with the various aspects of the coronavirus and any other pandemics or epidemics that follow on or launch themselves in the middle of all this.

Aaron Miri
Michelle, do you know if it's its own thing, or could we pull it out to focus on UDI or some strategy around patient matching, if we want to call it that?

Michelle Murray
I'm sorry, can you repeat the first part of your question?

Aaron Miri
Going to Christina's inquiry, is UDI or patient identifier a specific category or topic we can call attention to? How could we do that?

Michelle Murray
With having public health as a new target area, this is where things tend to be overlapping a little bit. At the moment, patient matching and UDI are topics within the landscape in interoperability, but not necessarily in gaps or opportunities yet. So, you could pull them completely up into public health or you could mention them throughout the document, wherever it's appropriate for the target area.

Christina Caraballo
Yeah, and we probably will get to some of that when we do our sessions on the crosswalk. I might have jumped ahead a little bit. The other thing I wanted to just note is that when we were evaluating the patient demographic for USCDI, a big guiding principle that we had was how the demographic data could be used for patient matching.

Aaron Miri
That's a good point. This also ties into USCDI and other strategies. That's a great point. I like that. So, let me ask this question, then: Should we leave this like it is or pull it completely out and make it another public health category? I think it's beyond public health; it's also general care, right? Not having UDI affects everything, essentially.

Christina Caraballo
I'd have to think about that as we build the report. I'd have to refresh my memory on our structure, but I think we'll figure out how it fits in when we do the crosswalk section. One thing on this section that I want to point out is that we have health IT response to COVID-19, which is immediate, but we should think about broadening that to just – COVID-19 got our attention, and it's been a catalyst that's made us identify major areas where health IT can help, but really, what we're looking at is not only responding to COVID-19, but creating an infrastructure that is going to enable us to respond better to future pandemics and other emergencies as well.

Aaron Miri
Yeah, it's just general pandemic response. I think you're exactly right. When we were putting down these topics, COVID had just happened to all of us, and were frenetically coming up with examples of things that were essentially gaps, so you're right, this isn't just COVID-19, it's everything. So, for now, what I'm hearing is we should leave this structured document where it is, and then we'll reevaluate as we look at the crosswalk and see if we need to elevate the topic, or we can even propose that to the big HITAC to ask them their opinion, but I'm hearing Carolyn and Christina say we should leave this in its current format, then we'll come back and revisit the formatting later.

Carolyn Petersen
I'm good with that. We may see some developments in the next two or three months that help us figure out where to place it and how to manage it in ways that are acceptable to multiple parties and useful in terms of actually advancing the field.

Aaron Miri
Christina, are you good with that?

Christina Caraballo

I think that sounds great.

Aaron Miri
Okay. Brett, are you good with that?

Brett Oliver
Yes, sir.

Aaron Miri
Cool. All right, next topic here. I'll take it because it's mine: The clinical workforce and patient education and reeducation on use of technology for telehealth, including smartphones. I remember this one distinctly, and it plays to everything. It's amazing. Particularly here in Austin, it's something I guess I realized but didn't truly understand or appreciate before this whole initiative, which is that just about everybody has smartphones, but not everybody is on the Apple Store or Google Play Store, and certainly, those who are socioeconomically challenged or in indigent care tend not to have those accounts with access to things, much less being able to read it in their native language, so I call that the health equity of applications in software and technology and educational how-to. That way, they can participate in their own care and help us overcome any gaps in care.

So, to the point of it, this was all about ensuring that people understand how tech can help you in overcoming either preconceived biases, fear, or other things which inhibit the adoption of health IT technologies. What's your take on that? I'm curious what you've seen and what you feel. Is this your main – is this something that's a priority? Where is this in the categories?

Brett Oliver
I'll take a stab, Aaron. Would you also include things like the awareness of the fact that my internet connection can support a video visit, for instance?

Aaron Miri
Bandwidth considerations, yes.

Brett Oliver
Because we certainly have quite a rural population that has internet access, and you think they can do a video visit, and when you actually get down to it, they don't have enough bandwidth to stream. So, as an organization, we've had to stand up a separate help desk with a third-party vendor just to do that patient education – "Do you know what a popup blocker is?" – again, just to enable those technology pieces. So, I think it's a good topic to talk about and to see if there's a role for the federal government. There's obviously a role in the piece about internet as a utility, but also, providing some resources to see if you can do that and giving you maps and a how-to guide. That's my take.

Aaron Miri
Christina or Carolyn?

Christina Caraballo

I agree with everything that's been said. I think we could talk about this one for a long time, but I do think that it's important. I think we've seen a lot more interest in telehealth, which is wonderful. One thing on patient access for things we might want to note – and, I hear that there are two sides of this; the providers are implementing solutions and educating patients on the availability as well. This could be an area that we just tag as part of the potential reengagement with the patient engagement place book that we discussed in one of our earlier workgroup meetings that came out of ONC. I think it was out of the former policy committee.

Aaron Miri
Yeah, they put that website together on how to. I remember that. It was a really great infographic website.

Brett Oliver
Aaron, what about from the perspective of the provider? I still see some traditional myths being perpetuated. We met with the leader of our oncology service line, and we were talking about – I asked him about some digital solutions, and he was like, "Our patients are older and don't want to use that stuff," but I was throwing out some actual facts, particularly this huge, worldwide pilot that we just went into where we found folks into their 90s utilizing video visits and doing just fine, and I don't know if that's part of what you were thinking, educating the clinical workforce on where that demand actually is, and that the elderly are just as likely to use it, and in our system, they engage more often once they learn how to do it.

Aaron Miri
I think you're spot on, Brett. It's the same here in Austin. We're seeing that we have not had a drop-off in demographic or age that are willing to use telehealth, and in fact, we've managed to basically keep the same volume level across our service lines irrespective of age. I would say that what's changed in the past couple of months is I give a lot of credit to CMS actually putting some real-world data out there. I saw some article that I think FEMA put out that 9 million people – something much more than that – engaged in telehealth in a 30-day period. There was some study by CMS on FEMA's claims data, and it was fantastic. To your point, Brett, they actually laid out facts. "These are the facts of what people did, how they did it, and their quality of care." I think we can tap into some of that CMS data that they're willingly telling people and teaching people about and see how we can amplify that, to your point, to overcome those preconceived biases about technology.

Christina Caraballo
Another thing to add to this is from a patient monitoring perspective.

Aaron Miri
What about it specifically?

Christina Caraballo
Well, there's telehealth, and then there's remote patient monitoring, which I think can go hand in hand, but can also be separate, so I just think that specifically calling out remote patient monitoring piece would be a good idea. It goes beyond – go ahead.

Aaron Miri

I would agree. Would you tie remote patient monitoring to continuous patient monitoring as well, or just to episodic care?

Christina Caraballo
I think it can be both. I know there's a lot of work going on in some of the groups like the Personal Connected Health Alliance and IHE on care-based approaches for remote monitoring, and I think there has been a lot of work done that could be highlighted as we think about some of the pandemic response, but I thought it would be helpful to also include the remote monitoring when I think about getting involved with devices, patient-generated health data, and that whole suite.

Aaron Miri
You're exactly right. As a real-world story, we did a lot of remote patient monitoring for COVID-positive and suspected patients, and it tied really well into our contact tracing efforts. You'd be amazed at how many – especially of the indigent care population – did not have a thermometer or Bluetooth monitor, and so, with credit to UT Austin, we just ended up buying some and donating them to the patients, saying, "Look, you need this. We need you to track your temperature. You're suspected; you're a PUI, so just stay home and input your vitals and temperature every duration, or it will automatically do it via Bluetooth." Those Bluetooth thermometers aren't cheap. They cost $20.00-40.00 a pop, but these concepts are buy-in. If you have someone you can keep out of the general public, you may have saved 10 other people from getting infected, so it's a worthwhile investment, but those concepts should be teased out, so I think you're right on, Christina.

Brett Oliver
Yeah, and even beyond COVID, I think the education piece for the patient side is that this is the continuation of your treatment. At CHS, we're allowing them to go home earlier than we normally would because of this continuous or intermittent monitoring. We've done some pilots before, and it's not good education on the front end. "Yeah, you're supposed to wear this thing, and we'll be calling you or keeping an eye" versus "Your doctor has ordered this, this is part of your treatment plan" – that falls into that education piece beyond the COVID stuff.

Aaron Miri
Good point. I'm hearing that we should leave this where it is, add remote patient monitoring/continuous patient monitoring to the category, and just enumerate on bullet points and use some of the CMS data. Are those the takeaways?

Christina Caraballo
Yup.

Brett Oliver
Makes sense.

Aaron Miri
Okay. So, are we now to the next section here, under the yellow part? So, these are topics that were carried over from last year. These are topics – Michelle, keep me honest here – at the time we published

the report to Congress last year, these items weren't finalized, like this one, the final rule wasn't launched until February, so the report had already gone out. Is that where we are right now?

Carolyn Petersen
Yes, I think so.

Michelle Murray
Yeah, this section is all topics that were in last year's report that may have updates for this year. Sometimes they were final or not final, but the deciding factor was that they were from last year, and we wanted to decide if they should be carried over to this year and summed up.

Aaron Miri
So, without expanding upon this ad nauseum, since we can talk about these extensively within the HITAC itself, are there components of this that we haven't already addressed or things here that, beyond the question of whether we should carry this forward and talk about it in this year's report, I vote yes, but I'd like to hear what you guys think about it. Should we talk about it again in this year's report?

Carolyn Petersen
I think we have to mention it. Perhaps we can reference some general feedback from the public or a general response from the health IT community – and, when I say "general," I mean pretty general.

Aaron Miri
Yeah. Brett and Christina, what do you think?

Brett Oliver
I think we have to comment.

Aaron Miri
Christina, any objections to that?

Christina Caraballo
Nope, it sounds good to me.

Aaron Miri
I think it's the same thing with TEFCA, right? Although, I feel like TEFCA hasn't been spoken about as much as the general final rule for 21st Century CURES. We're kind of just spinning that all up now, but I think we have to talk about it anyway this year because so much great work is going on right now around that in standards development and whatnot. Am I wrong on that?

Carolyn Petersen
No. Sequoia has been doing a lot more public engagement and reaching out to different stakeholder groups, and is trying to get the word out and see about patient engagement. Last year, for a good while, there just wasn't that much to say about it because there wasn't much that was happening in the front room. I think it was underground or in the back. But, we are getting to a place where there will be plenty to talk about by the fall.

Christina Caraballo
I agree with that.

Aaron Miri
All right. The last one on here with the federal activity guidance is the CMS interoperability rule, which I think – it's the same thing. We just need to talk about. But again, this is one of those that I haven't heard too much about. It's not like CMS hasn't been busy or something with a pandemic to respond to, but I haven't heard too much more about it recently, but we know it's there. Any objections to carrying it forward so we can keep talking about it?

Carolyn Petersen
I think we need to.

Christina Caraballo
Definitely.

Brett Oliver
I agree.

Carolyn Petersen
I would not be surprised if, sometime in late September or early October, we suddenly find a large wave of topics where things have been happening and it's all gone unnoticed because of COVID, so the more of that we have in our sights now, the better off I think we'll be.

Christina Caraballo
Excellent point.

Aaron Miri
I totally agree.

Carolyn Petersen
If for no other reason than we're all getting really sick of hearing about COVID and want to look at other stuff.

Brett Oliver
Amen.

Aaron Miri
Hear, hear. All right. Exchange of SDOH – challenges of operation of the capture and use of social determinants of health; business models across the healthcare sector do not yet support the capture of other data, and that's very true. This is one that we continue to talk about, although I've said publicly on the record numerous times that people's definition of SDOH does drive me a little batty. Can we be more specific? Are we talking about patient-supported outcomes or whatever else? Again, this is for the capture

and use of data due to lack of standards and data availability, patient matching, levels of technical maturity, the fact that the documents are free text – all that stuff.

This one continues to carry forward, and I think it's going to continue to carry forward, and from my perspective, at least, we've had a busier time just pulling out how to do national COVID-19 data trials, looking at the clinical notes, because one physician will type "COVID19," another will type "COVID-19," and a third just puts "COVID," so it becomes a bit of a nightmare. But, then again, is that SDOH? Should we talk about patient-reported outcomes around COVID-19 or whatever? I think there's – when you look at SDOH in general, there are a lot of opportunities. Christina, I'm curious about your part here. On USCDI standards, is SDOH called out, or is that still something that's floating out there nebulously?

Christina Caraballo
For USCDI, our task force does not recommend that it is in it, but we highlighted it as a use case that should be submitted to USCDI once it's open. I will tell you I'm actively involved with the work in HL7's Gravity Project, and I'm just pointing to the standards piece of this assessment. They are working on the standards part. Not to go into the whole detail of Gravity, but they've now submitted ICD-10 codes in May for food insecurity, and they're working on housing and transportation, and my understanding is that they're hoping to accelerate into more domains, so I think this is really relevant, and I think we'll have a lot of updates based on the work coming out of HL7 right now.

Aaron Miri
That is outstanding. I did not know they did that. Do you have any idea when those ICD-10 codes for food scarcity will be available?

Christina Caraballo
I can throw the link…

Aaron Miri
Yeah, would you? Let me give you an example. As we're doing contact tracing, we are coming across so many people that don't have access to care, access to food, are in food deserts, or whatever else, so we've linked them up with city resources, Meals on Wheels, or whatever it is to help them beyond COVID. You have the person on the phone, so you help them as much as you can, and being able to track that with an ICD-10 code would be priceless because I could do geomapping and really understand in a precise manner where those food deserts are and link the right resources to them. That's great. Thank you for that. So, I'm hearing that we should leave this on here. Carolyn, do you want to take the PGHD one? This is one of your passions.

Carolyn Petersen
Sure, yes. So, while the adoption of PGHD has increased in recent years, patients still face a variety of challenges to sharing their PGHD with their providers. Many providers lack the technical infrastructure, functional workflows, or course capacity and training to receive and use the data. So, last year, we put this in the "Patient Access to Information" category. Obviously, we are all aware of the privacy and security issues around data created by patients and transmitted to medical entities. I would add that I think this year, with different efforts to do contact tracing, and to get people's COVID test results to them, and to get people to take their temperatures and perhaps do other personal metrics to see where they are

and monitor themselves, this is going to be at least as important as it was in the past, and possibly more. I would keep it, but what do you all think?

Aaron Miri
I agree.

Christina Caraballo
I would agree as well.

Aaron Miri
Brett?

Brett Oliver
It's going to be a growing issue for sure.

Carolyn Petersen
Okay, so I think that one stays in. And then we come to the Internet of Things, and this gets at the limited interoperability among the vendors, and as IoT objects become more integrated with health IT, you get more security risks. The FTC has been a defender of privacy and security concerns related to the IoT, but there hasn't been a lot of strict regulation about that just yet. This fits into the emerging issues, interoperability, and privacy and security focus areas. Last year, we saw that it was emerging in a way where we didn't want to deal with it, but maybe it's emerged enough that we can.

Aaron Miri
Yeah, I think we have to. There are so many apps and things out there now. It's just everywhere, right? There's no way we can't talk about this.

Carolyn Petersen
I agree, but you're preaching to the choir here.

Aaron Miri
Christina and Brett, do you have any objections to leaving it on here?

Brett Oliver
Absolutely none.

Christina Caraballo
Sorry, no. You guys couldn't see me smiling. Yeah, it looks good. Sorry, Michelle. We're not taking anything off.

Brett Oliver
No, no, we're not.

Michelle Murray

From a process point, I'll add that that's okay, but we may want to think about streamlining how we talk about certain things. They might not have two paragraphs each in the landscape. They might just get a paragraph each this year, and a note that they're continuing and that gives what's new, but they might not necessarily go into next steps. That's a way to handle things that are lasting over time.

Brett Oliver
I think that's fair.

Christina Caraballo
That makes sense.

Aaron Miri
IoT could be its own dissertation, for gosh sakes, so at least just mentioning that we're aware of it and it's something we're tracking is important. And, I've seen some recent NIST publications that are trying to address this from a security and privacy perspective. There's even a draft NIST recently that started trying to set some standards for this stuff, so I know people are working on it. Okay, other potential topics – is that where we are now?

Carolyn Petersen
Yup.

Aaron Miri
All right. Again, back to the health IT response for COVID-19, public health authorities facing interoperability challenges to be able to collect information – again, this is another dissertation – from clinical providers and laboratories needed for proper reporting. I don't see how we could not have this on here. What do you all think?

Carolyn Petersen
I agree, and I think that the interoperability is just compounded by the other delays related to getting to the test results. The interoperability issues are just one more barrier to getting information in a timeframe where it's still meaningful and actionable.

Aaron Miri
Brett or Christina, any objections?

Brett Oliver
None here.

Christina Caraballo
No.

Brett Oliver
I agree with you guys.

Aaron Miri

All right. Next topic, then. Again, health IT response to COVID-19 pandemic – this one is about the biosurveillance efforts, including contact tracing, privacy and security issues, what data is classified as HIPAA minimum necessary, is usable, et cetera. I know that especially with collecting via mobile devices, there has been a whole lot of stuff written on this. I know that OCR has been putting up some guidance around this and trying to clarify what is in HIPAA's jurisdiction and what is not and what public health allows you to talk about. I would add on this maybe that we didn't think about it before, but I can tell you now, in the middle of it, there are considerations with FERPA related to this. It's not just HIPAA, but it's also FERPA, and when you're dealing with a public health emergency, what are you allowed to do or not do to comply with FERPA as well as HIPAA, so there's a Venn diagram overlay here in my head, so I think this is important. What do you all think?

Christina Caraballo
I agree. I was just scrolling up to the stuff we were looking at before with the COVID response, and I'm wondering if some of this can be consolidated. We don't have to do it now on this call, but it's something to think about once we identify…

Aaron Miri
That's fair.

Christina Caraballo
I don't…

Aaron Miri
I think that's fair. Michelle, what do you think? Is that doable?

Michelle Murray
Yeah, actually, because behind the scenes, ONC started working on a crosswalk, and it clearly needed to be consolidated around the pandemic, so there will be three or four line items there to start with.

Aaron Miri
You guys are so good. Thank you, Michelle. I figured you'd already be ahead of us. This is excellent.

Michelle Murray
Well, you have to be.

Aaron Miri
ONC is awesome. You guys rock. This will be in there, and then, exactly to your point, Christina, it will just collapse into the other topic there, just to highlight the need. All right, let's move on in the interest of time here. We're almost to the end of this. Interoperability standards priorities task force and prioritization, HITAC approved the report, the report established baselines to set priority standards for FY '20, including full revision results, closing referrals, and care coordination/medication pharmacy data, and just by the ONC. Oh, this is a finding from the IST task force of what they're saying we need to focus on for this year. Is that what this is saying, Michelle?

Michelle Murray

Yes. So, there was debate going on for a while about how to handle a requirement out of CURES to manage priorities. So, the IST task force took care of it the first year or two and published a report in the fall which fell into FY '20, so we need to report on it in our "Progress" section this year. I don't know if Lauren wants to say anything about future years, but we won't need to address it again for another year or so. We have the option in the report, so let me be clear about that. The HITAC more generally is a different question. If we want to, we can go into more depth with the topics in the report, so we don't want to repeat what's in the report. In the "Progress" section, there could be a link to the report, but if you want to talk about the detail somewhere in the content of a landscape analysis, you could also do that.

Aaron Miri
Got it. What do you guys think? Carolyn, what do you think on this? Should we go into details here, or should we just reference the final findings?

Carolyn Petersen
I would probably just reference the final findings because otherwise, what should all the other workgroups potentially be highlighting from their work? Some of them have done a lot of work and some of them have a lot of relevant findings, and I think this is an area where we can streamline reasonably and without getting undue criticism.

Aaron Miri
Good point. Any objections to that, Brett or Christina?

Brett Oliver
No, that's what I was thinking. We're opening up a Pandora's box where the report will never end.

Aaron Miri
Christina, any issues?

Christina Caraballo
No, I don't. Sorry, we're getting storms in D.C., and I missed part of Michelle's overview because my phone alerted. I'm sorry.

Aaron Miri
Be safe. It's alerting you to be safe. All right. Genomic data – address privacy issues specific to patient content for sharing their genomic data, and if fewer people want to share – this one is a mess. It could be combined with the precision medicine topic. Genomic data and issues around that are just a giant thing. I could go on about the privacy practices of 23 and Me and others, but I like the recommendations about merging that with the precision medicine topic. I think genomic data is coming more and more to the forefront, particularly as I've seen so many COVID trials now being done with genomic sequencing and looking for people with more susceptibility. I think you're going to see this play out more and more. How do we keep patient information safe, and how do you share it? There's just so much around this. So, I'm good with the suggestion of combining it, but what do you all think?

Christina Caraballo
I'm fine with it.

Brett Oliver
I'm good with combining it, and I might throw out an additional piece of the quality of the data. You mentioned 23 and Me. I wouldn't want to base my clinical decisions off of that testing. I'm not saying it's 100% bad, it's just that when you take those results to independent labs and you get 60-70% accuracy, it's very concerning, and you see more and more folks selling their 23 and Me data or other companies buying 23 and Me data so they don't have to go through that dataset collection. It's a little concerning. I don't know if that's the right spot for it or even appropriate, and I know we were talking more about privacy, but I think the quality of the shared data in the genomic realm is relevant.

Aaron Miri
Great point, Brett. Especially you as a provider – if I come to you and tell you I have a higher predisposition for some sort of cancer when I don't, it can change your entire course of care.

Brett Oliver
Yeah, when you think genetics, you think extreme accuracy, like you're looking at my blueprint, and to know that some of them – I'm not trying to slam 23 and Me, but I think there are some studies out there showing that for what they do, it's nice, but if you want to apply that in other spaces, you have to be careful and keep your eyes wide open.

Aaron Miri
Right, okay. Any objections to taking this topic and merging it, but also making sure there's quality within it? Hearing none, I think that suggestion is good, Michelle. All right, we're on our last topic here, with robotics. This is just a – I always think of *Star Trek* every time I say that word. Health IT implications of the use of robotics in diagnostics and treatment, including HIPAA-compliant chat bots, to augment practice capabilities. This is a really interesting thing. We did a chat bot to do the preassessment of COVID-19, and it really was some simple decision support – "Have you been around people that have COVID or traveled to certain places?", all the criteria that CDC lists – and it was heavily used on our website.

It was amazing, if nothing else, to alleviate some of the anxiety the general public felt. But, you could see the power of this, that if you have the algorithms fueling it, how it can be a really great interface tool, and particularly with the generation that likes to just chat and text. I see this as a developing opportunity area. I don't know if it's – we should limit it just to chat bots because I think there's other robotic technology out there in play. Nanotechnology is coming to the forefront. What do you all think?

Carolyn Petersen
So, when we say "robot" and "chat bot," are we thinking more about the technology or the algorithms, which I would argue are maybe more about the intellectual property, the user experience, and all of the issues – ethical, social, and otherwise – related to the AI?

Aaron Miri
Good question.

Carolyn Petersen

It's a technology, but what makes it actually function? It's really the AI and the algorithms that they're using that are learning how to engage with humans in a useful way, or on some sides, in a completely useless way.

Christina Caraballo
That's a good point.

Carolyn Petersen
Or, is it maybe something that we mentioned in terms of an AI topic and put on the list for next year, and we're really not ready to go here yet?

Aaron Miri
I'm leaning toward the latter. It's not that I'm not interested in this or we're not doing things around it, it just seems like such an emerging field. I don't know if we know what we know yet. It is interesting, but is it more important right now in 2020 than something else is? I'm not entirely sure about that. Brett or Christina, what do you think?

Christina Caraballo
I'm feeling more inclined to agree with what you just said. I'm struggling with this one. It seems a little off. I'm not disagreeing with its importance, but I'm just not – I think tabling it for right now sounds good.

Brett Oliver
Yeah, it's almost two different things. If you've got a really straightforward chat bot that's going on with a well-established algorithm and there's no machine learning or AI involved in it, that's kind of one thing, but back to what Carolyn was saying, there are certainly concerns about ones that are AI/machine-learning-based. That's a different topic altogether, I think.

Christina Caraballo
Yeah, I don't want us to lose focus om the things that we're really laser-focused on right now – the interoperability, patient access, and privacy and security – and I think if things that are really important that aren't within those buckets emerge that we should highlight, we should definitely bring it up, and **[inaudible] [00:49:15]** but I'm struggling with this topic. It just seems like it's a little bit out in left field.

Aaron Miri
I'm hearing that we should table the topic, and then we'll come back to it unless something comes up – maybe a new CPT code or reimbursement code will come up specifically around robotics that brings it back to the top, but right now, let's leave it in favor of other topics we should focus our attention on.

Christina Caraballo
Or if someone tells us to change our minds.

Aaron Miri
There's always that.

Christina Caraballo

Great backing on it.

Aaron Miri
There are always the people above our pay grade who say, “Hey, this is important to you now.” “Yes, done. Whatever you say.” All right.

Michelle Murray
Aaron, could I reply before you move on? Are you saying robotics should be an emerging issue, or should be deleted from the list for this year?

Aaron Miri
An emerging issue, but tabled for next year’s report. We’ll just have it as a bullet to track.

Michelle Murray
Got it, thank you.

Aaron Miri
All right, I think that does it for this document, right? Carolyn, am I missing anything?

Carolyn Petersen
There are actually more pages with proposed content for landscape analysis.

Michelle Murray
And, you all have a choice right now with your remaining time. There are still issues embedded in the slides that were lingering from further up in the document that we brought to the HITAC but didn’t discuss much yet that you might want to look at further now. Our contracting team helped us look into them a little bit more for you. So, you can look at those, and also, there’s more to the list that remains. Carolyn’s right. There is more to this list. It’s a quick look at topics that might be in the landscape analysis that probably don’t need a lot more research or discussion. At some point, we want a yes or no to keep them in the landscape analysis, and I personally think that’s less important than going over what’s in the slides, but it’s your choice with the direction you want to go right now.

Carolyn Petersen
We can probably push through what’s on the last – the stuff for the landscape analysis fairly quickly. Do you all want to look at that in the next meeting in a couple weeks, since we’ve already spent almost an hour debating topics today, or do you want to do all the topics at once and then look to kill another sacred cow next time?

Michelle Murray
And also, next time, in two weeks or so, we hope to switch over to the crosswalk, which will obviously be a lot more information to consider, so a third option here is to look at these offline and come back and raise any points you want to about this last set of line items. I don’t want to use a lot of our meeting time about this.

Aaron Miri

I like that. Let's take this offline and come back to it. I need to read through this again. That's all I think.

Carolyn Petersen
If Christina and Brett are fine with that, I'm fine with it, but I don't want to push homework on people if they're in a place where they can't really get to it.

Brett Oliver
It's fine. Whatever you guys want.

Carolyn Petersen
So, here we go. Circling back –

Aaron Miri
So, Carolyn, we have a half an hour left on this call. Is that right?

Carolyn Petersen
That's right.

Aaron Miri
Okay. I tremendously apologize. I have a hard stop here in a couple of minutes. Carolyn, is there any way you can finish it out for me so I can hop off, and we'll catch up later?

Carolyn Petersen
Sure.

Aaron Miri
I appreciate that. Thank you so much. Go ahead.

Carolyn Petersen
So, it looks like we're going to head into – I'm looking back at the HITAC member comments we previously discussed. I know there is about three slides' worth. Some of these have to do with hot-button things, and we didn't make a decision with some of them beforehand, thinking we would see how things played out. So, the first one is improving information exchange for research using health data that is in EHRs, and the backstory there is that there's a lot of information in EHRs that is hard to get out so you can use it for research purposes. There is a comprehensive list of challenges here – data quality and consistency, limited-governance structures and policies that permit access to the data or restrict it, there are different privacy and security issues that are related to organizations and states – and as we know, HIPAA is often not helpful in this research environment.

There are inconsistent implementations across different technical architectures. You have the varying needs of individuals and organizations that are creating and using data, and finally, there's the issue of how we clarify consent processes for patients and for the data that they are giving, particularly when it is created for some other purpose and wants to be repurposed for research. So, I think we can think about if we want to keep this in and how we want to frame it, or where it fits in. Is it something we can include in other topics we've discussed today or previously, or is it its own subsection? My perspective is that this in

an ongoing issue that we'll probably be talking about forever. Even when we get some kind of comprehensive rework of HIPAA, there will still be a lot to deal with, but I'm interested in all of your perspectives.

Brett Oliver
I would agree, Carolyn. I think it comes up almost every full HITAC meeting – some variant of research data needs. I agree we should keep it.

Christina Caraballo
I think we can combine this with precision medicine topics and genomic data that we discussed earlier on the call.

Carolyn Petersen
Yeah, that might be a place where we can talk about how that kind of data really exemplifies the situation and hit some of these challenges without having to go too deeply into them. Do you have any concerns about that approach, Michelle?

Michelle Murray
I don't have concerns. I'll just point out that precision medicine will be discussed in the "Federal activities" section because there's the NIH effort with all of us, so it might show up in a couple places in the document. I'm not sure exactly where we'll combine things, but I hear what you're saying.

Carolyn Petersen
I would think that that would actually be a positive development because it is such a prominent and reoccurring topic. In that way, we would clearly not be trying to sandwich it off or giving it short shrift, but it would be prominent in the document. Let's move on to the next slide, then, if we're finished with that one. So, here, this topic has to do with the organ transplantee's case, and the process of harvesting and transplanting organs is time-sensitive, and there are a lot of processes and a lot of moving parts in the donation and the actual surgical cycles and things that are done manually by the staff, and the organ procurement organizations have difficulty accessing donor medical records, which have to be involved in the assessment and evaluation aspect of all of this.

So, some of the particular challenges are the need for streamlined communication between hospitals and OPOs using these EHRs and the increased automation, lack of standards for the EHR capabilities related to transplant and data transfer within the transplant ecosystem and other organizations that are perhaps not typically involved in the healthcare or research side of things, and then, inconsistent adoption by transplant hospitals of existing EPIs to assist with data exchange. That's particular to organ transplant. So, this was probably mentioned six or eight months ago, and I'm wondering where we think it fits today as a use case, given everything that has come up with COVID and, of course, other developments. Is this important, but something we should keep on the list for next year as an emerging use case later so we have time and space to look at COVID-type use cases, or do we think that this one has matured to the point where we should really follow up on it?

Brett Oliver

Carolyn, this is one I struggle with because I always think of IT as supporting, and this is one that, when we dug into it a little bit, Steven and I were queried by one of the groups, and there's no standard from the different organ procurement organizations, so if they could standardize it, then I think health IT can fall in behind and say what the requirements are. I almost feel like we're putting the cart before the horse from a clinical perspective. I'm sorry, Christina, you started to say something.

Christina Caraballo
No, you're fine. We were actually thinking the same thing. This is one I struggle with taking off as well because it is just that… "Simple" is the wrong word, but it sounds like it is an interoperability and data exchange issue that we could solve and have a real big impact in this space, and this is a group that actually reached out to USCDI as well and was inquiring about how to get this data class within USCDI. So, there is a lot of interest, and I think it's one of those high-impact use cases, so I would hesitate to take it off.

Carolyn Petersen
Do we want to perhaps identify it as a use case to be unpacked more in a future report and identified as something to think about, but not something that we're ready to take apart today? I think it's good not to lose it. I wouldn't want to take it off the list, but it sounds like there are still enough challenges remaining that maybe it's not a good one to try to tackle this year.

Christina Caraballo
Again, I'm just going to say this out loud – I'm wondering if this is another one of those topics that, as we were discussing it, thinking if it is out in left field or if it should be in the bundle of things we're looking at, and we might consider a section with emerging data needs or things that have been identified where we've also identified interests within the communities. Of course, my head goes to teeing up candidate data elements and data classes for USCDI submission. I don't know if this belongs in the report or not. I'm kind of trying to think through how we structure it to not lose some of this information, but I'm okay, Carolyn, if you think we should just table it for now.

Carolyn Petersen
I think we –

Michelle Murray
Sorry to interrupt. Before you decide anything, a thought I had while you were talking is what if it doesn't stand on its own as equal to other topics? You keep saying "use case." Maybe it fits within another existing topic that's being carried over from last year, like health IT exchange or standards – one of those other ones that we've put in the landscape analysis under interoperability that would call out this use case as a key one that's forward-looking and emergent in the sense of urgent just to call attention and acknowledge it, but not necessarily try to make it stand on its own.

Christina Caraballo
I really like that idea.

Carolyn Petersen

I'm fine with that, and I'm fine with revisiting this in September to think more about where it fits in that way and what it can be attached to. Do you have any thoughts, Brett?

Brett Oliver
I agree with you guys. Christina's outline made a lot of sense.

Carolyn Petersen
Okay, let's go with that, then. And then, if we could have the next slide. This is the third one of these topics. This one has to do with ensuring patient access and engagement in data exchange, maybe using the TEFCA. So, the background here is that the consumer-mediated exchange is emerging as a viable pathway for sharing data, but patients continue to face barriers in accessing and sharing their health information. Two primary challenges are the need to consider where patient access fits into the evolving TEFCA approach – for example, the common agreement in QHIN's technical framework to emphasize how the individual access service exchange purpose supports the patient access and engagement, or that QHINs could be established to focus on supporting patients.

And then, the second challenge is a need to address patients' health disparities that affect the exchange of their health information. So, we know not all the patients are on the same playing field. Again, this is another topic we've not wanted to lose in the past that's clearly within one of the priority target areas for the HITAC. How do we want to deal with it? Don't all shout at once.

Michelle Murray
I was just thinking – this is one that I've supported and brought up multiple times. I'm trying to think where it fits. Carolyn, I know we recently – RCE reached out to us, and we talked about this concept with them recently, and I don't know how that – I think it was an interest, but I don't know where it fits into the work that they're doing now, so I don't know the best place for this. I think it does belong somewhere within TEFCA that we look at what patient access looks like. I'd like it to have its own callout in the report because I think it's important.

Carolyn Petersen
Does it fit as a discussion point within the section on TEFCA and the progress that's been made this year?

Michelle Murray
Yeah, I think so, and even if it's not doable today, I think it's really important to start thinking about how we have – patients have access to information on a broad scale that's not tethered to an individual healthcare organization or provider. My theory is that as we build out this exchange framework, patients are still going to need to go into different places or even different QHINs to find their information, so I want us to start thinking about how we lay a foundation, whereas as a patient or an organization that may act on behalf of me as a patient is able to plug into the network just like a provider can and be able to get and share information across the whole network. And, if I thought through this more, I'm not sure if that's a QHIN that is on its own, which would make me really happy, but I don't know if that's the correct approach, or if it's having this place within the QHIN that would serve that purpose where – like maybe a patient-facing piece within each QHIN to enable that kind of data exchange for patients across QHINs.

Carolyn Petersen
As I recall, one of the discussion points was if you had separate patient QHINs, would that just make it possible for other QHINs to simply not get into the weeds at all on that issue, and just expect people to use the other QHINs? Would you wind up helping to add a barrier by not requiring others to get involved? I don't know that we ever had resolution about that; I think there was just some debate about whether it was better for patients that it be a requirement for all the QHINs, or if a separate QHIN focused on patients would serve them better.

Christina Caraballo
Honestly, I think we need a deeper evaluation on this. I think that we would all agree that patients being able to have easy access to all of their information is the direction we want to go, but at least there, we have a long way to go, and when I think about it, what I don't want to do is keep having the same conversation because we haven't started to think about what this foundation looks like. So, if we don't have all the answers, then let's start to think about a framework that incorporates patient access that's not tied to a specific healthcare provider or a specific QHIN, but is broader.

Carolyn Petersen
It sounds like maybe this is something that is best addressed as part of the section on the TEFCA and noted as an emerging issue that needs fuller development at both the workgroup and the annual report level in fiscal year '21.

Michelle Murray
Yeah, I agree with that. That would be a really good approach.

Carolyn Petersen
Then we don't lose it, but we don't have to try to make headway on the issue ourselves. Okay, that sounds good. So, what I'm seeing is we have a slide about next steps, which is for the next meetings, and we also have that list with some more potential topics for the landscape analysis, so we can either end early or go back to that list and see if we can knock off a few items. What's your preference?

Brett Oliver
I might suggest we wait, just to have Aaron's input, but I'm fine either way.

Carolyn Petersen
I lean a bit toward waiting for Aaron also, but I don't know what your availability is for the August meeting, so if today is a better day, we can certainly start down that path.

Christina Caraballo
I'm fine waiting for Aaron as well.

Carolyn Petersen
Okay, let's do that, then. Can we have the next slide? I think that's No. 10 – yeah, there we go. So, our next steps – we will be reviewing the draft crosswalk of the topics with the gaps, opportunities, and recommended activities across the target areas at our next meeting, and then we will have the goal of presenting that for discussion at the HITAC meeting in September, so that would be our first opportunity

to get some fairly significant and detailed feedback from the HITAC. Is this meeting on the 6th an hour, or is it 90 minutes? Do you recall, Lauren or Michelle?

Michelle Murray
I believe it's 90 minutes.

Carolyn Petersen
Okay. So then, we would have quite a bit of time to do that, and perhaps enough time also to double back and finish the list of landscape analysis items.

Michelle Murray
Right. One thing I'll point out that we changed after discussing it with the cochairs of this group in the schedule is that we're not going to try to push hard toward an outline as soon as October, so we have a couple months on the crosswalk, and we'll schedule some meetings to do that. I did have a question that was more of an administrative **[inaudible] [01:13:37]** right now if the group would want to spend a lot of time on an outline or use the crosswalk for that purpose. That's kind of what did happen last year. A little **[inaudible]** people preferred the crosswalk tool. Either way, we can get to a draft from either type of tool; I just promised a slide to the HITAC. If we don't want to do that, we don't have to do that. I just need to know so I don't keep messaging publicly that we're going to if we aren't. Does that question make sense?

Christina Caraballo
I think so. I would say whatever is the most efficient for you guys.

Michelle Murray
I think we need to agree quickly at some point on a general outline, like that slide we use repeatedly last year. It was a very high-level outline. Getting into a detailed intended outline has been working well between me and our contractor, but it's kind of in the weeds for the amount of time that you all have, but the crosswalk gives you a more holistic, visual point of view of what's going in the report, and we can work from there, and then you turn to the draft after that. We can also show you an outline if you want. That's not a problem, but I just need to know so I can schedule it properly.

Christina Caraballo
I liked the crosswalk last year, and I thought it made it easy for the full committee to look at the topics more quickly.

Brett Oliver
Yeah, I liked the crosswalk as well.

Carolyn Petersen
I agree.

Michelle Murray
Okay, good. So, I'll check with Aaron too. It seemed like we were leaning in that direction, but I didn't want to assume anything. Thank you.

Carolyn Petersen
So, it looks like we're at public comment time. We're actually right on schedule.

Lauren Richie
Okay. We'll ask the operator to open the line.

Public Comment (01:15:51)

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

Lauren Richie
Thank you. Do we have any comments in the queue?

Operator
There are no comments at this time.

Lauren Richie
Okay, I guess I'll hand it back to Carolyn for any closing remarks before we adjourn.

Next Steps and Adjourn (01:16:31)

Carolyn Petersen
I just appreciate everyone's time and attention today. I think we made some really good progress in terms of wrapping up the topics and getting a sense of what will be in the outline and on the crosswalk, thereby helping Michelle and the team to get that started for us, and I look forward to everyone's participation in a couple weeks here on August 6th. Have a great summer, and be safe out there. We want to see you back again.

Brett Oliver
Thanks, Carolyn. You too.

Lauren Richie
Thanks, everyone.

Christina Caraballo
Bye.

Michelle Murray
Thank you. Bye-bye.

Lauren Richie
Bye.