Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) MEETING

March 9, 2023 10 AM – 12:15 PM ET

VIRTUAL

Speakers

Name	Organization	Role
Medell Briggs-Malonson	**UCLA Health**	**Co-Chair**
Aaron Miri	**Baptist Health**	**Co-Chair**
Shila Blend	North Dakota Health Information Network	Member
Hans Buitendijk	Oracle Health	Member
Sarah DeSilvey	Larner College of Medicine, University of Vermont	Member
Steven Eichner	Texas Department of State Health Services	Member
Cynthia A. Fisher	PatientRightsAdvocate.org	Member
Lisa Frey	St. Elizabeth Healthcare	Member
Hannah Galvin	Cambridge Health Alliance	Member
Rajesh Godavarthi	MCG Health	Member
Valerie Grey	State University of New York	Member
Steven Hester	Norton Healthcare	Member
Jim Jirjis	HCA Healthcare	Member
Bryant Thomas Karras	Washington State Department of Health	Member
Kensaku Kawamoto	University of Utah Health	Member
Steven Lane	Health Gorilla	Member
Hung S. Luu	Children's Health	Member
Arien Malec	Change Healthcare	Member
Anna McCollister	Individual	Member
Clem McDonald	National Library of Medicine	Member
Deven McGraw	Invitae Corporation	Member
Aaron Neinstein	UCSF Health	Member
Eliel Oliveira	Dell Medical School, University of Texas at Austin	Member
Kikelomo Adedayo Oshunkentan	Pegasystems	Member
Naresh Sundar Rajan	CyncHealth	Member
Alexis Snyder	Individual	Member
Fillipe Southerland	Yardi Systems, Inc.	Member
Sheryl Turney	Elevance Health	Member
Thomas Cantilina	Department of Defense	Federal Representative

Name	Organization	Role
Adi V. Gundlapalli	Centers for Disease Control and Prevention	Federal Representative
Ram Iyer	Food and Drug Administration	Federal Representative
Meg Marshall	Department of Veterans Health Affairs	Federal Representative
Michelle Schreiber	Centers for Medicare and Medicaid Services	Federal Representative
Ram Sriram	National Institute of Standards and Technology	Federal Representative
Nara Um	Federal Electronic Health Record Modernization (FEHRM)	Federal Representative
Steve Posnack	Office of the National Coordinator for Health Information Technology	Deputy National Coordinator
Elise Sweeney Anthony	Office of the National Coordinator for Health Information Technology	Executive Director, Office of Policy
Avinash Shanbhag	Office of the National Coordinator for Health Information Technology	Executive Director, Office of Technology
Seth Pazinski	Office of the National Coordinator for Health Information Technology	Director, Strategic Planning and Coordination Division
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Brett Andriesen	Office of the National Coordinator for Health Information Technology	Presenter
Holly Miller	MedAllies	Presenter
Vassil Peytchev	Epic	Presenter
Ben Rosen	Netsmart	Presenter
John Rancourt	Office of the National Coordinator for Health Information Technology	Presenter
Mark Knee	Office of the National Coordinator for Health Information Technology	Presenter

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

Michael Berry
Good morning, everyone, and welcome to the March 2023 HITAC meeting. I am Mike Berry with ONC, and we are always glad when you can join us. This meeting is open to the public, and your feedback is always welcomed, which can be typed in the Zoom chat feature throughout the meeting or can be made verbally during the public comment period that is scheduled at about noon Eastern Time. Before we get started with our meeting, I would like to welcome ONC's executive leadership team to the meeting. With us today is Steve Posnack, the Deputy National Coordinator, Elise Sweeney Anthony, the Executive Director of the Office of Policy, and Avinash Shanbhag, the Executive Director of the Office of Technology. I would like to begin rollcall of our HITAC members, so when I call your name, please indicate that you are here. Let's start with our cochairs. Aaron Miri?

Aaron Miri
Good morning.

Michael Berry
Medell Briggs-Malonson?

Medell Briggs-Malonson
Good morning.

Michael Berry
Shila Blend?

Shila Blend
Good morning.

Michael Berry
Hans Buitendijk?

Hans Buitendijk
Good morning.

Michael Berry
Sarah DeSilvey? Steve Eichner?

Steven Eichner
Good morning.

Michael Berry
Cynthia Fisher? Lisa Frey?

Lisa Frey
Good morning.

Michael Berry
Hannah Galvin?

Hannah Galvin
Good morning.

Michael Berry
Raj Godavarthi?

Rajesh Godavarthi
Good morning.

Michael Berry
Valerie Grey?

Valerie Grey
Good morning.

Michael Berry
Steven Hester? Jim Jirjis?

Jim Jirjis
Good morning.

Michael Berry
Bryant Thomas Karras?

Bryant Thomas Karras
Hello, everyone.

Michael Berry
Ken Kawamoto? Steven Lane?

Steven Lane
Good morning.

Michael Berry
Hung Luu?

Hung Luu
Good morning.

Michael Berry
Arien Malec?

Arien Malec
Good morning.

Michael Berry
Anna McCollister?

Anna McCollister
Good morning.

Michael Berry
Clem McDonald? Deven McGraw?

Deven McGraw
Good morning.

Michael Berry
Aaron Neinstein? Eliel Oliveira?

Eliel Oliveira
Good morning.

Michael Berry
Kikelomo Oshunkentan?

Kikelomo Oshunkentan
Good morning.

Michael Berry
Naresh Sundar Rajan?

Naresh Sundar Rajan
Good morning.

Michael Berry
Alexis Snyder?

Alexis Snyder
Good morning.

Michael Berry
Fil Southerland?

Fillipe Southerland
Good morning.

Michael Berry
Sheryl Turney?

Sheryl Turney
Good morning.

Michael Berry
And now, our federal representatives of the HITAC. Thomas Cantilina? Adi Gundlapalli? Ram Iyer? Meg Marshall?

Meg Marshall
Good morning.

Michael Berry
Michelle Schreiber?

Michelle Schreiber
Good morning.

Michael Berry
Ram Sriram?

Ram Sriram
Good morning.

Michael Berry
Nara Um? All right, thank you, everyone, and now, please join me in welcoming Steve Posnack for his opening remarks. Steve?

Welcome Remarks (00:03:23)

Steve Posnack
All right, thanks, Mike. Good morning, everyone, and thank you for joining our March edition of the HITAC meeting. A colleague of mine previously described the deputy national coordinator's role as a bit of a spare tire, but I like to think of myself more as the run-flat version. Micky is out on assignment today, so you are here with me, a dressed-up version this time. I happen to be downtown in D.C. I will give a quick recap of a few things since we last met and a few other items that are important for you to keep in mind going forward. On February 13th, we hosted a TEFCA event where the HHS secretary recognized the first set of organizations that were accepted for onboarding as qualified health information networks. We will provide a recap of that work and go-forward progress during today's meeting. So, I just wanted to thank everyone that participated again. If you had FOMO from the pictures on Twitter and the like or the livestream, it was a really great event in the Great Hall that was tremendously successful in getting everybody together and really building a sense of energy and momentum.

Equally, in the past few weeks, we have released a new social determinants of health information exchange toolkit, and this toolkit is a practical, on-the-ground resource designed to aid the health IT community in the implementation of SDOH-related initiatives. There is a ton of material in there. I would encourage everyone to check that out if your work intersects with SDOH. At today's meeting, we will also have a presentation on the toolkit and our past and upcoming SDOH information exchange learning sessions, so, stay tuned for that. Also, as a reminder, we have a public comment period open. I know it seems like we have public comment periods open all the time. This one in particular focuses on the 2023 Standards Version Advancement Process. The comment period is open until May 22nd.

As a reminder, we introduced the SVAP, as we call it, as part of our CURES rule, and it allows certified health IT developers to voluntarily update their certified health IT modules to newer versions of the standards that we have previously adopted in the rule, so you can go to HealthIT.gov and check that out as part of our SVAP page. There are two events coming up that HITAC members may be interested in participating in. The first is an ONC health IT certification program developer roundtable. There are a number of programmatic activities that go on throughout the implementation of our program administration and rules. This event will be on March 22nd from 12:00 to 1:30 Eastern Time.

The second is focused on Sync for Genes, which is a long-running project that we have had. This will be a webinar where you can learn about how HL7 FHIR and other standards have been tested throughout the genomics pipeline. That event is scheduled for March 25th. It is a rescheduling from last month, and it will be from 2:00 to 3:00 p.m. Eastern Time. Again, you can find out more information in general about events that ONC is putting on or helping to host that are available on our events page on HealthIT.gov.

Lastly, I wanted to call your attention to a *Federal Register* notice that is regarding OMB's updates to race and ethnicity statistical standards. The Office of the Chief Statistician seeks input on suggested revisions to OMB's statistical standards for collecting and reporting race and ethnicity across federal agencies, and I think it goes without saying, as I am sure all of you know and have experienced, what the impact of the OMB policy direction has been in this regard and how it has affected the health domain, so I would encourage everyone to submit their comments. They are due by April 12th, so you have a little bit more time, but you do not want to sleep on it. You can also visit the working group's website to read the full *Federal Register* notice, provide feedback, and participate in upcoming listening sessions and town halls that they may be hosting through our OMB colleagues. So, in closing, again, I want to thank you all for joining our virtual session today, and I will turn it over to Aaron and Medell. Thank you.

Opening Remarks, Review of the Agenda and February 8, 2023, Meeting Notes – HITAC Vote (00:07:39)

Aaron Miri
All right, thank you, Steve, and we always love seeing you give your opening remarks, and you are looking dapper, my friend, so, well done, thank you for that. All right, welcome to our March session here at the HITAC. We have an exciting, exciting day ahead of us. We are really pleased to see you all here. Hopefully, you are having a great spring, as I think we are into springtime now. We sprang forward here this weekend, so the times are exciting. We have a great agenda today, and we will get into it in just a minute. Medell, over to you.

Medell Briggs-Malonson
Thanks, Aaron, and yes, I also want to say good morning, everyone. It is always such a pleasure to be able to spend some time and reflections with each of you. Before we jump into the rest of today's meeting, I just want to go over a few housekeeping reminders for the HITAC, especially before we begin the rest of our presentation. So, please remember to turn off your cameras during presentations, and questions and comments will be acknowledged at the end of each presentation, but feel free to raise your emoji hand to indicate that you do have that question. In addition, we really encourage engagement, so feel free to go ahead and put any of your questions or insights into the chat function. Aaron, how about we go and jump into our agenda?

Aaron Miri
Let's do it. All right, so, today, we are going to obviously go through the opening remarks, as we are obviously doing right now. We will get the Interoperability Standards Workgroup update. At 10:40, we will do an update on 360X Closed Loop Transitions of Care. We have a TEFCA update at 11:20, which is exciting. We have a social determinants of health information exchange toolkit and learning forum. As Steve mentioned a little bit ago, there was a really good release by the ONC last week on this, again, with a lot of attention on the internet. Of course, we will go to public comment about noontime or 12:05, and then will have final remarks and adjourn. So, that is a quick agenda for the day, but an exciting one.

Medell Briggs-Malonson
Great. How about we proceed onto our first order of business, which is approval of the notes from our last meeting? I would like to call for a motion to approve the February 8th, 2023 meeting notes as written. Do I have a motion?

Hans Buitendijk
So moved. This is Hans.

Medell Briggs-Malonson
Wonderful. So, we have a motion by Hans. Is there a second?

Deven McGraw
I second. This is Deven.

Medell Briggs-Malonson
Great, wonderful. There is a second by Deven. All in approval of the notes, say aye.

Several Speakers
Aye.

Medell Briggs-Malonson
All opposed, say nay. Any abstentions? The motion has been appropriately carried. Wonderful. So, let's go ahead and jump right on into our next section. I would like to bring up Sarah DeSilvey as well as Naresh Sundar Rajan, in which they are going to give us a nice overview of the Interoperability Standards Workgroup update. Sarah and Naresh?

Interoperability Standards Workgroup Update (00:10:25)

Sarah DeSilvey
Thank you so much. It is our honor to be here today to present on the ongoing and very invested work of the Interoperability Standards Workgroup. I am here with my cochair and colleague Naresh, and we are going to jointly share the presentation today. Next slide, please. We will be going over the membership, Naresh is going to take on talking about the charge and areas of focus, and then I will close by briefly discussing the work to date and our timeline for completion to deliver the report back to this committee. Next slide, please. As you can see here, this is our roster. Many of the members of HITAC are there. We also have critical subject matter experts from the community. Again, we are very grateful to this collective for meeting every single week and in multiple subgroups outside of the standard meeting in order to complete the charge to ONC and HITAC. Next slide, please. Naresh, I believe you are kicking off this part.

Naresh Sundar Rajan
Thank you, Sarah. So, just to reiterate, our overarching charge here is to review and provide recommendations on the draft USCDI V.4 elements, specifically new data classes and elements associated with those classes, and also, part of this is to look at the Level 2 data classes and elements that are not included in draft USCDI V.4 for the recommendation to HITAC. Our due date is April 12th, and we are working towards that as part of our subgroup. Next slide, please. Since our update on February 8th, we have had four different meetings, and we have predominantly discussed USCDI V.4 data elements, medications and laboratory, and we have also had subject matter experts talk about physical activity, medication instructions and adherence, treatment intervention, and care experience preferences. I will pass it to Sarah for the details on the data elements on our next slide. Sarah, back to you.

Sarah DeSilvey
Thank you so much. This is a work in progress, but just in our accountability to the charge and this committee, we do want to note that we have discussed most of the elements that we have in green here pretty thoroughly. Elements in yellow are in progress, most significantly because we have identified subject matter experts that we wanted to include in those conversations, and you can see that detailed on future slides. You see we have, in some way, gone through all of the elements of the draft USCDI V.4 elements, and we are moving through the Level 2 elements that are suggested by our committee members. Next slide, please.

I do want to just give great thanks and honor to the subject matter experts who volunteered their time to come present on areas of focus. On the 1st of March, we had representatives from the extensive work of the physical activity implementation guide in HL7, two subject matter experts from the American Heart Association, Laurie Whitsel and Paul Chase, and then, Lloyd McKenzie from Dogwood Health Consulting, a well-known FHIR expert. They presented on the physical activity work just to make sure that we were aligned, as we always hope to be in IS WG, to the work that is happening in the standards development ecosystem.

That same day, on March 1st, regarding medication instructions and adherence, Scott Robertson came from HL7 as well to present on existing standards in that space. We have a subcommittee of the IS WG currently working on definitions so that we can gain consensus on those elements going forward, and we will revisit medication instructions and adherence in our next meeting. On the 8th, we welcomed experts

well known to the work of standards development to talk about treatment intervention preferences and care experience preferences, Holly Miller, Terry O'Malley, and Maria Moen. I am sorry Maria is not on this list, but she was a critical subject matter expert yesterday in our work. Again, we are very, very grateful for individuals in the standards ecosystem coming to help us understand the readiness for elements being part of USCDI. Next slide, please.

We look forward next week to welcoming our experts from CMS and CDC. Of note, the CMS and CDC participate weekly and add comments to all the elements, but we are specifically welcoming them to speak on facilities information. They are coming back next week to do so. We are on target to developing our final recommendations in order to get it back to this committee for the due date of April 12th. We are very, very grateful for the work of that committee. Next slide, please. I believe we are done with our brief update, hopefully representing the investment of the IS WG to complete the charge to ONC and HITAC. I believe I pass the mic back to Medell in order to facilitate questions.

Medell Briggs-Malonson
I am more than happy to do so. Any questions for the team here? Wonderful updates and great progress. We look forward to seeing all of those final recommendations. Any questions? I am not seeing or hearing any, so we will continue to move on. Aaron, I will send it on over to you.

Aaron Miri
It helps if I am unmuted. Next up, we are going to do the 360 Closed Loop Transitions of Care, please, and I will turn it over to Brett. Brett, you may be doing what I did, which is mute.

360X Closed-Loop Transitions of Care (00:16:27)

Brett Andriesen
I was double muted. Hi, everyone. I am Brett Andriesen, Infrastructure Branch Chief here in our Office of Technology at ONC. I am joined by others from our 360X project team today to give you some background on the 360X work, as well as an update on some of our progress to date. Go to the next slide. 360X was launched back in 2012 as part of the State Health Information Exchange Cooperative Agreement Program, part of the HITAC ops programs that were launched back in 2009. We are really looking to enhance referral management across different EHR vendor products, and it has since been extended to include initial care transitions, and we will talk about some of those different items further on in the presentation today.

At the time of launch, this was really looking ahead at standards that would be included in certified health IT products that would be used for Meaningful Use Stage 2. If we fast forward a decade, those standards are really ubiquitous across the industry now. That does include C-CDA for clinical content, direct protocols for transport, XCM metadata for establishing context, and HL7 V.2 messages for referral workflows and tracking, and we will go into those in a little bit more detail today. For those going to HIMSS, you can see 360X in action in two different vignettes in the interoperability showcase as well as a number of previous demos that are available on the 360X project page that is linked on the first slide. I will turn it over now to Dr. Holly Miller to take us through the next set of content.

Holly Miller
Thank you, Brett. I am Dr. Holly Miller, an internist and the Chief Medical Officer at MedAllies. Next slide, please. Thank you, that is perfect. I would like to thank you for inviting us to give an update on the ONC

360X project. We are honored to do so at this time, as several vendors now have 360X functionality in general availability, and a pilot is actively in progress between Epic and Netsmart, which my colleagues, Vassil Peytchev from Epic and Ben Rosen from Netsmart, will be speaking about shortly. My role in this presentation to you is to review 360X from a clinical viewpoint. 360X was designed with the goal of making patient care transitions efficient and effective through an entirely electronic process. Sending organizations push the required clinical information to the recipient. The recipient organizations, having seen the patient, send timely information back to the initiator, closing the loop.

We start with an enhanced scheduling process in which the initiating organization requests a referral. In the ambulatory specialty use case, it is a referral, or an admission in the transfer use case. All messages are sent electronically, eliminating faxes and decreasing or eliminating phone calls. The recipient can either accept or decline the referral. If the appointment or transfer is accepted, the office staff can go on to schedule the appointment or admission. 360X demos have included integration with FHIR scheduling, making this a truly seamless process, and entirely electronic. If the request is declined, the initiating staff can quickly move on to make the request of another organization. Once the appointment is scheduled, real-time status information can be exchanged so that both sides of the referral or admission process are always informed of the status of the patient. These include things such as no-show, canceled, rescheduled, and others.

Once the consultation or the patient's admission has been completed and the recipient organization sends this information back to the initiator, this closes the loop. Next slide, please. As you can see on this slide, there are many health information technology vendor organizations and healthcare organizations actively participating in the project, attending weekly meetings where the use cases are carefully delineated. Subject matter experts are invited to attend as needed. Many members of the 360X team have actually been engaged since the very inception of the project.

One important thing to note is that our 360X group is predominantly composed of EHR and health information technology vendors, who want to offer better functionality to their customers. The engagement and adoption by EHR and HIT vendors with ambulatory, acute, and LTPAC EHR offerings ensures that the 360X functionality is not a one-off and can be implemented across the spectrum of care. The group also performs a live demo every year at the HIMSS interoperability showcase, giving us all a chance to ensure that we are meeting the specifications and that they accomplish the intended clinical goals. At the request of ONC, we are in the process of creating a report on the 360X development status for the main EHR and HIT vendors with large market share. Next slide, please.

The initial use case was the ambulatory closed loop referral. The subsequent use cases were prioritized, selected by majority vote, and then developed by the 360X group. 360X as referenced started with the ambulatory closed-loop referral use case in which a PCP is requesting a consultation with a specialist. When we started the project, I still had many physicians, specialists, and PCPs complaining that when patients arrived for a consultation at the specialty office, the specialist had no information about the patient, and then, when the patient eventually returned to the primary care physician office, the primary care physician had no information about the consultation. The ambulatory acute transfer to skilled nursing facility or rehab facility use case defines a patient referred and admitted to a skilled nursing facility either from home by an ambulatory physician, the patient's PCP, for example, or from an acute setting.

The team considered that the admission request might be to more than one skilled nursing facility, and that if more than one accepted, the patient would choose where they wanted to be admitted. The selected SNF would have to be informed of the selection and the non-selected SNFs would have to be informed that they had not been chosen. The skilled nursing facility or rehab transfer to an emergency department is a very common use case where, after arriving in the emergency department, the patient may be treated and released back to the skilled nursing facility or rehab facility where they came from, or they might be admitted to the acute facility. The emergency department needs up-to-date patient information to be able to provide care, and the sending facility needs to be kept in the loop of a patient's status after arrival.

Some considerations we had to think about were if the patient is admitted, does the skilled nursing facility hold the bed, how long is the admission, etc.? The ambulatory acute referral to emergency medical technicians for planned transport is a simple use case where a planned transport request can be made from the electronic health record and the EMT can be selected that can manage the patient's needs and most expedite the transportation. The ambulatory acute referral to home health has been a surprisingly complex and important use case, in which the 360X group was assisted by a home health subject matter expert. When the team initially considered the ambulatory or acute referral to social determinants of health services, we were reluctant to take it on, but during the COVID pandemic, it was deemed too important a use case for us not to tackle. This work continues to be in progress.

I would now like to introduce Vassil Peytchev, the lead technical advisor from Epic, who has been with the project since inception and has done the technical writing for the project, as well as steering each use case through the IHE for approval. He will present the IHE status for each of the use cases. Sorry, is Vassil with us?

Vassil Peytchev
Yes. Hello, everyone. My name is Vassil Peytchev, I am with Epic, and I have worked with implementing and designing standards for the last many years. So, I will quickly try to decipher the status of each of these specifications that Dr. Miller talked about before me. The IHE process involves multiple stages. First, there is approval of each proposal to be an IHE profile, then there is the development process, where that profile is created, after that, there is public comment, after which a profile is published for trial implementation.

After trial implementation and demonstrated real implementations in existing products, a profile then becomes final text, and I am happy to share that original 360X ambulatory closed-loop referral is in preparation to be published as final text by IHE. The ambulatory acute transfer to SNF and rehab is about to be published for trial implementation. The transfer to ED is in preparation for public review. For the rest, we have various stages of development. The SDOH services are at the final stages of clarifying some edge cases regarding social determinants of health and trying to accommodate as wide a variety of services as possible. Next slide, please.

All of these specifications are built on the same foundation. When we started our work, we looked very hard at what is available, what is upcoming, and made a decision to base the specification on the direct protocol, requiring metadata so that it can be done through an XDM or XDR transport between systems. We looked at what standard can be used to convey the workflow information, basically to make sure that the state of the referral is known to each site at all times, and at that time, HL7 Version 2 messages were well

understood and in wide use for lab orders and results, and therefore, they seemed at that time and they have proven to serve that purpose very well.

And then, for the transactions or the data exchange that requires clinical information, the availability of C-CDA documents at all types of care settings or a lot of types of care settings was a deciding factor to make sure that a well understood and available standard was used. As we gather more information about how those standards are used, we plan to look at how our medical societies can contribute and further clarify or further make more precise information that is being shared. Currently, this is done by the initiator. The provider that initiates the referral makes a decision of what type of information needs to be shared. Next slide, please.

Our specifications place certain requirements on both sides of the exchange that have to do with their system implementations. These are requirements that are really not tied to technology, so, regardless of the underlying technology, these requirements must be there to achieve closed-loop referrals. The first one is that the systems must have patient identity management capabilities and be able to manage multiple identifiers from different sources. For 360X, the referral initiator must send a patient identifier that shall be used throughout the whole exchange. This is critical to make sure that things do not fall through the cracks, that everything is routed back to the same patient's chart and to the providers that take care of that patient. Next slide, please.

At the same time, we also want to uniquely identify each referral. So, again, the referral initiator assigns a unique referral identifier, and it has to be used in any further communications regarding that referral. Having that unique identifier is invaluable when we start looking at further uses, and that is where we were able to go from the initial use case to several other use cases because this one requirement helps a lot when you may have cases where you are not quite sure whether the referral is complete, like is in the case of social determinants of health, but any communication regarding that referral can be tied into it using that referral identifier. Next slide, please. I would like to pass this on to Ben to talk about the pilot, which is a collaboration between OCHIN, MedAllies, Epic, and Netsmart. Thank you.

Ben Rosen

All right. Hey, everybody. Good morning. Thank you, Vassil and Dr. Miller, for your presentations and information. My name is Ben Rosen, I am with Netsmart, and I am going to talk to you guys here for a few minutes about the initial pilot that we have started. As Vassil mentioned, it is with Epic and OCHIN on that side, and then, Netsmart, one of our behavioral health clients, has agreed to participate as well, so we have started that pilot, and the biggest thing is the closed-loop referral use case is the end goal, and throughout this, we have some really nice pre- and post-measure key performance indicators that we are working through, so, from a metric perspective, something we will be able to measure, as we all probably can attest to, is the use of paper in referral workflows and how we are going to really explain the ROI and the timesaving process, and that is one of the bigger pieces of this pilot.

So, the healthcare organizations that are being involved with this are Multnomah County Health Department, which is out of Portland, Oregon, and the Netsmart client is Lifeworks Northwest, also out of Portland, Oregon, with some locations in Seattle as well. So, we have a planned go-live for this upcoming quarter of 2023, and then, we are currently testing through the referral workflows of accepting and rejecting notifications for when a referral is received by the behavioral health provider, as well as closing the loop,

which is what Vassil was just talking about, so, the clinical note being sent automatically after an appointment is completed, so not only will you get a notification of the appointment being complete, but also the clinical note with some progress notes and maybe some updated medications or clinical data pieces that will be sent automatically as well.

So, it is one thing to talk through the pieces here, but we are really excited to hopefully come back and maybe show you some of our results here in the next few months because that is something we have been working really hard on, and the entire group with Dr. Miller went through a lot of participants and a lot of people who are making this possible for us. So, as Brett mentioned also, I wanted to plug again the interop showcase at HIMSS. We will all be there, showcasing and demonstrating. This will be like a live demonstration of how we are doing everything, so if you are there, please stop by in the solution area. It will be great to show that. Thank you for your time today, and Brett, I will give it back to you.

Brett Andriesen
Thanks, Ben. Go to the last slide. Thanks to Ben, Vassil, and Dr. Miller for walking through all of that and for all the work that you all have done, as well as our 360X group, to date on this. In addition to any questions the committee has, we also have posed some questions to you for discussion today, including how we can grow the number of vendors that are implementing this to have more widespread adoption across the industry, how the group can expand upon the current work that has been done and add more value, and if there are additional use cases or opportunities that the 360X project should be exploring. With that, I will turn it back to Aaron and Medell.

Medell Briggs-Malonson
Thank you so much for that wonderful presentation, and, as we all know, really making sure that we have closed-loop referral systems in place are incredibly important to optimize both patient care outcomes as well as overall care coordination. And so, there were several questions that were actually within our chat, and thank you all for even answering my question about how we are going to ensure the integrity of the overall patient matching when we are doing referrals, so, thank you for answering that question, but I want to open it up for discussion from the HITAC committee, and if there are no immediate questions, we will go directly to the chat. So, the first hand that I see is Steven's hand, so, Steven, we will start with your question, and then we will circle back to the chat questions as well.

Steven Lane
I will just put voice to the question I put into the chat. I noted that there was reference to the use of the Common Clinical Data Set as the payload standard of the clinical data that will be shipped, and obviously, in most settings within HHS at least, and rules and suggestions, that has transitioned on to USCDI Version 1 at the very least. Is there any thought of updating the 360X standard so that it looks to that newer content standard?

Vassil Peytchev
I can answer that. We do not directly reference the Common Data Set, we actually reference the C-CDA specification and the associated guidance of how to use C-CDA. So, we are moving together with the use of C-CDA, and I believe at this point, there is clear guidance of how C-CDA satisfies USCDI. If that is not the case, then we should definitely update it, but the link between 360X and the actual data elements goes through the C-CDA specifications and the document types that are there.

Steven Lane
Thanks, Vassil. That makes sense.

Medell Briggs-Malonson
Thank you for that answer. Ike, you are up next.

Steven Eichner
Thank you so much for all the presentations this morning. Looking at the work going on with Epic and Netsmart, are those referrals focused on strictly behavioral healthcare, or are the referrals related to the interface between primary and behavioral health, and which way are the referrals actually flowing?

Vassil Peytchev
As far as I know, and Ben can correct me if I am wrong, the referrals are initiated by a primary care provider or possibly a specialist within the Epic system, and then they are received, accepted in the behavioral health system, and after a behavioral health visit, with the consent of the patient, the visit summary is sent back to the primary care provider.

Steven Eichner
Thank you for that. I have a couple follow-on questions.

Holly Miller
Ike, I can expand on that just a little bit. So, one of the two organizations that are engaged in the pilot is a primary care organization, the other is a behavioral health organization. One of the things that has become exceedingly clear to us as we have worked in this arena has been the fact that many patients being seen frequently in behavioral health do not have primary care or are not receiving primary care, and as a result, there is an interest in the second phase to have referrals go from the behavioral health organization to the primary care organization as well, but at this stage, it is strictly from the PCP to behavioral health.

Steven Eichner
Thank you so much for that. You answered one of my follow-ons, which was looking at exploring the other way. I have done a lot of work in the interface between behavioral health and primary healthcare over the years, including shared risk assessments and a variety of other things, and that is something that the State of Texas is most certainly interested in.

Holly Miller
Absolutely, and that is something we hear over and over. Sadly, infrequently and frequently, some behavioral health patients do not have any primary care, so we will definitely eventually be doing the referrals bidirectionally.

Steven Eichner
It is wonderful to hear that, and I guess, to the same point, making sure from a patient involvement perspective that there is also patient access to the data and referral information throughout, and if the information is not ordered over to where the patient can get it in one portal or the next, there is at least a pointer informing the patient where they can get the information.

Medell Briggs-Malonson
So, thank you for all those questions and answers. I am going to go directly to our chat. There have been several different questions that we would like to pose to the group, and so, one question I am going to combine because I think it gets at some of the same various different elements is a question of how referrals are currently handled, especially to outsource care and home providers, such as palliative care, but in addition to that, when the care providers are actually within the home, how are the current standards being looked upon right now?

Vassil Peytchev
Right now, with the home health area that is being developed, the starting point is between a healthcare organization and a home health agency. We have not discussed communications between a healthcare provider and a family person who is trained to provide the care at home. That is a very good suggestion to look into, and it is probably a natural extension of where we are right now. In terms of outsourced care, palliative care, and hospice, we have not distinguished what home health is, so, right now, they fall within that whole home health umbrella, and we have not looked into whether there are any specific requirements that may be needed for the different types of those home providers.

Medell Briggs-Malonson
Excellent, thank you for those answers. Going down the list as well, we have a question of how we let this group know we are interested in participating. Any insights on that?

Vassil Peytchev
On the slide, there is a link to a portal where you can send an email to us or sign up for a mailing list, and in the chat, Brett provided his email address, and any emails to him will be routed to us. We have calls every Friday at 10:30 Eastern Time, so anybody is welcome to join and participate.

Medell Briggs-Malonson
Great, an open invitation, everyone, so please make sure you get all the different engagement there at the call. The next question also came in of what nonclinical administrative information is transmitted, and really thinking specifically about the price transparency requirements that were mandated in 2022.

Vassil Peytchev
Great question. There is a proposal to add insurance information as part of the referral. It is not complete yet. The single most important barrier we are hitting there is the ability to describe the insurance from one organization to another. While within a state, that may be possible with some help of the state health administration, etc., once you get across states, it is really hard to identify the type of insurance, the plan, and the coverage so that that information is actually meaningful to exchange. So, we are working hard on figuring out at stages how to provide that information.

Other administrative information the crosses the boundaries between the nature of clinical is that we require that the diagnosis codes are sent, but no specific building information is sent as part of this. The other thing to understand is that for the ambulatory clinical referrals, these are focused on consultations, which means that if you refer for a specific procedure, and usually, specific procedures have a price associated with them that may vary and is important for price transparency, but for these types of exchange, other integrations

may already be taking care of that, which are order results, interfaces, and other types of integration, as opposed to referrals for consultations.

Holly Miller
Also, for referrals for consultations, we like to include the timeframe of the request. So, how urgent is the request? Is it a standard request, or is it something that needs to be seen in a shorter timeframe?

Medell Briggs-Malonson
Great. We have time for a couple additional questions, and so, these are directly from our HITAC members, and do not forget, HITAC members, that you can definitely put a voice to these questions. We want to hear all of your various different insights. This also came from Hannah. Working on social drivers of health, as we all know, is very important to providing highly comprehensive overall healthcare that leads to wellness. And so, has the team already engaged findhelp or one of the other social-driver-of-health engines in which many of our current healthcare organizations are making direct referrals to CBOs through this vendor, and a few others as well?

Holly Miller
Brett, I think you and I can take that. I will say that when Brett and I first decided to take this social determinants of health needs use case, we did talk to several of what I will call social determinants of health hub organizations, such as Aunt Bertha, to invite them to attend, and some of them took us up on it, such as Unite Us.

Brett Andriesen
Yes, we did have a number of different conversations with those groups. Some were very helpful in helping us craft what we are working on. Some are more actively participating on an ongoing basis than others, but we have had awesome conversations.

Medell Briggs-Malonson
Thank you again. The last question before we continue on is directly from Dioli. You mentioned that the original referring ND is the Epic system. In other words, what happens if they are not utilizing Epic as their EHR? For instance, Meditech is listed as a vendor. What about all of the various different independent physician groups? Are they engaged in this process?

Vassil Peytchev
As you saw with the list of participants, we have representation from Meditech, from Nextgen, from and eClinical Works. When any of those vendors turn on their implementation for 360X, they can be the originator. There is nothing special about the originator being in Epic. It is just that we managed to get our implementation done and made it part of our general releases. So, what we are talking about today is a specific pilot where the originator is in Epic and the recipient is in the Netsmart system, but there is nothing that is locking participants in any of those vendors. The whole point of 360X is that it is vendor agnostic, and the vendors all agree that it makes sense that things work exactly the same way, no matter what the system is.

Holly Miller

In addition, we also have Altera and MatrixCare, and we are excited because, as I referenced, we have several vendors, such as Netsmart and MatrixCare, that are long-term post-acute care vendors that really could enhance the ability for 360X to be working across the spectrum of care for these transfers and referrals.

Medell Briggs-Malonson
Excellent. All right, I see one additional hand, and then, because we are running ahead in terms of our agenda, we definitely have time for the HITAC to engage in the questions that you all have proposed to us, so we want to make sure to save space for that, to answer your three questions. All right, Bryant, I see your hand, and then we will go to the questions on the screen.

Bryant Thomas Karras
Holly and Vassil, extending that PointClickCare is another of the long-term care facility vendors with a substantial piece of the market, are they waiting to engage? Are they monitoring? How would you characterize their participation?

Holly Miller
I certainly would never speak for them.

Bryant Thomas Karras
Maybe the better question is you mentioned the referral organizations that were invited to participate. Were other long-term care organizations invited to participate?

Holly Miller
Brett, help me here. I believe they were, but perhaps your memory is better than mine.

Brett Andriesen
Yes. As we went through each of the different use cases and identified them, we definitely did reach out to different groups, and a number of other groups came in to participate as they heard about it. As we have worked through different use cases, we have been engaging with folks that we are aware of in the industry to make sure we get their insights there as well.

Bryant Thomas Karras
Thank you.

Medell Briggs-Malonson
Thank you, Bryant. Steven?

Steven Lane
Just another question about evolving technical standards. Obviously, this has been in flight for some time, and was built on Direct as the transport mechanism. I know that some work has been contemplated to move this to FHIR, and as we look ahead to the implementation of TEFCA push messaging, there are clearly other ways that these messages could be moved besides Direct or in addition to Direct. Can you say anything about the thinking about how this may evolve over time in terms of the transport mechanism?

Vassil Peytchev
Sure. So, the first thing to understand is that the transport is just one piece of it. We looked at it as more of a holistic problem, how we can make sure that we can specify the parts end to end. As other standards evolve, obviously, there is particular interest right now in the TEFCA push mechanism, and we will be looking at how that can be used and using the current payload for that. And then, as far as FHIR is concerned, I hate that I was a good prognosticator. In 2017, when we first presented 360X in the interoperability meeting at ONC, at that time, FHIR was in Phase 2-3, and the question came, and at that time, the whole area of ordering and managing that administrative information was in big flux, Resource was renaming, etc., so at that time, I said that in the next five years, things would be settled and FHIR would be a viable alternative.

Well, last year, five years later, finally, one of the workgroups in FHIR started a project, which is called Clinical Orders Workflow on FHIR, COW on FHIR, or, as somebody else pointed out, steak. There are activities in flight, and Hans really hates the name "COW on FHIR," but not the project. This is where we are. There are 17 different ways in FHIR that you can manage workflow, and until we have guidance and a more stable path to manage the referrals workflow, we will have to work with what is currently available in different systems. Obviously, if there are 17 different ways you can manage this, it is not maintainable to require every system to manage all 17 ways of doing it. So, this is where we are. As FHIR matures, and it will mature, especially after the R5 release, I suspect that now we are not five years out. Probably, in three years, we will have a definitive path forward.

Medell Briggs-Malonson
Excellent, thank you. Hans, you have your hand up.

Hans Buitendijk
Thank you. If I may add to what Vassil mentioned, particularly the effort on what is happening in FHIR and the consistency that is being pursued right now to ensure that what is done in 360X in terms of content, what is done in FHIR in terms of content, that there is alignment. There have been a fair number of discussions already started over the last couple of months to work on that. A number of the people on the call here are involved in that to really ensure that regardless of the underlying technology or methods being used, the data that is going to be in play can be consistently expressed so that you can effectively go back and forth as needed, so there is a fair amount of effort going on. It is a standard activity, so that takes some time, but there is a good focus on that, and I am talking about that with the head of one of the parties in HL7 that is involved in that, trying to see what we can do there.

Medell Briggs-Malonson
Thank you, Hans. I really appreciate some of those additional insights. Alexis?

Alexis Snyder
I just had a couple of thoughts and comments related to the discussion questions that are posted, and I just wanted to mention, in terms of thinking about the second one for how we add more value for the industry, to really also reflect and think how we add more value for the end users, the patients, caregivers, and families, because a poor transition and a poor referral really create a lot of stress, a lot of anxiety, and a lot of extra work on the patient and family or caregiver, and also, as we all unfortunately know, it causes mistakes and medical errors and really can weigh in on patient safety and poor outcomes.

So, just mentioning all that, I wanted to make sure we do not lose sight of that, and my recommendation, for whatever it is worth, is to expand those use cases to explore patient voice in using use case stories where things went well because they were helped with this closed-loop referral system and find those stories that worked well, and also presenting, when you are disseminating to vendors how to implement this for greater adoption, those use stories as well as use stories where things do not go well because there is no closed-loop communication. So, I think as much as you can involve patient and caregiver voice in the process, it would be helpful for dissemination and greater adoption.

Holly Miller
Thank you. Excellent points.

Medell Briggs-Malonson
Alexis, I appreciate you bringing up those points, and thank you for officially transitioning us also to answer these three questions. I want to amplify what you just mentioned about the involvement in centering the voices of the patients and their caregivers, as well as our direct frontline providers, in every single way, and what I would like to also do is talk about transparency. So, one of the challenges that we see so often when we are doing referrals for patients is that patients have no clue where the process is. So, because of that, as you mentioned as well, Alexis, we can actually have additional errors as well as delay of care.

So, what I would also recommend is making sure that there is that transparency for patients, their caregivers, and families, as well as for their primary teams, because sometimes this may not be going from their primary teams in terms of the referrals to others so that there is appropriate tracking of where these referrals are in the process. I personally have had to deal with this numerous, countless times in my field and over my professional work overseeing this. The second thing I would like to add, too, and then I would love to hear more thoughts and comments from HITAC, is in terms of additional use cases for opportunities for the 360X. To the team, it seems like we are focused a lot on referrals, whether it is to specialty care, to a lower level of care, or, of course, transitioning to home.

I would also state that there is an opportunity for referrals for higher levels of care. For instance, when we are thinking about some of our critical access hospitals or we are thinking about some of our other areas in which you have to refer somebody in for tertiary or quaternary care, that may be another opportunity. Yes, there are transfer processes for those, but having that direct referral may also help a large amount in terms of efficiency, so that may be an additional use case.

And then, absolutely, making sure that there is very strong bidirectional referrals for social drivers of health in terms of our community-based organization, our social service agencies, and public health organizations with our healthcare providers as well because we will not really get to where we need to get to in terms of equitable and just care and overall outcomes without having that bidirectional, very tight, closed-loop referral cases. So, those are just a couple of thoughts there as well. Any other questions or thoughts from the HITAC committee? So, there are three questions here. How can we grow the number of vendors implementing this for greater adoption, how can the group expand upon current work to add more value for industry, and are there additional use cases or opportunities that 360X project should be exploring?

Rajesh Godavarthi

Hello, this is Raj. Dr. Holly and team, you have done tremendous work. I have seen it in the last two teams as well. You guys do a pretty good job demoing the value. One thing I am exploring is that we have been working with the home health EMR in terms of capturing all the clinical documentation and sharing with other entities. I think we have an opportunity, probably, to bring that vendor to the mix and see they do have a good market share in the home health space, and probably use them as one of the vendors to adopt this because this seems to be very important for the future of healthcare, where everything seems to be home health. So, thank you very much for all the work you are doing. I will definitely introduce the team to you guys.

Holly Miller
Raj, that would be just terrific. We would love to have them join and participate.

Rajesh Godavarthi
You guys work with WellSky as well. I saw Kno2 is one of the vendors. Is WellSky in the mix?

Holly Miller
Not at present.

Rajesh Godavarthi
Okay. Those are the two ones we can probably have conversations with. Thank you.

Holly Miller
Terrific.

Medell Briggs-Malonson
Thank you, Raj. Any other comments from the HITAC? Bryant?

Bryant Thomas Karras
Just following up on my previous probe, in terms of greater adoption, I think extending to have that FHIR use case completely fleshed out so that it would be interoperable with the direction that vendors are working towards would increase its utilization. In Washington state, direct messaging was evaluated and deemed not really great for these kinds of bidirectional exchanges, so I think getting to FHIR would be a fabulous priority for you all. In terms of additional use cases, you mentioned behavioral health and referrals into counseling treatment, and I think finding bed availability in treatment programs is a use case that would be really timely and well needed across the whole country. Keep up the good work.

Medell Briggs-Malonson
Great, thank you. All right, I am giving the committee a few more seconds and then we are going to transition, but there is one comment that was here. How do practitioners know the actual services side is accredited or has experience to provide that care? So, in other words, is there any way to vet any of the services that referrals are going to in terms of the organizations?

Holly Miller
I certainly think that is critically important, but I think most organizations and most practitioners know the clinicians and the organizations that they do refer patients to, and that is really out of the scope of 360X.

Medell Briggs-Malonson
Thank you for that. Any other comments or questions for the 360X team? Excellent. Well, we once again thank you for this wonderful presentation as well as the engaged discussion, and we look forward to the continued development of this amazing and very important work, so thank you again for coming. All right, we are a little early in our agenda, but that is okay. As we mentioned at the very top of the meeting, this is going to be a highly concise and very impactful meeting. So, the next person we would like to bring on up to our virtual stage is John Rancourt, and he is actually going to provide us an update on TEFCA. John, I will turn it on over to you.

TEFCA Update (01:06:52)

John Rancourt
Thank you so much, and thank you to everyone on the HITAC. My name is John Rancourt. I am the Director of the Interoperability Division in the Office of Policy at ONC, and I will be giving an update today on TEFCA, the most recent activities, and looking ahead. Next slide, please. This is what we will cover today, starting with, as Steve mentioned at the top of the call, the secretarial recognition event on February 13th. I will talk a bit about our timelines and then focus in on a couple of the activities that are going on, and also our work with CMS. Next slide, please.

So, I am going to do my best to channel Micky and the comments that he made throughout the day on February 13th. That day really marked an important milestone in the implementation of the 21st Century CURES Act, and a historic day in health information interoperability as a whole. On that day, Micky talked about the history of what brought us to this point, starting with ONC's founding in 2004 and all the work on the Nationwide Health Information Network, the HITECH Act, and how it resulted in widespread adoption of electronic health information records and technology, and the initial progress that the country had seen on interoperability, but also, he talked about the recognition of the gaps that exist in interoperability, which this committee knows of so well, but maybe folks of the public are not aware of, starting with providers, where we have nearly 30% of hospitals not connected to a nationwide network, issues with ambulatory providers not having the interoperability that they need, public health gaps, not being able to have our public health agencies connect into the nation's healthcare data ecosystem to satisfy and support their public health goals, but also, payer participation in these nationwide networks, these clinical data networks, is a gap as well.

Lastly, Micky talked about how patients easily getting access to their records is also a gap, and really, he then talked about the 21st Century CURES Act, which called on ONC to develop a model for networks' connectivity, and that is the Trusted Exchange Framework and Common Agreement, or TEFCA, which is the acronym we use. TEFCA creates those baseline legal, technical, and policy requirements to connect those health data sharing networks to one another with strong privacy and security, so we can get to that place where we have seamless exchange among providers regardless of the system that they are on, similar to how if you are on one cellular provider, you are able to easily call your friends or anybody else on a different cellular provider with your cell phone, or ATMs, which all interoperate with one another.

So, it was a year ago that ONC published the common agreements, but the February 13th event was the recognition of the first six candidate qualified health information networks that have been accepted for onboarding to TEFCA. As you can see in the picture here, we had a packed house at the HHS Great Hall,

over 200 people there, thousands watching online, and a strong demonstration of support across the federal government for TEFCA. I want to summarize some of the comments that were made from our various leaders that spoke, starting with Secretary Becerra, who said that each and every one of us recognizes that this is one of the many long-term ways that we are going to bring down the cost of healthcare. He also talked about this is going to benefit patients, support providers, and be good for healthcare companies, but most importantly, for everyone who has some connection to the healthcare system for health and safety, this is going to take us to the next level.

We heard from Dr. Prabhakar, the Director of the White House Office of Science and Technology Policy and the President's science advisor, who spoke about the possibilities created by TEFCA, including for improving health outcomes across the country and for the long-term goals associated with research, and we have been working with OSTP on that. Next, we heard from CMS Principal Deputy Administrator and COO Jon Blum, who pledged to work with ONC hand in hand and pledged to use CMS tools to help support TEFCA. CDC Director Dr. Walensky spoke about those public health gaps and said that we have to have a nationwide approach to public health interoperability. Lastly, we heard from Veterans Administration Undersecretary for Health Dr. Elnahal, who spoke to the potential of TEFCA to improve care for veterans and improve the VA's ability to access data in support of our public health mission, and we also were able to unveil a new TEFCA logo, which was on the last slide. Go to the next slide, please.

It was at this event that the secretary publicly recognized these six organizations, Kno2, Epic, Health Gorilla, KONZA, eHealth Exchange, and CommonWell. We want to thank these organizations for stepping up, for committing the time, people, and financial resources to become qualified health information networks. I want to take a moment just to repeat what the secretary said and what Micky said, which was a huge thanks to the recognized coordinating entity. You see Mariann Yeager, who has presented to this committee numerous times in the past, our partner in our cooperative agreement work together. She and her team are tremendous partners, and we are so thankful for all the work they do, but also, I want to reiterate Micky and the secretary's thanks to ONC staff, ONC leadership, all of our federal partners, and also to the HITAC for all the work that you have done to help us get to this point.

These six organizations held a panel discussion where they talked about the opportunity of TEFCA, and at the event, the representatives from these organizations agreed to a go-live timeframe of the end of 2023, beating the 12-month requirement that is set by TEFCA by nearly two months, so we are so appreciative of that. I do want to take just a second to be really clear that there are no designated QHINs at this point. These folks have been accepted for the onboarding process, but there is a process that remains for them to go through in order to be designated. They have to do extensive testing and do peer testing with one another.

There is no guarantee that any of them will be designated as QHINs, and there will be no first QHIN, but there will be an initial group, a minimum of three that would be designated at the same time. Next slide, please. This is a good segue to share that the application process is still open and applications are being accepted, and others are going through that process, submitting letters of intent. We are so encouraging and want to continue to allow for others to meet the requirements to become candidates that then could potentially go through the onboarding process and potentially become qualified health information networks. Next slide, please.

We did have, again, as I mentioned on the right, thousands viewing. We have had 14,000 views of the recording. Hundreds have read the blog post that was released. We had 16 members of the media in attendance, both virtually and in person, resulting in more than two dozen pieces of media coverage, so we are really glad to have had that level of engagement with the press and the public about the event. Next slide, please.

So, the timeline here does not cover all of that history that Micky talked about and I mentioned up until 2021, but just to recap, there has been extensive public engagement, there will be ongoing, continued public engagement, and in the last year, there really has been an enormous amount of work and whirlwind for folks to be engaged and so much stuff going on, whether that is from the publishing of the common agreement, like I mentioned, the publishing of SOP, or seeking feedback on that and starting work on the TEFCA FHIR roadmap. So, that is the goal that has been laid out. There will be a process to move towards that, and that is where we are right now. If you look at the purple section there, the bottom right list of bullets, that is where we are and where the RCE is with the process of starting that onboarding work, accepting additional applications, doing the work related to FHIR, payment, healthcare operations SOP, and public health, which I am going to go a little bit deeper into in the next slide, so why don't we go to the next slide to talk a little bit more about that?

So, "public health exchange purpose implementation SOP" is kind of a mouthful, but let me explain just to level set, again, with everyone. Public health is one of the six authorized exchange purposes under the current state of TEFCA, and that means that if entities have signed on and are onboarding, connected, and sharing with each other, they optionally can use that as an exchange purpose under TEFCA, but it is not necessarily going to result in the level of exchange that we want to see because all of the detailed specifics of what would be involved in that exchange purpose have not been fleshed out. That is what this implementation SOP will do to identify those policy specific to be able to move toward requiring response under TEFCA for the exchange purposes, like public health.

And so, to get this underway, we have been engaging with our public health partners, state, local, territorial, and tribal entities, seeking deep engagement in the work, really on two fronts. This is my first call to action, which is for any STLTs that are watching or hearing this later, we do want you to be engaged, and we would love for you to be engaged as potentially one of those early TEFCA adopters, and for doing that, please do reach out to Grace, our contact at CDC, but also, we would like you to be involved in this cohort of folks that are engaged on the SOP development itself, and for that, we ask you to reach out to Lisa and Debbie from the Sequoia Project, our CE team that are leading that work.

This has been already initiated with the RCE, having three public health partner meetings, including one last month where the RCE was reviewing the most recent version of a scoping document that includes feedback that has been received and suggested edits from public health partners. It has been really great engagement, but I do want to say we want all public health entities to be engaged and understand what they could be doing right now, which includes reviewing the common agreement, identifying your requirements, considering what your current infrastructure is and could be, and understanding the qualified health information networks. Go ahead and call them up if you can. I should be clear that you can call up and start engaging with the candidate qualified health information networks. Lastly, please join the RCE in their calls. We really want to get this right. We want to hear as much feedback as possible. Next slide, please.

So, on that slide, there is a lot of work going on that is looking forward, including work to update the common agreement to Version 2. This is going to be needed for some clarifications and minor changes, but most importantly for changes that are going to be needed to accommodate FHIR in the future. So, the RCE started work on that and we are working on that with them. It is going to be a decent amount of work. Stay tuned for more on that. The next bullet talks a bit more about that healthcare payment operations implementation SOP work. Last year, the RCE completed robust stakeholder engagement on this, and they plan to release drafts of those documents very soon, with the plan to release the final version of those this year.

The additional security requirements for QHINs, participants, and subparticipants have been released as a draft SOP. The RCE got a lot of feedback and is working through that to better understand it. Lastly on this slide is the work on FHIR to move towards that FHIR future. There is work going on right now at the IHE Projectathon in Austin. We have folks there working on the TEFCA IG, and specifically, the RCE had released a second draft of that IG. It is available, and really, the team has been working with these industry partners like IHE and HL7 in order to find the best way to bring folks together and really identify where the gaps are and what needs to be done, but bringing in those candidate QHINs, potential participants in TEFCA, and IAS server providers and payers… Again, we really want to make sure this works, so the team is engaging across the board.

Lastly, in May, the RCE is expecting additional specific use cases that are detailed out by then for testing, so the RCE then plans to update the FHIR IG under TEFCA as needed, publishing final versions and doing that in concert with the work to update the policy components there. That is very exciting work there. We really appreciate everyone's participation. Next slide. This is the last slide. We do continue our engagement with CMS on TEFCA. As I mentioned, Jon Blum pledged to use CMS's tools to support TEFCA. That is already happening. As an example, the CMS interoperability rule, the advancing interoperability and prior authorization processes proposed rule, included a request for information about TEFCA, and so, the comment period is open on that, but only for a few more days, until March 13th, so we really want to encourage people to provide comments on all the questions that are in there, and we want to hear all feedback. Please comment even supportive comments. We love to hear all of that and make sure that we do get this right.

I want to mention, just as a reminder, that TEFCA was included last year as an optional measure in the Promoting Interoperability program, the IPPS and patient prospective payment system final rule, and the physician fee schedule. These were summarized in a blog post. We encourage folks to read that. Also, we have been working with the CMS folks on the healthcare directories work, including the RFI they put on that. So, stay tuned. There is more to come, we are so excited, and again, thank you all for all you have done. Next slide. Let's go to questions.

Aaron Miri
All right. Thank you, John. Great presentation there, and great session and update for all of us, so, thank you for that. All right, HITAC members, if you have questions, please get those hands up and let's talk through it. What are you curious about? All right, we have a hand raised by Deven McGraw.

Deven McGraw

Thanks, Aaron. I took my camera off because I was not sure if I had gotten onto the top or not. So, thanks for that great presentation, John. That was a really tremendous day to be there in person, to see so many folks, and to be celebrating this milestone, and it is exciting that there is a commitment from these early QHINs to be live and in production by the end of this calendar year. For which use cases will they be required to be live and in production? There are a number in the common agreement that identified treatment and response to individual access requests as mandatory, but I know from some other discussions that the individual access use case is one with a lot of components to it that make folks nervous and that we are still trying to nail down.

So, I just wanted to get some feedback from you about what use cases should be live with these initial QHINs by the end of the year, if not more QHINs that come on board. And then, what could possibly be the role of this committee? I know there is an entire infrastructure associated with the recognized coordinating entity, RCE, regarding committees, public input, and things of that nature, but it feels like this committee could provide some valuable input to ONC around some of that, and so, I am just curious about your perspective on that as well. Thank you.

John Rancourt
Great, thanks, Deven. Let me start with the first question. You mentioned use cases, and TEFCA does not talk about use cases. It does talk about exchange purposes, and potentially infinite use cases could fit into those different exchange purposes, but they are very specific categories, including… Well, why don't I just state all six of them? So, there are treatment, payment, and healthcare operations all using the definition of those terms from HIPPA, then there are individual access services, public health, and government benefits determination. The way the common agreement works is that those are the six exchange purposes, and how folks are required to implement them is then specified in corresponding SOPs that are referred to in the common agreement, and it kind of starts with the exchange purposes SOP. If we go to the RCE's website, which we can put in the chat here, they have all the SOPs listed out there. That SOP defines which of the exchange purposes are authorized, which are all of them, and then, which ones require responses.

So, if you make a query to an entity, when are you required to respond? The two exchange purposes that initially are requiring responses are treatment and individual access services, and those require responses per the requirements spelled out in the implementation SOPs for those particular exchange purposes. There is not one for treatment, but for individual access services, the RCE has published an SOP on the implementation of that SOP, which does spell out, like you were hinting at there, some of the nitty-gritties where folks are very much needing to focus to make sure they understand what the obligation is, and really, what they can do to work within those.

And so, that is the approach that the common agreement takes to exchange purposes and what would be required. As I mentioned, we and the RCE are working together on the payment and healthcare operations SOP and the public health one, so stay tuned. We are looking to get those out and to get more comments so we can hear feedback. To your second question, Deven, we would love to get feedback from you, from the committee, and from the public in any way possible. Let us know. I am not sure exactly what the plans are for engaging with the HITAC specifically, but I am sure we will be coming back for more presentations and keeping you guys all updated, and we love having this type of dialogue and being able to answer your questions.

Deven McGraw
Thank you, John. I appreciate it.

Aaron Miri
Good question, Deven. Next up is Sheryl Turney.

Sheryl Turney
Thank you. Great presentation, John. I really appreciated the update, and I was on the phone for the event as I was not able to get there in person, but it did sound quite exciting. So, I have a couple of points that I want to share. Early on, I signed up for all of the updates from the RCE and Sequoia, so I am kind of surprised to see the request that you presented in terms of public health input because I have seen nothing from them on that, so I would recommend that for anyone who has signed up or is interested in information that the RCE at least reach out to that stakeholder group and ask those people to participate because we actually have found the same thing with the work that I am doing with FAST, and we are working more closely now with the RCE, and I think that is definitely helping, but the other thing is that as comments are presented for the different documents, like the common agreement and the SOPs, and I know I have shared this in the FAST forum with the RCE as well, not a lot of time is provided for feedback, so that is a challenge for all of us, but regardless of that, unlike what happens in Da Vinci, HL7, or any of those forums, we really do not get to see what the discussion was or what comments other people made.

I would heartily recommend that they post the comments that people have provided and at least have some response or discussion on why those comments either did not make it into the revisions or something because right now, what we get is basically nothing, so it is hard to understand how those comments were actually processed as part of the revision. Those are my two suggestions.

John Rancourt
Thanks, Sheryl. Let me take those two in order there. So, I think that is great feedback on the use of other channels to reach out to folks. Sometimes there are things that get shared in one forum, and maybe using the email blast forum from the RCE. Sometimes, people might not want all the additional emails because they come at least once a week, it seems, but I think that is good feedback, and I will pass that along. As far as the question about the comments goes, all the comments on the SOPs and all of the work of the RCE are published on the RCE's website. I am happy to share with you the links on those, so I want to make that clear. Also, to your point as far as how the feedback is processed and what the thinking is behind the approach taken to those, that has been shared via webinars and through the RCE's monthly calls, so I do encourage you and others to sign up and participate in that way. Sheryl, we have had call with you and others, and we want to do calls with groups to help them understand, really, what the approach is and why so that everybody is very clear on the goals, the reasoning, etc.

Aaron Miri
Good points. Thank you, John, for that, and thank you, Sheryl. Good questions there. Ike, you are up.

Steven Eichner
Thank you. John, thank you so much for your presentation today. From a public health perspective, public health has been working with the RCE pretty intensely over the last few weeks, working on the SOPs, which is great. In some ways, public health is a different kind of component because there are two aspects to

public health. There are public health functions, but there are also public health entities, so looking at teasing out those two different aspects of public health is really important. Many of those are hybrid entities sometimes really engaged in public health services, sometimes engaged as service providers, performing things like immunization patient care for specific diseases and the like.

I think as we are looking at the evolution and adoption of TEFCA, some of the challenges that we still need to figure out how to address from a public health perspective or from a public health agency perspective are looking at how connectivity actually works for public health and how we operationalize and fund this connectivity. Public health has been underfunded for a number of years. There has been significant improvement over the last couple of years, where we have begun to catch up, but looking at transitioning to use TEFCA as a different framework does present some challenges, and for public health in particular, we are very interested in ensuring that we have good communication with all healthcare providers that are out there, not exclusively the ones that are connected to TEFCA.

Obviously, we expect there to be increasing connectivity to TEFCA, but we need to figure out how we look at that transition phase so that we are connecting exclusively through TEFCA. We still need data from those entities that are not connected, so we need to figure out how we do that transition in an effective way. I think another piece that we need to look at as well is looking at governance, and as the SOPs are coming out, we need to look at the TEFCA governance model to make sure that there is good representation through the process in the different venues that also respect the sovereign rights of states and other jurisdictions that are, again, a little bit different, and making sure we revisit TEFCA to ensure that those rights are observed and fit into the model.

John Rancourt
Steven, thank you. Let me start by thanking you for all the participation you have contributed to date. Really, it has been very valuable to hear all the points that you have been sharing and the contributions there. I think I am going to work backwards on a couple of the points that you brought up and make sure that everybody is very clear on a couple points. So, as far as respecting the sovereign role of states, the common agreement is very clear. It operates within applicable law. The CURES Act did not give us authority to preempt state law, so there is no component of TEFCA that would do that type of preemption, and instead, it is a matter of working within state law requirements.

Really, just to respond generally on a couple of the thoughts there, TEFCA needs to provide a value proposition for public health, and we think it does. We think there are numerous potential opportunities, and maybe it is starting with the basic stuff of reporting to public health via push, which TEFCA does enable. I see Bryant's picture there. I was meeting with Chris Baumgartner from your team, Bryant, this past week just to talk about those initial types of use cases and how that is a way for public health to start to be involved, or even start to be involved for just getting contact information for individuals so that if there is a use case that is being employed by public health, and they have infrastructure set up that can leverage TEFCA to augment that, that is another idea. So, we are working through all of these topics with regard to what the SOP is and how implementation guides are directly related to the public health SOP. That is really what this workgroup has been engaged in, and again, it has just been such a pleasure to have the engagement from you all in these different ways.

Aaron Miri

Great points. Any other questions from HITAC members? All right, Bryant, you are up.

Bryant Thomas Karras
John, thanks so much. Chris was live texting with me as he was chatting and sending me updates from the conference that you were at yesterday. First of all, I agree with Steve. This is a really exciting opportunity for public health. Our state, Texas, and six other states are engaged with Sequoia in developing those standard operating procedures, but as I think Steve hinted at or pointed out and as you said, the rules of engagement and the rules of the road do not supersede applicable local laws and statutes.

I think there is going to be a continued process to make sure that this works smoothly across all of our jurisdictions, and that does not even tackle the sovereign rights of the tribes and territories that oftentimes have been even less invested in in terms of their infrastructure and capabilities, so I think there is a tremendous need to raise all ships with the tide so that we are all able to take advantage of this fabulous resource. I will start by encouraging that if we had had TEFCA in place before the pandemic, I think our ability from public health to respond, engage, and control of the spread of COVID-19 could have been very different. So, we need to have this in place before the next time. That is going to take investment, engagement, and attention to the details, as well as investment and attention to the infrastructure. We are getting the down payment of that infrastructure. Could you comment on how we are going to keep this momentum going as memory of COVID-19 fades?

John Rancourt
Just recognizing the time, I will keep it brief to say that this is a priority of the department, as you saw. You heard comments, including from Secretary Walensky, to advance interoperability for public health. I think there is even more that we could talk about, and I would love to follow up with you, Bryant, but I just wanted to say that and also quickly get in a huge thank you, again, to HITAC for the opportunity today and for all the work that you do.

Aaron Miri
Absolutely. Thank you, John. Thank you all for the questions. All right, to keep the time, let's keep going here again into the next one. John, thanks again for the presentation. Up next, Mr. Mark Knee for social determinants of health.

Michael Berry
You are muted, Mark.

Mark Knee
Can you hear me now?

Aaron Miri
We can.

Social Determinants of Health (SDOH) Information Exchange Toolkit & Learning Forum (01:42:20)

Mark Knee

All right. Hi, Aaron, how are you? Thanks, everyone, for having us here, and I am happy to talk about SDOH today. As you can see on the screen here, I am going to focus the conversation first… Well, actually, if you go to the next slide, I will go to the agenda. So, I am going to give you an overview of the SDOH work and how ONC is thinking about SDOH, and then we will move on to talking about the exchange toolkit that we recently put out and were really excited about, and then I will talk about the learning forum series, of which we had Phase 1 already, which took place last year, and now we are underway in Phase 2, which, again, is really exciting for our office, and then we will leave some time at the end for questions. Next slide, and then the next slide after that.

So, here you can see why SDOH is important, and I want to emphasize that ONC views SDOH information exchange as extremely important. Healthy People 2030 set data-driven national objectives to improve health and wellbeing over the next decade and was released by HHS in 2020, and one of the Healthy People 2030's five overarching goals was specifically related to SDOH, which emphasizes how important it really is to create social, physical, and economic environments that promote attaining the full potential for health and wellbeing for all.

As you can see on the screen, we are looking to improve care for the entire patient and looking at all the different ways that their health can be affected. There is a growing awareness that SDOH information improves the whole-person care and lowers cost, and unmet social needs negatively impact health outcomes. You can see a couple examples here on the screen, with food insecurity correlating to higher levels of diabetes, hypertension, and heart failure, housing instability factoring into lower treatment adherence, and transportation barriers resulting in missed appointments, delayed care, and lower medication compliance. Next slide, please.

All right. So, now I am going to explain how SDOH and health equity weave into the bigger picture of ONC's work, and again, I want to emphasize that SDOH is so, so important, and that is why we are pushing the toolkit as well as the learning forums. SDOH data refers to the conditions and environments where people are born, live, learn, play, worship, and age that affect a wide range of health functioning and quality-of-life outcomes and risks. Central to addressing these health inequities and social determinants of health is data, and ONC is huge on data exchange, including data collection, documentation, reporting, and access, and ONC coordinates nationwide efforts on health information technology and the electronic exchange of health information. This administration in particular is pursuing a comprehensive approach to advancing health equity to create opportunities for the improvement of communities that have been historically underserved, providing everyone with the opportunity to reach their full potential.

Advancing the use and interoperability of SDOH data is really a priority to ONC, as I have already emphasized, consistent with the mission to improve the health and wellbeing of all individuals and communities using health information that is electronically accessible where and when it matters most. SDOH data can be used to help identify and eliminate health disparities and to improve health outcomes at an individual and population level, and as examples, these efforts support social care referrals, improved healthcare delivery, person-centered decision making, research population improvements, and public health, and the list goes on and on, but there are gaps.

As John talked about with TEFCA, we want to be realistic here, and there are gaps in available standardized SDOH data that make it difficult to leverage available technology to collect, share, and use it for individual

and community health. We recognize the further potential of data-driven technologies to impact health equity and take an equity-by-design approach to our work, which we think is really, really important, advancing the use of interoperable standardized data to represent social determinants of health.

I do want to point out one other important point before I move on, and that is that I want to highlight that while we are emphasizing the significant value of exchanging and using SDOH information, we also want to highlight that this SDOH information can be misused for purposes that are not intended by those sharing the information, and with that understanding, I want to emphasize that as we advance the exchange of SDOH information, we all need to be very cognizant of this potential misuse and work to ensure that appropriate guardrails are in place to make sure SDOH is being used to help patients and not to the detriment of patients, obviously. Next slide, please.

All right. So, here is a nice graphic representation of HHS's SDOH action plan. ONC's work as relates to SDOH and health equity aligns with the 2020-2025 Federal Health IT Strategic Plan. The aim of the plan is to outline concrete steps that federal partners can take to improve health through health IT, informed largely by the public input and comments, and here, you can see that Goal 1 is to build a robust and interconnected data infrastructure to support care coordination and evidence-based policymaking, Goal 2 is to improve access to and affordability of equitably delivered healthcare services and support partnerships between healthcare and human service providers, as well as build connections with community partners to address social needs, and Goal 3 is to adopt whole-of-government approaches, support public-private partnerships, and leverage community engagement to address SDOH and enhance population health and wellbeing. Next slide, please.

So, ONC has an approach to advance health IT across the care continuum that includes SDOH data to promote health equity. We execute our work in many different ways, and I will just list off a few of them. We leverage the Health IT Advisory Committee right here, the federal coordination and Federal Health IT Strategic Plan, which I mentioned, health IT standards dissemination and collaborative development, implementing the ONC health IT certification program, which includes social, psychological, and behavioral criteria, identifying SDOH data interoperability challenges and data gaps for creating health IT tools and approaches, collaborative learning workshops and stakeholder engagement, which I am going to talk more about, and the learning forum is one of those types of opportunities, collaborating on specific agency initiatives and programs, and focusing on four health IT areas, which you can see on the screen here, standards and data, policy, infrastructure, and implementation.

Quickly, on those, for infrastructure, ONC works with federal partners, states, and the health IT community on SDOH interoperability initiatives. Related to standards and data, ONC supports the development of SDOH data and exchange standards, including the incorporation of SDOH into USCDI. For policy, social determinants of health were included in the strategic plan that I mentioned, and SDOH standards are incorporated into HHS regulations. Lastly, with implementation, we have developed the toolkit, which I will talk more about, and the learning forum series, which we have heard has been very valuable so far and will hopefully continue to be valuable to different interested parties. Next slide, please.

All right, So, let's talk a little bit about the SDOH information exchange toolkit. This was developed by ONC with the support of our contractor, EMI Advisors, and the panel of technical experts. I am not sure, but it is possible some of you may have been on the technical expert panel, and that panel was essential to the

development of the toolkit. In response to emerging and evolving environments in this SDOH space, the technical expert panel on SDOH information exchange was convened by EMI Advisors in 2021 to inform the creation of the toolkit. Participants included 12 federal participants and nine non-federal participants with experience and knowledge in areas that are relevant to SDOH information exchange. They met monthly from March 2021 to August 2021 to complete an environmental scan to inform the SDOH toolkit, and the discussions were very collaborative and engaging, and the technical expert panel members shared really valuable perspectives from the field, as well as informational resources for the environmental scan, and these, in turn, informed the foundational elements which are central to the toolkit.

So, here on the slide, you can essentially see what the elements of the toolkit are. It provides information on the SDOH information exchange landscape to stakeholders of all experience levels, it identifies approaches to advance SDOH information exchange, as well as focusing on these foundational elements, which I will talk about, it provides examples of common challenges and promising approaches, and also shares questions and resources to support implementers at whatever stage they are at, whether they are in the beginning, starting to think through what it might look like to have SDOH information exchange, or if they are further along in the process and trying to figure out how to implement certain pieces of the exchange. Next slide, please.

All right. Now, let's talk a little bit about the purpose of the toolkit. The toolkit is intended to be a practical guide that enables implementers of SDOH information exchange to learn more about the current landscape and identify key considerations and approaches to advance their goals, and as I said, it focuses on these foundational elements for planning, implementing, and evaluating SDOH information exchange initiatives. Based on our interactions with the community involved in SDOH information exchange and the learning forums, wee think it will be helpful for a broad group of interested parties, and that includes these organizations listed here on the screen, and there could be more as well, obviously. This is not an exhaustive list. Next slide, please.

Here is a graphic depiction of the foundational elements that I will discuss in more detail. As you can see, the framework starts with consideration of the mission, purpose, values, and principles of the effort, and this can vary based on the community, obviously, what the initiative is, and what the goals and purposes of that initiative are. Then it builds up to community readiness and stewardship on to the overarching considerations, including policy, legal measurement, and financing, and then on to the specifics of implementation, technical infrastructure, and user support and learning network. So, the governance here on the screen is very key, and as you can see with this yellow box we have here, it is a foundational element that intersects with all of those levels.

It is a consideration woven into all of the other foundational elements, and that was the topic of the first learning forum that we just had for Phase 2. The toolkit contains the following information for each foundational element. There is the overview, challenges, opportunities, spotlights, which is really important to see how entities on the ground are doing great things and great work, and we want to make sure that we highlight those initiatives and also bring them in. We try to bring these speakers into the forum series to let them talk about what successes they have had, what challenges they have faced, and how they got past them. There are also guiding questions and resources. We believe that including these components will provide readers with the structure and the foundation to guide their work on SDOH, like I said, wherever they are in the process. Next slide, please.

All right. So, here are the first five foundational elements. The first one is mission and purpose. The stated purpose of an SDOH information exchange initiative should address the various value propositions held by interested parties, as well as the vision, scope of service, and expected benefits for collecting, sharing, and using the data. The next foundational element is community readiness and stewardship. Community readiness is a reflection of the existing landscape of needs, assets, initiatives, and challenges in the geographic area and/or population of focus. Community stewardship entails the development of stakeholders' shared rights and responsibilities in the process of codesign, evaluation, and decision making.

Next is the values and principles foundational element, which helps to establish a framework for ethical decision making in pursuit of health equity. Next is the financing foundational element, which encompasses startup investments and ongoing costs, and then we have implementation services, and these include technical implementation services. Some examples, as you can see on the screen, are defining requirements, standards specifications integration with existing infrastructure and services, and programmatic implementation services. Next slide, please.

All right, here are the last six foundational elements. We have technical infrastructure, which focuses on IT systems and includes the alignment of hardware, software, data, processes, and standards to enable scalable and interoperable data and IT systems. You have legal, which is near and dear to my heart as a lawyer, which includes activities to establish the framework of business operations and rights and obligations related to data sharing. Next, we have the policy foundational element, which includes use of federal, state, and local policy levers to advance the ability to collect, share, and use standardized SDOH data as well as collection and alignment with other relevant efforts in the community, region, and/or state for collective impact and improved outcomes.

Next, we have measurement, which includes the activities of monitoring and evaluation of performance metrics, including individual and population outcomes, program effectiveness, and quality management and improvement, and using different types of data, interested parties can ensure that you are looking at process, utilization, quality, and financial measurement. Next, we have user support and learning network, which includes education, communication, training, peer-to-peer learning, identification of best practices, etc., and last, we have governance, which I talked a little bit about. Next slide, please. All right, next slide again.

Now I am going to talk quickly. I know we want to leave time for comments about the webinar series. Like I said, we have had a really successful Phase 1 of the webinar series. We had five public sessions, as you can see here, and they are all publicly available, so if you would like to see them if you did not catch them the first time, please do so. They were held between March and July of 2022. There were over 2,400 live attendees as of last time I checked, and 800-plus views of the recordings, so there was really a ton of interest, which we love. And then, with Phase 2, we kicked it off on February 23rd with a session focused on community-level governance, and we had great participation there, over 350 total users and 290-plus unique views. Next slide, please.

Real quickly, just to close the loop on this, I will highlight some of the key takeaways and insights that we have learned from the learning forum so far, and again, this is not by any means an exhaustive list, and we look forward to learning more and more as we go along with the learning forum Phase 2. So, we learned

that community interoperability is based in standards. Standards, including HL7 FHIR, support SDOH information exchange and facilitate interoperability in communities for service provision and coordination. We found that there is room to advance standards development, and standards adoption can support greater electronic service coordination in communities. I have said it a number of times here, but equity is so important as a core design feature. Ethics and equity are important features to consider throughout the planning, implementation, and evaluation of SDOH information exchange initiatives.

We have talked a lot about the foundational elements, but they are so important to understanding that SDOH information exchange in communities is more than the underlying technology, it is looking at these foundational elements and understanding how we can make this work, both from a technological perspective and a policy perspective. Governance intersects across all foundational elements of the SDOH information exchange framework.

This last one is really, really important. The time and investment in human resources is so, so important. SDOH information exchange efforts require time and investment to build the capacity and trust to ensure that the mission, purpose, and decision-making processes of the initiative are aligned with the needs of the community, and I touched on this, but I want to say it again, that it is not a one-size-fits-all kind of thing, and what we tried to do through the toolkit and the learning forum series is to provide help in a way that creates flexibility to implementers of SDOH information exchange initiatives in different communities with a focus on each community's goals and needs because we understand that you have to be able to adapt these elements of the toolkit into your community to make it work. With that, I think I went one minute over, but I will open it up to questions. Aaron, over to you.

Aaron Miri
Before we go to questions, we need to go to public comment, then we can come back to questions right after that, just so we stay at time. I have not lost you, Eliel. Hang on one second. Mike?

Public Comment (02:03:57)

Michael Berry
Great. If we could put up the public comment slide, that would be great, and I would like to thank all the members of the public for joining our meeting today. If you are on Zoom and would like to make a comment, please use the raise hand function, which is located on the Zoom toolbar at the bottom of your screen. If you are on the phone only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. Let's pause to see if any members of the public would like to make a comment. While we wait, I just want to remind everybody that the next HITAC meeting will be held on April 12th, and that today's meeting materials can be found on HealthIT.gov. I am not seeing any hands raised, so I will turn it back to Aaron and Medell. Thank you.

Medell Briggs-Malonson
Great. Thank you so much, Mike, and I want to say thank you so much, Mark, for really giving this wonderful presentation. In addition to that, a special thank you to ONC, as well as the EMI Advisors, for putting together this toolkit. I personally have reviewed it thoroughly, and it is a 77pae report, but it has so much great information, so I highly recommend that everyone take a look at it. We have so much interest, so that is really great, and we are going to start at the top, and we are going to go directly through all the different hands that are raised. Eliel, you are up next.

Eliel Oliveira

My video does not work, so I am going to turn it off, but thank you so much, Mark. You released that you are an attorney, so you are going to be in trouble. I am going to ask you questions forever now. Just kidding, but seriously, one of the key challenges that I believe we face in health information technology is that it is really hard to find attorneys that specialize in healthcare information challenges. Now that we are talking about SDOH, it becomes even more complex because we are trying to bring in data from the educational sector, from PRPA, and mix it with healthcare data, or from the incarceration system and another regulatory aspect, and we keep hitting walls.

I think CMS released some clarification during the pandemic, actually, that was very helpful to basically help us understand that we could actually release data for care coordination to social service agencies so that they could carry on, and that was very helpful. We could start releasing some clinical data to our homelessness authority, and that helped a bit, but I think we are still being bombarded by legal folks from our healthcare providers about what we can and cannot do, and we keep going back to that CMS guidance, but sometimes it has not really been helpful enough. So, I guess I am trying to see here what you are thinking that we are going to be able to see federally, maybe from ONC or from this SDOH umbrella in terms of support and legal guidance to help clarify for everybody because there is so much here from so many regulatory aspects, from so many directions, that it is going to get very hard to be able to answer to everybody what to do.

Mark Knee

Thank you, Eliel. That is a great question, and to give a typical lawyer answer, I may not be able to give you all the answers you are asking for here. From a legal perspective, my office cannot change the legal landscape necessarily. I think with a lot of this information, at least the first step is what we are trying to do here with the toolkit and the learning forum, have folks understand that there are these complexities, including the legal issues, that you are talking about, and trying to dig down into each specific use case and understand what the applicable laws are. Would HIPAA apply to the information we are talking about, or would there be some kind of local law or something else that could affect it?

And then we try to go from there because like I said, it is not one-size-fits-all, and we are not in the business of making laws, but even if we were, I think it is a very case-specific kind of thing, and I am sorry to hear that you are having trouble finding good legal advice, which is unfortunate, but find good people who understand what you are trying to do, and then, I would say definitely reference our toolkit as much as you can. We are happy to help you if you have questions related to the toolkit or leaning forum and point you in the right direction, if we can, as far as maybe there is a federal office you can ask your questions to, for instance, OCR for HIPAA-related questions.

An important piece here with the forums is that what we are trying to do as well is connect the community and provide opportunities for folks who are different stages of SDOH information exchange initiatives to navigate these complicated policy and legal matters, and even if you are not getting the answers in the learning forums, maybe you are learning where you need to go or what questions you need to be asking to get yourselves those answers.

Medell Briggs-Malonson

Thank you for that great question, Eliel, and thank you, Mark. Hannah?

Hannah Galvin
Thanks, Medell. Mark, thank you for this presentation, and I also want to commend you on this toolkit. I have also reviewed it, and there is some excellent information in the toolkit, and as a leader of a safety net health system, this is just so important for our population, and having this information, hopefully being able to exchange this information in the future with more ease, not just with other health systems, but community-based organizations, where there are some gaps right now with those organizations not having certified EHR technology, being able to do that in the future would be so helpful.

I do want to highlight, though, that some of this information can be stigmatizing for individuals, and as you mentioned, it is important that we as an industry are using this information for good and not in ways that could harm patients. And so, I did want to bring up the need for and the ability to protect patients' privacy in this way, and we have had discussions in this group before about granular segmentation of data and that ability. In other conversations, we have certainly heard of instances where social determinants data has been exchanged. For instance, the mom of a patient has reported financial insecurity that is then in the child's portal, and the dad of the child has then read that information and used it against mom in a custody hearing. There are unintended ways that this data can be used that are not beneficial to the patient.

The other thing I wanted to bring up is that more and more payers are asking for this data now, ostensibly to help patients, and we know that there are huge revenue implications for addressing these really costly issues for patients. At the same time, I think we want to make sure that in the future, payers will not increase premiums for patients based on this data, and I wondered, Mark, if your group had had conversations with CMS or others about some of those implications and whether there would be a policy put in place around sharing this data at broad scale and the implications, specifically in the payer space.

Mark Knee
Thanks, Hannah. Let me start by saying those are two really important and great points. I will take the first one. There is not much else to add, I guess. I will just say that we hear you 100%, and we agree. I was just having conversations yesterday with my leadership about this and how it is a point that we need to hammer home. This needs to be used in the right way. This is information that can really help provide full care for people, but we have heard the same types of things that you have heard, that this information can be used to the detriment of patients, and we are trying to highlight good practices and best practices.

When we had, I believe, San Diego 211, an HIE out on the West Coast, I believe they have some approaches they are taking to address how toe make sure that the information is being used for the right purposes. Again, we are trying to use the forum as a vehicle to emphasize the people who are doing the good things and as a roadmap for how you can do similar types of things with your initiative, but also, there need to be those guardrails, and that is part of the work that is ahead of us. As far as CMS goes, I think it is definitely a good point, and we can bring it up with them, but I do not think I have anything to add as far as current work going on on that.

Medell Briggs-Malonson
Hannah and Mark, thank you. It is very clear that we need more time to discuss this high priority for all of us, and I have to sincerely apologize to Sarah and Anna, and maybe you can put your questions and

comments in the chat right now so we can capture them, but we are over time, and so, we do have to respect those time limits, but on behalf of HITAC, I would say it is very clear that we need to have more conversations about social drivers of health, data information exchange, privacy, as well as the appropriate utilization of this data, so hopefully we can make sure to save some space and time for that in the future. Thank you again, Mark, for a phenomenal presentation, and we are going to go back to our agenda because we do have to wrap up. I am going to turn it on over to my cochair Aaron. Any last, final remarks?

Final Remarks and Adjourn (02:14:42)

Aaron Miri
I will keep it brief. I appreciate everybody's remarks. Again, Anna, Sarah, and others who had questions, I am sure Mark is available, or we can definitely schedule follow-ups. It is also a great topic for the annual report. I think it dovetails into really double-clicking SDOH and the nuances there because, to the point that Hannah and others were making, there is a lot of meat there. Net-net, great meeting, I appreciate the conversation, good engagement, and we ran over time, which is always a good thing when you are having a conversation. Medell?

Medell Briggs-Malonson
You already said everything I was going to say. So, thank you so much, everyone. We look forward to seeing you during our April HITAC meeting.

Aaron Miri
Bye, all.

Medell Briggs-Malonson
Have a great day, everyone. Bye-bye.