Transcript

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

September 25, 2023, 3 – 4:30 PM ET

VIRTUAL

MEMBERS IN ATTENDANCE

Medell Briggs-Malonson, UCLA Health, Co-Chair
Aaron Miri, Baptist Health, Co-Chair
Hans Buitendijk, Oracle Health
Hannah Galvin, Cambridge Health Alliance
Eliel Oliveira, Dell Medical School, University of Texas at Austin

MEMBERS NOT IN ATTENDANCE

Jim Jirjis, HCA Healthcare
Anna McCollister, Individual

ONC STAFF

Mike Berry, Designated Federal Officer, ONC
Michelle Murray, Senior Health Policy Analyst, ONC

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

Mike Berry
Hello, everyone, and thank you for joining the HITAC Annual Report Workgroup. I am pleased to welcome our co-chairs, Medell Briggs-Malonson and Aaron Miri, along with our workgroup members Hans Buitendijk, Hannah Galvin, and Eliel Oliveira. We are expecting Anna McCollister to join us shortly, and Jim Jirjis will not be with us today. Public comments are welcomed, which can be typed in the Zoom chat or made verbally during the public comment period later in our meeting. Now I would like to turn it over to Medell and Aaron to get us started and for their opening remarks.

Opening Remarks, Meeting Schedules, and Next Steps (00:00:37)

Medell Briggs-Malonson
Great. Thank you so much, Mike. It is a pleasure to be with everyone today for our next Annual Report Workgroup. We have some great items today. We just want to wrap up our crosswalk topics and then continue to move through our journey of getting the annual report together, so we are really looking forward to today's discussion. Aaron?

Aaron Miri
Ditto. Let's get started. It should be fun. Let's knock this crosswalk out so we can really get into it.

Medell Briggs-Malonson
Excellent, wonderful. Aaron, how about I go through our meeting agenda and then sum up our administrative tasks? Today, in terms of our meeting agenda, we are going to go over our next set of meeting schedules, and also the next steps after that. We will then dive into the discussion of the draft crosswalk of topics for the annual report. As Mike mentioned, we will definitely ensure that there is time for public comment, and then we will do some last closing items at the very end of the meeting. Next slide.

So, for the next upcoming schedule of meetings, today is actually the 25th of September, and this is specifically for our Annual Report Workgroup, so you can see all the other meetings we have had to date.

This is our second-to-last meeting in order to finalize all the various different topics of the crosswalk, and then, of course, going into prioritizing those various different topics as well. During November, as well as December, we are going to make sure that we are finalizing the draft of the annual report for HITAC review and approval, and we expect transmittal to Micky, as well as to others, beginning in February through March of 2024. Next slide.

This is actually when the Annual Report Workgroup will report out to the full committee. Last month's meeting was canceled, so this upcoming October 19th, we are actually going to provide an update on the status of the annual report and really present the crosswalk to the HITAC in order to see if there are any items that we need to include or exclude and any other discussions that may come from the full committee. As of November 9th, we will then continue to give an update on the status of the report, and we should be working on some of those different drafts. In January 2024, we will review the draft of the Annual Report Workgroup and try and gather that feedback from the full committee, and then, in February, we hope to receive HITAC's approval so that we can move forward with its transmittal. Next slide.

What are our next steps for this group? Well, as mentioned, we will continue to develop the draft of the crosswalk with the gaps, opportunities, and recommended activities across the different target areas, and hopefully we will get this all wrapped up by next month. And then, we will take this crosswalk, as I just mentioned, on October 19th, and then, from the crosswalk, we will start to develop the entire draft of the report itself so that we can then take it back to the full committee in November if needed. Next slide.

All right, I think the next part is to dive deep into the crosswalk, and we want to wrap it up, just as Aaron mentioned, so that we can hopefully start getting to the prioritization of all these different topics in order to get us a little more clarity and direction for the annual report. Aaron, I will now turn it on over to you.

Discussion of Draft Crosswalk of Topics for the HITAC Annual Report for FY23 (00:04:15)

Aaron Miri
All right, let's get going. We will start on Page 6, I believe. We are at the priority target area of patient access to information, and we need to talk about the patient-reported electronic health record update processes. I will read these out loud. Again, the gap there is transparency and accuracy of patient data and an easy mechanism to update incorrect data. We have been talking about this for a while. There is no simple way to do this and ensure that people can self-edit and self-correct their data, whether it is accurate or inaccurate. We are opening it up now for conversation. There are opportunities for better advocacy of data, better provenance of data, data accuracy veracity, and all sorts of things that people then should be able to update, and then some activities. So, what does this group think? Are there other thoughts, comments, questions, or opportunities here? I will start calling people's names. Hannah, you are up.

Hannah Galvin
I would still request some clarification around HIPAA in regard to this. I would certainly welcome others on the call to speak to this, but my reading and my understanding of HIPAA is that at this time, patients can request an amendment to their record, but we do not allow patients to just go in and rewrite their record. I certainly think that now, in light of 21st Century CURES, where we are putting data back in the hands of the patient, perhaps that should be challenged. Senator Cassidy has an RFI out right now asking about this, among other things, related to healthcare privacy and the level of control patients should have over their data, but my understanding and read of HIPAA is that if a patient was to do this, it would still need to

go back to the covered entity to approve the amendment, so any sort of technical way to do this would still need to be submitted and then reviewed. We do have some messaging technology to do that today. I am interested in others' thoughts on that. So, I would say that this is dependent on a clarification of HIPAA and whether there are any changes there.

Aaron Miri
So, you are saying a direct modification to the medical record versus an addendum?

Hannah Galvin
Right, exactly, whether patients could make any direct modifications.

Aaron Miri
Makes sense. Got it. Hans?

Hans Buitendijk
On that note, that step from a request for changes and then having documentation thereof, that it was either declined for some reason or accepted and then having the record be reflective of that, at least as we understand it, it will still have those steps of the request and then follow-up documentation as to what actually happened. HL7 does have a published implementation guide on FHIR on how one can manage requests for updates, but I think part of the challenge is one of priority. How does this use case stack up to all the other use cases with USCDI, FHIR US CORE, and other public health? Where does it stack up in the collection of needs that we need to push more or say we are fine with them because the other ones are more important. I think it is very much a prioritization issue: Where does this fall on the rest of the list?

Aaron Miri
Interesting. That is good feedback, Hans. Medell?

Medell Briggs-Malonson
I actually agree with what Hannah and Hans just mentioned. There are numerous different reasons for why patients asked to either add information to their electronic health record system or to addend their electronic health record system, and we have processes in place in order to make sure that those changes or those requests are rooted in the integrity and the veracity that we need them to be, but I think it is also one of those situations where, from a patient standpoint, oftentimes, if you are requesting to change your medical record for whatever reason, it does tend to be a very arduous process. Oftentimes, it does tend to be using paper and emailing paper documents back.

And so, I wonder if this topic area or this concern came up, just thinking about how we make this more streamlined, but it still seems like it would need to go through the appropriate review processes if it is going to the EHR. And so, with all of these other really important pieces of items that we are trying to address, I also agree with Hans's question of where this is on our prioritization list. Especially when looking at the needs of a patient, is this something that should be looked upon and addressed right now, or do we still need to just even understand how that information flows electronically with our current processes and then modify our processes to be even more efficient? I feel like there is more to this that may need to be explored. It is not as simple as "Hey, we need to create a simple technical fix."

Aaron Miri
Good feedback, Medell. Eliel?

Eliel Oliveira
There are two opportunities that I can think of. Last year, when we talked about this, I had a chance to meet with AHIMA and a few other folks to discuss it, and we came up with the thought that there is likely a breakdown of amending, fixing, or changing a record could happen. There are probably records that cannot be edited at all. As an example, let's say it is a lab result that came out of a device. The number is what it is. It may not be the most appropriate example, but there are some elements that cannot be changed. There are others that the individual could request to be changed, and that could be done by a staff member that has access to the systems. There are still others that may require some medical knowledge to be validated before change is executed, and you cannot just allow anyone to do that. So, that categorization might be an opportunity to physically look at the USCDI and define what could happen with each one of those elements.

The second opportunity that I see here is on the policy side. I know people who have challenges with this, where healthcare organizations have basically refused to make the changes that are very important to them. One of my colleagues has to go to the hospital every time to sit at a bedside to prevent certain things from happening, just because the records are wrong and the organization will not fix them. So, it seems like a policy change to reinforce some of these to protect patients might be necessary as well.

Aaron Miri
That is interesting. First of all, that is really sad for your friend, Eliel. That is a horrific story, but a real-world issue of what this is so important to address. It also brings up a question that I will just ask out loud. I do not know the answer to this. Does that run afoul of information-blocking statutes in some way, the hospital refusing to share information or make an addendum? I do not know. Is there a consideration of intersection with information blocking or potential needs of modernizing information blocking to incorporate that for future iterations? I do not know the answer to that; I am just asking out loud because that just seems very dangerous for the patient and patient health, not allowing them to make updates like that, so it is interesting.

Eliel Oliveira
That is a great thought. I like that, Aaron. Information blocking could be a good place to go.

Aaron Miri
It is almost like a learning session or listening session. I would love to know things like that. I think we are all hitting on that. Are there other activities going on? We have now talked about HL7 and information blocking. What are the other dimensions and intersection points? So, we have talked about listening sessions and potential future USCDI considerations. What else? What other activities should HITAC look at? What do you think?

Eliel Oliveira
I suggest a listening session for some of those individuals directly, Aaron. That would be great. I remember one article I saw, I think in Dallas, of a health system and a patient situation that was on the news, and I remember reading that online as well. That would be very interesting to listen to in order to highlight the

challenge here. That was exactly the same point. The person would request a change, and the health system would just not perform it.

Aaron Miri
Well, you have two physicians on the call right now. I am certain that in their course of care and treating patients, they have encountered stuff that is wrong in the medical record where they say, "That cannot be right." It has to be part and parcel of the job.

Medell Briggs-Malonson
Yes, but there also should be communication back to the patient. I agree with that, and that is why I mentioned additions to EHRs, plus amendments to some of the information, and sometimes patients may request for something to be added and removed, and they are told, "No, this is essential, this is part of your medical record, and I cannot modify this." But, there should be a closed-loop communication back of saying, "We appreciate your concern, please let us explain this" versus zero acknowledgement of the patient's request. That is a huge issue.

Aaron Miri
Great point. Hannah, were you going to say something? I know you were off mute for a second.

Hannah Galvin
Thanks. I agree with Medell. I forget who said this earlier, maybe Hans, but I also agree that capturing that the patient did make the request somewhere is helpful because if the patient disagrees with the health system's decision not to make the amendment, it can be helpful for patients to even have that documented somewhere, that they disagree with what is written, even if the health system or the provider says, "No, this is what I think is clinically important and needs to remain in the record." That said, I do agree with Medell that we have a lot on our plate, and I wonder whether this is coming up as a priority. It is not something that I am hearing as a significant priority from my patient population as much as concern about how their data is being shared. I am not hearing as many concerns or complaints about not being able to amend their data.

Aaron Miri
That is good for our purposes. Part 2 of this is tiering and priorities. We have to prioritize everything, so that is a good nugget to have. Thank you for that. Hans, you have your hand raised. Hannah, were you finished? Sorry, I did not mean to cut you off.

Hannah Galvin
It all goes together in part and parcel. If I have information in the record that I do not want to share and that I wish I had not put in the record, maybe I want to withdraw that if I cannot granularly make a determination or control how that data is shared, but I have not heard that use case as much as the other ones.

Aaron Miri
Anecdotally, I am actually hearing that because we have a very rapidly growing genetics program, and if genetic data gets shared with insurance carriers inadvertently, that is a very gray area right now, and I am saying this as an individual patient. That information could be used against you by an insurance carrier or whomever else, and so, there are a lot of times you want to exclude certain aspects from the record that

become a bit of a battle. To your point, that clarity and granularity is critical. Hans, you have your hand raised.

Hans Buitendijk
I would like to support Hannah's statement. From a priority perspective and based on what is happening, it is more likely that the concern is bigger on the side of sharing privacy and security in the authorized use than it is with changes to the record that can be made, but I do like Eliel's suggestion of a listening session or something that has a little bit better inventory of what is out there and to what extent those means currently exist in current practices, though they may not be electronic, with the HIM or otherwise so requests can be made or documented and how that is being managed. That also makes a difference. Are we looking at a gap because there is nothing there, or are we looking at a gap because it is nicer and easier to do it electronically?

This is not a value statement one way or the other, but is the volume at hand of what we have sufficient for some period of time that can help with prioritization of other things? Do we believe that there is a significant gap there that we need to fill to really manage that well, though perhaps not at the level of privacy and patient consent directives? Where does it sit on that scale? That kind of insight from different perspectives, both on what we do today manually and electronically and what we should be doing, might help give us some better insight as to where it sits on the scale.

Aaron Miri
Got it, okay. So, do we feel like we have enough feedback here and can go to the next topic? Let's go to the line. Okeydokey, PGHD, lacking standards and interoperability among platforms. PGHD, patient-generated health data, can be challenging to transfer in EHRs and time-consuming for providers and patients. PGHD device and software developers are not subject to health IT certification, and play a critical role. This is very true. The challenge is that standards to incorporate PGHD in wearables and others are difficult, and the jurisdiction of a patient device data is spread across multiple federal agencies, and I would say state agencies too. In Florida, there is a new patient digital bill of rights that was passed about where data can reside from Florida institutions, which is calling into question a lot of PGHD partners that they had, where they store their data, UBAAs, and all kinds of stuff. So, to the degree of that, there are a lot of opportunities there. There are a lot of opportunities here. I will open it up to the group. What do you guys think? Eliel, go for it.

Eliel Oliveira
Aaron, as you all know, this is something that can get quite extensive very quickly. The amount of data that can be extracted… I definitely believe that these standards are needed. I am not so sure about the ability of enforcement that everything goes into the EHR, given the amount of data that we are talking about here. I do not find EHRs to be very efficient in terms of data parsing, and I am fearful of this ballooning into so much information that becomes unattainable for EHR vendors. I feel like an opportunity here is yes, there is a need for a standard so that everybody is playing by the same rules so that we know what data is coming in in what way, but maybe they are stored alongside the EHR, but not in the EHR, and that is a specific distinction that I think may be important on this. That is the thought that comes to mind that I feel is important to raise.

Aaron Miri

Let me paraphrase that to make sure I understand what you are saying, Eliel. What is the "there" behind it? Why are we importing that data? What is the purpose of this? Do we care that Aaron had a latte at 3:00 in the afternoon? Maybe, if it leads to dysrhythmia or something, but to your point, are you asking for clarity on the "why"?

Eliel Oliveira
The clarity is on the way EHRs as operational systems are being used for care. It requires us to perform at a certain level to be able to extract data and visualize at the course of care. When you add so much data here, that requires so much more of an analytics platform because if you are just getting data from wearables, for instance, you are not going to be looking at the raw data, you are going to be looking at a **[inaudible] [00:23:01]** or any movement, and that requires an analytics platform or things that can actually deliver data efficiently. It is not how EHRs function, and I feel that that could derail the performance. It might be that the EHR vendors can bolt that on and make two work in one, but I feel also that there should be standards, but not necessarily that it has to be built within the EHR system, so that is going to be quite a push for change, in my opinion.

Aaron Miri
Got it. Medell?

Medell Briggs-Malonson
Thank you so much, Aaron. Just so that the workgroup also knows a bit about this topic, this came from one of our HITAC members, the other Aaron. One of the things that Aaron brought up was the challenge when information is needed for providers to try to figure out how to get this information from patient-generated health data. I think it is an interesting topic. I will just say that from my own clinical practice, I oftentimes see patients that come into the emergency department, and for instance, maybe they have their own insulin pump that measures how much insulin is given at a certain point in time and also helps to track their blood glucose levels, or someone who has a history of dysrhythmia who is now coming in complaining of chest pain or feeling a little bit faint, and we want to try to bring that information out.

With all these different devices, let alone the devices for wearables or other apps that patients are using, there is such a large amount of content, and some of that information is very important for clinical care, while with some of the other information, as you mentioned, Aaron, do I really care if you had a cup of coffee at a certain time? I do not know. It is probably a little bit less relevant than if your heart is going into a bad rhythm or your blood sugar level is low because your insulin pump is providing too much insulin at that time.

Because of the challenge here, which is so nicely stated, I think part of this is that patient device data is in the jurisdiction of so many other federal agencies, and one of my questions is if there is a collaborative right now of all these different other agencies that are specifically looking at health devices and applications and which ones should potentially be interfaced with the EHR, or, back to Eliel's point, if there is another way in which we identify which patient-generated health data is critical for patient care and have some level of criteria, are those the ones that may get some type of health IT certification to interface with the EHR, or is there just another way that we can easily interface into those devices as needed?

I think this is an important issue. I am not sure, though, that ONC is the agency that is supposed to oversee it. It is definitely an important agency that should be working directly with FDA, FTC, and some of these others, in which this may fall a little bit more in line, and CMS, because this is also truly about quality of care. To summarize this, Aaron, because you are probably going to tell me to summarize it, I think this is an important topic, especially for clinically relevant data that we need to act upon, but the question is can we explore if there is a collaborative in which the agencies are already all together that can help to define what type of PGHD is important to potentially go into EHRs versus those that may be a little bit more peripheral.

Aaron Miri
That is a great point, Medell, and I liked your idea of if there is some sort of crosswalk or mishmash of all these efforts that are going on, and if one does not exist, maybe we build one. Maybe it is part of the coordinating entity component of ONC to help at least take what OCR, FTC, and all these other people are working on. Great point, Medell. I love it. Hans?

Hans Buitendijk
Thank you. I have a couple of points there. There is work to be done in a number of different areas. On the standards side, there is an understanding that if you talk about PGHD, what kind of provenance data do you need so that, whether you integrate it with the rest of the EHR or not, you can track it so that, in the right context, you can manage it separately, together, or in contrast. The question is then going to come up for developers on where it is going to live. Eliel indicated that perhaps some of it lives in analytics today. Other times, we are being asked as patients to keep a log of something over the next couple of months or whatever, and you want to share that. Does that need to be in analytics, or is it in the context that the physician who asks for it wants to see it, but it is still in PGHD? Are there opportunities as there are more patient-focused apps evolving to keep the data in them? Typically, we talk about how smart apps can access EHRs, but how can EHRs access a patient's favorite app that they can tap into for a period of time to view it or otherwise?

So, I think there are many different aspects that are still not clear. Asking ONC to progress a particular certification or other process is somewhat premature. We are not quite clear what kind of data we want or where it should live, and therefore what IT we should be looking at to support some capabilities. To Eliel's point on analytics, some of the data might be voluminous **[inaudible] [00:29:04]** interest of some analytics of sorts, the other kind of data is to say that over the last couple of months, I collected this data that I can share to get some insights that further decisions can be made on. I do not think it is clear enough yet, but we need to keep it in mind and on the list.

I am not convinced that we can recommend anything quite yet as to what it means. There are some baby steps and initial steps being taken in the FHIR space on how to write cycles and do those kinds of things, just writing. It is not even a question about whether it is a provider or a patient, but that it can write to an external site, an app or environment outside the EHR. That needs to have a level of trust, provenance, or otherwise to do that, regardless of what I am going to use it for. I think steps are being taken, but the picture is not complete yet to say what the right thing is that we can ask everybody to do.

Aaron Miri

Good point. I like your point, Hans. Just because data is there, it does not mean that is good data to import, which goes to the "why." Case in point, I have been an avid jogger for over a decade, and I have my steps going back five, six, seven years. I have never provided that to any physician or primary care doctor I have ever met, even though they could say, "Aaron, prove that you walked your 10,000 steps every single day." I can prove it, but they do not care. They care about my cholesterol and all this other stuff, but they do not care about my steps. They can tell if I have or not. So, to the point of it, if I imported all that data into the EHR, it would just be there and be waste, so, to your point, what is the validity of it?

Hans Buitendijk
Yes, and if you go in reverse, if you have a Fitbit, Garmin, or whatever, do you have temporary access so you can at least see that little graph that says if your activity was stable or went up or down, just to view it for a moment and not do anything more?

Aaron Miri
Interesting. Any other comments? Hannah, any comments from you?

Hannah Galvin
I was going to say I think there is the standards piece about how you technically bring this together, and then I think there is the implementation guidance piece. To your point, Aaron, if you have seven years of data on your steps, how would you want to visualize that in a way that is meaningful so that you do not just have data, but you actually have information and knowledge in a way that would be meaningful to a provider looking at that?

If you are doing continuous glucose monitoring, which has become very big, not just for diabetics, there are all these companies that are selling continuous glucose monitors. How would someone visualize that in a way that is actually meaningful to them and does not increase provider burden? There is that piece, and how there can be implementation guidance on how to process the data, and also, where is this data stored? How can you store it securely and in a way that does not increase processing times so the system goes down? We have this exponential rise in healthcare data. How are we going to manage that? We have had trouble managing it over the past five years, so how are we going to manage it 15 and 20 years from now if we are storing all of that data centrally? So, I think those are some things that need to be thought through in addition to how we are traversing pipelines to share data.

Aaron Miri
I like that: Data lineage, data storage, that whole process.

Hannah Galvin
Metadata would be the one other thing I would add. Just as a clinician, it is meaningfully different to me if the patient has taken their own blood pressure at home versus having it taken in the office if I am seeing trends that are abnormal. We may want to bring them in and have them calibrate their blood pressure cuff against ours. So, having metadata on if this data is generated by the patient at home, do we have some recommendations on what type of metadata might be in the provenance of that data? It may be helpful for us to make some recommendations there. There may be published recommendations already, and I think there have been some folks who have published some of these recommendations, but consolidating some of those may be helpful.

Aaron Miri

Good points. Any other thoughts on this topic? All right, let's go to the next one, user-friendly price/cost data transparency. This one has been up on the HITAC for quite some time. I recall the conversations even under Don Rucker. This conversation topic has come up over and over again, and it was timely because at that point, the price transparency rules and all that were in flight, so this is important for a lot of people on the HITAC, and I have even heard it recently from several members. We still want to push the envelope, but it is a great topic for us to talk through. The gap there is price and coverage data provided for transparency can be difficult to understand, meaning it is only machine readable or there are other rules limiting it, or some health systems refuse to comply, which I do not know how they get away with doing, but they do.

The challenge is that implementation of price/cost transparency rules are ongoing, which is true. Obviously, an opportunity there is visibility, transparency, and trust for the general public, giving them choices, which I think is what we all strive for. I will tell you there are so many moving parts on this, and I keep hearing about updated rules and regulations coming out. I do not even know what the latest is with price transparency. I know that we comply with it, but that is all I know in the health system. I just know it keeps pushing the envelope, so I am curious about thoughts or feedback here. Eliel?

Eliel Oliveira

I think an opportunity here, Aaron, is in partnership with CMS, given the patient access API and payers APIs that they pushed and forced that now exist, is for ONC and CMS maybe devise strategies. I think this is in the bucket of patient access, so I would love to see them devise strategies on how this can be fomented or incentivized so that developers and others can actually build. If the tools are out there, the regulations are out there, and the APIs are available, how do we incentivize users and developers to basically build the access that patients would need in terms of that? Again, I think the data is out there now and there is some enforcement, but we have not seen solutions on this point because maybe there is no incentive for anyone to build anything. I would love to have an app when I sign up for the doctor prescribing a medical service or treatment of any kind that could actually tell me exactly from my insurance company what it is going to take. Why hasn't anybody built that yet? I think maybe there might be an alignment there between CMS and ONC to sponsor and support some of those initiatives.

Aaron Miri

When I talk to colleagues in the industry, some of them tell me there is a strategy not to put it out there because they do not want to give away their rates for payer negotiations. Some say they are worried that the rates they show and what the payers actually will reimburse are different, so they would not put erroneous information out there. Some say they truly cannot calculate what the actual bill is because there are so many affiliates that partner with the health system that drop their own bills, it is almost impossible to forecast if Aaron's bill is $300.00 because all we charge to the health system is $100.00. I am just making that up, but there are these nuances to it, as you were talking about, Eliel, that have to be unpacked. I have not heard anybody say they do not want Aaron not to be able to price shop, but… It is always the "but" asterisk kind of thing as it trails off, all these other things that cause a complexity. Hannah?

Hannah Galvin

I think the difficulty here is understanding healthcare billing in general and having patients understand that because it is so complex, and it is one thing to be able to surface at the time that I prescribe an ambulatory medication what the copay is through the PBM, which is relatively simple, or potentially paying for a lab test. You start to get into health system-negotiated payments for multiple tests and thinking about, and then it is not just nuanced in that way of having you negotiate this rate, though it is that, but it is also quite a bit nuanced if you get one test at this health system, maybe of a better negotiated rate there, and maybe the other test would have a better negotiated rate in another health system, but it ends up being cheaper and better for you to get all of your related care at the same health system.

Figuring that out can be very complicated, and I do not know if that many patients are really willing to price shop to that extent. If I need cancer care, am I going to try to get this chemo treatment at this system, but my MRI over at this system, because I want to negotiate that rate? So, what can we do to really make it as simplistic as possible for patients? I do not know how many patients out there are going to… They want the best care, but how many people are going to price shop to that granular level? How can we rethink this in a way to provide that information, but also provide the bundled care in a bundled manner so that people can really understand what it is they are getting for their condition?

Aaron Miri
I think we are all saying the same thing here, needing to understand from CMS what their next steps are. I am personally curious what pressure is going on on the payer side. What kind of agitations are occurring over there? It seems to me, in my personal perception only, that the bulk or the onus of this work is on the provider health systems, and while I understand that that is where care is delivered, what about the payers releasing claims data and getting data out there to show that? I am not saying this has not occurred, but I have not seen major efforts or public shaming of the payer information as much as I have on the provider side, or at least I have not read it personally, so it would be interesting to hear from CMS what is up. What is the next step? How do we make sure this is a two-way street? Eliel?

Eliel Oliveira
I just have a comment, Aaron, on what you said about the sensitivity and why there is not a focus to make all this available. Maybe the opportunity here would be for the patients themselves, and what I mean by that is making the pricing data publicly available may not be a good strategy. I agreed with it to start with, but if we just have a solution where the patient can know what that is going to be for them, that is a huge advancement. We should focus on that, whether it is going to be a safe email delivered to the patient or if it is an app that basically delivers those details. We all know that this is the only industry where you are getting a service, but you have no idea what is going to cost, so maybe focusing just on the patient as opposed to anybody accessing pricing information could be a good target.

Maybe the opportunity here is to smart small because there are too many things like we are talking about here. This can get very hairy pretty quickly. We should say that if you have been prescribed labs or specific groups of things, we should be able to know what that is going to take based on your plan very quickly. For other things, maybe not, but at least start somewhere so individuals can get some notification of what it is going to be. Right now, we just do not know anything, and that is a pretty bad place to be as a client, as a paying person.

Aaron Miri

I agree, although I would say another service industry that has variable pricing is your favorite rideshare apps. It seems like things cost three times as much, but we will not go there. That is not the point of this talk, but everything is variable these days. Hans, you are up next. You may be muted.

Hans Buitendijk
Let me go off mute. Progress has been made in some areas, and in others, we clearly need to go quite a bit further in order to make it work. I am wondering whether this is a time to reflect back and understand how far we have come. In some areas, we do have some standards, but they are not necessarily adopted. Aaron, I like your point from earlier that I need to stitch together what the different parties you are working with are contributing across the health system to get the total sum of it. If I have the overall plan, it is relatively, with an emphasis on "relatively," easy to get information on what that might cost, but I need to have a good plan. I need to know all the components that are in there. That is where I would agree with Eliel. If there are opportunities to start more simply with more targeted, individual services, I would love to know that.

In our area, if we get a CT scan or MRI scan, we have three, four, or five different places you can go to. Which one is actually going to be the most cost effective for my health plan? It is at least a simple, singular decision. Which pharmacy should I go to if I want to have a choice and I am not going to go to the same one all the time, or which lab am I going to go to? If the intent is for consumers to be more informed and make decisions on availability of prices and comparisons, the opportunity is to start where you can make those choices in a little bit more isolation, where it still has good value for everybody, and then begin to build it up.

It is complex. We have always looked at the moment you need to go beyond a singular doc and what they are going to do with the patient and provide an estimate as a substantially different to the coordinated effort of a care team that spans multiple organizations, and we have to take that last step before we actually figure out how to do the first step, but how far have we gone? Are there opportunities for us to look at some best practices that we can already start to share? Can we get a group together to share what they have done, how far they got, and what they are still missing?

Aaron Miri
Good points, Hans. Medell?

Medell Briggs-Malonson
What I am going to say is that, No. 1, I always feel that all of our patients should always have as much information as possible for them to make data-informed decisions, and we should always be transparent. However, there is a difference between price and cost when it comes to all of healthcare, and as we all know, the price is an arbitrary number that, oftentimes, healthcare systems or providers make while, of course, the cost to the patient may actually be their out-of-pocket cost based on their insurance plans.

So, overall, as we all know, this is a very complex issue, and for us to move the needle, which I feel is what has been some of the challenge behind all of these transparency rules, for us to truly be there to support our patients so that they can make informed decisions, that does require, as you mentioned, Aaron, having the health plans really demonstrate what the out-of-pocket costs will be for each patient, but that has to be incorporated someplace into all of these systems that our patients are looking at, and we have thousands

of various different health plans, let alone how even showing the cost and the prices demonstrates the level of inequity that we have within our healthcare systems and that we have baked into the way that our overall healthcare industry functions.

So, I feel that while we can think about some of the technical pieces of this and we can even think about some of the standards and the additional policy pieces, I think this overall topic is so broad, complex, and rooted with so many nuances, I really do not know if we are ever going to get to a point, based on what we have on the table in the country today, of really having true cost transparency that actually does benefit our patients consistently and equitably across the country.

And so, for me, it makes me wonder if this is the right thing for us to do in thinking about how to demonstrate this transparency or if this is another area where we go back to the policies and advocate for changes in them so that they are created in a more equitable way that does ensure accountability for health plans, government, or payers the way it should to really ensure that all patients understand what they are responsible for when it comes to making decisions about their healthcare received. So, those are just a couple of thoughts. I really do not have recommendations on this one, except that I think there needs to be more understanding of this and more policy advocacy because in my mind, it is still not equitable. We are still not at a place that is really going to help our patients the way that we should.

Aaron Miri
Well said, Medell. Hannah?

Hannah Galvin
I just wanted to say that I agree with Medell. I do not know that there is an action item for ONC at this point, other than, potentially for us, in our conversations with CMS, this would be an area I would like to ask them more about and understand what their intentions are and where this is on their roadmap. I do not see a very specific action item for us at this point. Potentially, we could put this in our parking lot, be intentional about asking CMS more about this any time they are at the table with us, and potentially, this may be on our annual report roadmap for a future year, but I do not see a specific action item for us at this point.

Aaron Miri
Good points. I think we have gone through this topic. In the interests of time, we are going to keep going. Next topic, Michelle. Is it the one at the bottom here? Is the one in brown font one we would fill out as well?

Michelle Murray
Sorry, I was double muted. I think there is one on the very bottom in the parking lot list. Go to the next page. Here it is, “decision support interventions.” This was one that you guys started, and then asked for ONC to take a look and give more direction on where to go with it, so we added a sentence in the opportunity column to get more specific around the saves on what areas in particular we cared about, and we did get good feedback from the technology side of the house. We are proposing a recommended activity for you to discuss, where we could use some feedback, but you can go further than that if you want to.

Aaron Miri
All right. So, in particular, it would be helpful to gain more consensus across health IT and industry. All right. So, a listening session is a proposed activity for the HITAC for us to consider other activities around DSIs

and predictive models. I can tell you there is a lot of worry about DSIs with the FDA. I know that does not fall into the ONC bucket, but there is a lot of conversation about DSI suddenly becoming a medical device. There has been a lot of advocacy around that. I think double-clicking on DSIs is important, and I have heard loud and clear from my physicians that they do not want to slow down the velocity because they get encumbered with bureaucratic red tape. Let's see. Hans, you are first.

Hans Buitendijk
I have a question around the opportunity and intersection with ONC. The question is as you have DSI that is being developed, there is an FDA component to it, there is an overall analytics component to it, and there is a patient component to it that then all come together into understanding how appropriate or not DSI is as it is being used in a particular context. How much is that really down to ONC versus other parts? Can ONC pull that together?

In what they are doing and what they have proposed with HTI-1 to have transparency by the provider, they have focused a lot on the EHR to make it transparent, but in the end, it is about the developer or provider of the DSI to create that transparency or involvement. I am not convinced whether that goes to ONC beyond ensuring that wherever certified HIT makes that information available, it can help make that available to the users of that, and if it is an EHR, it is typically more provider-focused, and if there are other parts, how do we make that extensible to the patient and the caregivers as well? What is the role of EHRs or other HIT to do that there? But I am not sure whether this opportunity falls in ONC's wheelhouse as currently described.

Aaron Miri
Good points. Medell?

Medell Briggs-Malonson
So, we initially brought this onto the crosswalk after our recommendations for HTI-1, and I think that is why it came into this report workgroup. Of course, I think DSI is near and dear to everyone's heart, definitely near and dear to mine, especially making sure that they are built, tested, implemented, and monitored in the appropriate way. We know that a large amount of this, as Hans just mentioned, is falling within FDA and other agencies, but I believe this was specifically along the lines of transparency when the DSI is interfacing with certified health IT about what type of standards there would be to ensure that the DSI did meet the FAVES criteria of being fair, appropriate, valid, effective, and safe.

And so, we really still do not know what is coming out of HTI-1, since we do not have the final rule yet, and I know we were saying maybe we should table this until the final rule to see how they develop it, but I do agree that with all of the work that is going on around DSI and all the discussions about the ethical use of DSI and other forms of artificial intelligence, I think really understanding all the different entities that are working on this and holding that listening session to see how everyone is truly defining "fair and appropriate" is very important so that we are all using the same lens, the same terminology, and the same objectives, because looking at all the various different approaches for different agencies and societies, everyone is going about things a little differently.

Does ONC have a role, potentially at a point in the future, and especially when we are bringing in the DSIs and if it is, of course, truly through some type of certified health IT linkage there, to say what types of criteria that ONC may want to consider for them to say that yes, these DSIs do meet the FAVES criteria? So, that

may be an area where we hold a listening session and get a further explanation of what ONC's final definition will be in order to say what is fair and appropriate.

Aaron Miri
Great points. Eliel?

Eliel Oliveira
I am thinking that a lot of what this is related to in terms of predictive intelligence gets very tricky. I am putting a link in the chat. AHRQ has done a lot of work on CDS, and I have delved into that quite a bit because that is one of the things we do with our work here and our research. The conclusion on that is that it has not been very successful because the integration of CDS across EHRs is very difficult because the data does not match or the EHR has a different way for clinical decision support to be done. My point is that we do not even have a mechanism to deliver decision support that is uniform, and now we are talking about something that is going to have predictions or AI. We do not have a mechanism for delivery yet. So, it might be that the place for ONC to start would be clinical decision support. Patient-centered decision support is another one that AHRQ is exploring quite a bit, where patients are part of their own care. Once it is established that all EHRs have a specific standard they have to follow to deliver clinical decision support, then we can come back to the subject of predictive models, AI, and other things.

Aaron Miri
Good points, Eliel. Hans?

Hans Buitendijk
I have too many mute buttons that I need to go through and turn off. I agree with some of the comments that Medell made that there needs to be good clarity that we all are understanding and assessing whether something fits all the FAVES aspects. I am wondering whether that is much more about transparency and what ONC has fundamentally done so far on awareness of what it is that can be followed, but I am not sure whether there is a clear arbiter to say what is or is not fair, appropriate, valid, effective, or safe so we can say we have clarity around that and know how to measure it, other than that we can speak to it and clarify on it, which others may or may not agree with.

For me, that makes it very hard to understand what ONC's role is in this other than, as it evolves, help ensure that, where such DSI is used, the users of it have the ability to get access that information, whatever that might be. But the "whatever that might be" falls somewhere else, and I have no idea at this point in time whether that fits in one place or five places so there is insight into that so everyone can make an informed decision to see whether it is appropriate to be used in a particular context or not, or that it might be for some, but not for others. I do not see ONC getting to that level of detail of having a declarative statement around that.

Aaron Miri
Hannah?

Hannah Galvin
I agree with Hans on that. All of these qualities are relatively qualitative, and so, having some quantitative approach, or at least a little bit more of a metrics-based approach, can be helpful to be able to compare

apples to apples. When I think about safety, there are some people who are going to say that nothing is safe because there could be one edge case that may not be safe, and I think AHRQ does have some guidelines around this that are used by patient safety organizations in trying to evaluate how safe is safe and how unsafe is unsafe, and to have some measurable standards and a listening session here may be helpful in informing these conversations and to see how that could be used more effectively to gain some of this feedback.

Aaron Miri
Any other comments or questions on this? All right. Medell, I think you had a good point at the beginning. There are forthcoming rules that we have to see finalized to see where this goes, so I think this is a great conversation, but as we have done historically in reports, this may be one where we get to prioritizing the table until that comes out because it may reframe some of our thoughts, depending on where it finally lands, and there are some great task forces coming up like the HTI-2 Task force and others that Micky has alluded to coming up soon in the fall to further add clarity, further touching the DSIs and others, so there is more to come. Do we have any others that we had to go back and do, Michelle?

Michelle Murray
We do have one on Page 3, to get clarity around pharmacy interoperability. We proposed language based on what we heard because you guys had it together in one topic, and we split them apart to pull out and separate long-term care and addressed what we had heard so far in labs, but I do not think we went deep enough yet in pharmacy to be firm on the language. It is a challenge in particular that needs some clarity, but I think it flows through to the other columns.

Aaron Miri
All right, so this is specifically the lab reporting pharmacy one?

Michelle Murray
Yes.

Aaron Miri
I just wanted to make sure I was on the right one. So, the gap is lack of consistent use of standards in laboratories and pharmacies creates a barrier, the challenge is LOINC, SNOMED, etc., pharmacies TBD, and the opportunity is to explore requirements for reference labs to meet USCDI standards and explore requirements for pharmacies to supply NCD and RxNorm codes, which would be great. If they all could standardize on that, that would be helpful. Activities: What could CMS be doing to incentivize? Refer to HITAC's report to the national coordinator on pharmacy interoperability and emerging therapeutics and the HITAC report to the national coordinator on public health data systems, Recommendation 38. Michelle, you are asking us if we agree with these recommendations and/or if we want to add anything to them, correct?

Michelle Murray
Yes, you could do that if you want, but we tried to back up into what the challenges and opportunities were that you were addressing here with those recommendations, and I think the challenge is to connect that back to more of a general topic. We need a link that makes it flow through better. Really, the challenge in the column is the second bullet that is missing right now.

Aaron Miri
Got it. Hans?

Hans Buitendijk
I may have a little bit of insight on the discussions around the pharmacy task force that might help with the challenge. While on the laboratory side, there are a lot of productivity points already there, a lot of interoperability already occurring, and therefore the focus is on the vocabulary to create consistency, enhance it, and make better use of it in that context, with pharmacies, I think one of the themes that is coming up is the actual connectivity beyond the filling of prescriptions. As pharmacists are getting integrated into the care teams and becoming more and more part of the test-to-treat processes, whether for emergency scenarios or in normal operations, the pipelines to connectivity are not quite there yet.

So, this is not specifically only about the use of certain codes, but it is about getting the pharmacy and pharmacist more fully connected with the other providers so that everybody in the care team has access to the data they need. Pharmacies have an increasing amount of data, which might be tests, observations, or other documentation. They administer certain medications. How does that come back to the other providers, such as the primary care doc, etc.? And it goes the other way around. As information comes from providers, how does that become available to pharmacists to help them in their decision making? I think the theme is more around that challenge. How do we connect pharmacies and pharmacists better bidirectionally with everybody else? The task force is looking at a variety of different things on how to advance that, but that seems to be the biggest challenge that we need to look at at this point in time.

Aaron Miri
I can tell you from firsthand experience, Hans, that I have had EHR vendors push back on opening up various data feeds to various pharmaceutical information, NDC information, and others because of the worry of some sort of NDA violation and whatever else, so it is not just technical interoperability, but how you play in the same sandbox together and work through these things. I think that is a great point.

Hans Buitendijk
The elements in the discussions have been around if there are currently contractual barriers in some of the information sharing in different parties, not just between other providers and pharmacists. As TEFCA evolves, are there opportunities for them to really need to make sure that there are no barriers for pharmacists to participate in the treatment use case and other ones as well? As you are sharing information, let's try to avoid having to go point to point, but how can we find proprietary solutions while, at the same point in time, recognizing that the incentives that have been out there for hospitals, inpatient, and outpatient in a category of settings like long-term care have not had much of that, and pharmacies have not had much of that easier? What are the levers and incentives to help everybody connect? Standards are there, networks are there, and the acknowledgement of authorities is there, but now, how do we make that truly happen?

Aaron Miri
That makes sense. Are there other comments, questions, or thoughts to add or clarify what Michelle has asked us for around laboratories and pharmacies? Michelle, to me, it reads pretty good. We are weighting output to more output. To what Hans is saying, this ties in my mind.

Michelle Murray
From what Hans just explained, is there anything we would add to or change around the opportunities and recommendations? Right now, I think those are still a little bit more lab-focused.

Hans Buitendijk
Perhaps the gap might a little bit more that it is not only a consistent use of standards by pharmacies, and I am picking on that particular aspect of it, it is the infrastructure, the funding, and the ability to actually connect, as well as clarity on the authorities that are there. It is not only the standards, it is building up the entire ecosystem to be able to get more data shared across the parties.

Aaron Miri
Yes. Exactly like you said, Hans, we always think of the big-box retailers, but do you know how many independent mom-and-pop pharmacies there are that still get fills and live off of paper scripts? There are tens of thousands of them everywhere. Some of them do not even have EHRs or anything electronic. They still send faxes.

Hans Buitendijk
Right, and phone calls.

Aaron Miri
Right, and phone calls. There are lots of them. Any other comments and thoughts?

Eliel Oliveira
Just like you said there, Aaron, it is a big problem. When you try to then service the FDA, for instance, in surveillance, the fact that you are not capturing it consistently and these mom-and-pop shops that you are describing are not necessarily either coding the right way, like Hans was saying, and cannot even connect, having that pharmacy data well defined and highly accessible is very important for many aspects, not only for care, but research and surveillance as well.

Aaron Miri
Any other feedback on this topic at all? Hannah or anybody? All right. Michelle, any other topics?

Michelle Murray
There are no more specific topics. It is more of a chance to go over the whole crosswalk as one entity or by target area and groups of topics to see if you have any changes before we go into our next HITAC meeting.

Aaron Miri
Medell, do you want to take a stab at this?

Medell Briggs-Malonson
I will give you a break. You have been doing wonderful speaking. Let's go to the very top of the crosswalk. As Michelle just mentioned, now we are almost getting to the point where it is time for us to think about prioritization as well, so maybe we can do a little bit of review of each section, and then we will think about the prioritization right after reviewing these sections because now that we have done all of this work,

especially for those who are new to the Annual Report Group, we see all the topics that we placed on the crosswalk, and then we go back and ask if each is a priority this year for the Annual Report Workgroup or a priority that we may want to wait for another year or so to add, include, or explore more at a later time. So, let's first go over the entire crosswalk from beginning to end very quickly so that we can all be reminded of what is in it and see if there are any modifications or changes that we need.

The very first topic area starts off with design and use of technologies that advance health equity, and the very first topic was focus on artificial intelligence and algorithmic bias. I will not go too deeply into all of this, but I will just mention the challenges and some of our proposed activities. One challenge is AI that furthers inequities and biases, which is a significant concern that must be balanced with potential benefits as policymakers develop efforts to regulate AI. What we are proposing is to hold a listening session in collaboration with relevant HHS agencies focused on the current landscape and both private and public AI initiatives. We are also recommending supporting the development of guidance to assist providers, certified health IT developers, and other health IT developers with the implementation of the HTI-1 final rule, since we know there is so much that is in the HTI-1 final rule. So, to start, are there any additions or revisions for that one? Go ahead, Hannah.

Hannah Galvin
This is not really a revision, but I think our focus here is really on bias, whereas in the DSI piece, which I know we are still waiting on the final rule for, the focus is really more on the transparency of the algorithm. My thought is whether we want to tackle both of these together because the transparency of the algorithm also helps to reveal any bias in the algorithm. I think that would be my only thought. Do we want to address those two somewhat in tandem?

Medell Briggs-Malonson
That is actually a really good point that you bring up. If we are looking at all artificial intelligence overall and all the various different forms of DSI, a lot of the same recommended HITAC activities were included in that most recent area we were talking about in terms of the FAVES criteria. Let's take a look at that and see because they are tracking very similarly. Are there any objections to adding those two together?

Hans Buitendijk
No, I think that makes a lot of sense because that allows us to holistically address it. Whether it is advanced generative AI or simpler DSI on that scale, it is still DSI. It still has all the factors of FAVES in there that need to be addressed and that we had the same conversation around, so I think combining the two makes a lot of sense.

Medell Briggs-Malonson
Wonderful. So, maybe what we will do is make a recommendation to modify the topic name to "artificial algorithmic bias and transparency" so it is actually more encompassing of both areas.

Aaron Miri
I like that.

Hannah Galvin
I like that a lot.

Medell Briggs-Malonson
Excellent. Good job, team. Let's go to the second one as well, missing health IT infrastructure for health equity and social-drivers-of-health data. The challenge in particular is that yes, we had some gaps, but the challenge we are referring to is that additional standards are needed to support the collection and electronic exchange of health equity and SDOH data. Many CBOs lack the IT infrastructure in order to do so. Our proposed recommendations at this time are to hold a listening session to identify gaps in SDOH standards, including those that have been developed and are under development, as well as to explore the development of a framework to support the adoption, implementation, and use of health IT by CBOs. This should, of course, include strategies to support both private and secure exchange of the use, including pilot demonstrations. Are there any additions or revisions?

Hans Buitendijk
I have a question. I have no disagreement with the scope and content as defined here. The focus is on CBOs. What I am curious about is in this context, are there other data sources, whether they are from public health or other data elsewhere, that provide input that can advance the collection and use of this data appropriately, or are we only focusing on CBOs as a source of that data?

Medell Briggs-Malonson
That is a very excellent question because again, yes, we have CBOs, but we have our public health entities as well, and some people call social services agencies very differently than CBOs, but we also have all of our post-acute care facilities. So, that is a really great question. Do we want to expand all those different data sources so that it is not just focused on our community-based organizations? I would say yes because it is pretty much the same in order to collect social driver data. For that true interoperability, it is not just one entity in itself, it tends to be multiple types of data source, so I would say yes. Eliel, your hand is up.

Eliel Oliveira
I was going to answer that to say there are electronic health systems that capture referrals and assessments of needs out there. They are called directories of social services, and they do not necessarily comply with standards, so that is another source, Hans, that I think is quite important. There are some that are trying to integrate with some EHRs, but that is based on partnerships, not necessarily on following a standard so that everybody can take advantage of accessing that data. I even covered that a little bit in my demo when I presented in a face-to-face meeting.

That is a key set of electronic systems out there that are a source of information, and the standards are there, but they are not necessarily enforced, so they do not get followed. They create a big hole in terms of coordination and getting this national infrastructure to understand what is taking place. If we had another COVID right now, at a national level, we would not know what needs the population is faced with. It is all a manual process. If you remember, social needs were a big challenge. I remember here in Austin, we would have Porsches driving through the food banks to pick up food because you could have money, you could have all kinds of resources, but it did not mean you could find what you need during the pandemic. The need for coordination here is very relevant, and those systems should be able to communicate with EHRs and others.

Medell Briggs-Malonson

Great. So, it sounds like you are in favor of expanding to include other data sources from other organizations that we know play a significant role. Hans?

Hans Buitendijk
I am not sure whether this is part of this one or whether to sit somewhere else on the side. The challenge is also what is the best source for serving SDOH? It is not always the EHR, it is not always the community, and it is not always social services. It depends on the kind of data and the context what is actually the best opportunity for either higher quality or more completeness of the data together, and that is one of the challenges that exists. At times, the way the programs are currently developed, focusing on what we can get into certification, there is a tendency to look at EHRs because they are the most certified, but are they always the right ones to focus on if we want to get better data than is useful for everybody? Does that mean we need to get other communities included? I think part of the challenge is that by expanding the connectivity to other systems in the community, such as social services, we can better connect the best sources of the data.

Medell Briggs-Malonson
Very good point. At least for this one, it sounds like we are going to expand it beyond just CBOs, based off the comments that were just mentioned, but also, Hans, for that last point, maybe that is part of the proposed recommendations, to explore the development of a framework and/or whatever setting may be best in order to make sure we are exchanging that SDOH data because the EHRs may not be the best one, so that may go directly back into that HITAC activity with a little bit more finesse and explanation there. Excellent. So, we have about four minutes until public comment, so we will keep on reviewing what we already discussed just as a refresher for everyone.

The next one was reducing the digital divide, which was more of a general aspect of it, versus reducing the digital divide, which is going to be more specific in the next topic. The challenge here was lack of or limited access to broadband and mobile internet is correlated with worse public health and public health outcomes. Our recommendation was to encourage ONC to work with other HHS agencies and standards developers to adopt standard SDOH data elements about a patient's internet access status and health literacy status. That is what we have there. Are there any questions or revisions there? Okay, I will raise my hand really quickly just to make sure that we are very clear.

Just going back to Michelle as well as the AI team here, I think that it is really important to also make sure we are talking about standard data elements about a patient's internet access, but there is also a difference between digital literacy and health literacy, so I think that while it may be a little bit harder to put that into standards, we need to explore how to appropriately assess a patient's internet access status, digital literacy status, and health literacy status because those are three separate pieces that are very important for what contributes oftentimes to the digital divide, especially when using health IT. Eliel?

Eliel Oliveira
The point that I have here is that, as you all know, the country has put out a lot of funding recently for telehealth and internet access in pretty much any rural area of the country, but there is still quite a bit of missing connectivity for individuals, and I think we talked a little bit about this when we discussed this topic. Because we work a lot with underserved populations, we find that whenever we need them to be involved in their care, that involves getting access to their data and being part of the care coordination electronically,

they do not have the access. They may not have the cell phone service to just be connected, meaning if someone is already suffering with challenges, such as healthcare, food, or whatever that is, it just gets exacerbated by the fact that they do not have access.

We did fund quite a bit of infrastructure and build out to make sure internet is in rural areas and everywhere, but I think that probably missed individuals, and there are services out there that they can actually get for free and all that, but the process is just hard. It is not an automated process that allows an individual to be part of their own health. Even though I am saying all that, I am thinking to myself if this is ONC's job to get into. I am not sure, but there is a place to make sure that folks understand that the ones that suffer the most are being further affected by the fact that they do not have access to healthcare information and to their data.

Medell Briggs-Malonson
I could not agree more, Eliel. That was a really important piece, and we always have to keep that centered and in context. So, we are going to pause everyone right now and go to public comment. Mike, I will ask you to come on camera and lead us through public comment.

Public Comment (01:24:16)

Mike Berry
Thank you, Medell. We are going to open up our meeting for public comment. If you are on Zoom and would like to make a comment, please use the hand raise function 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 just for a moment to see if any members of the public raise their hand. I am not seeing any, so I will turn it back to our co-chairs to close us out. Thank you.

Next Steps and Adjourn (01:24:46)

Medell Briggs-Malonson
Thank you so much, Mike. During these last minutes, what we will do is just go over a little bit of homework that we are going to ask the Annual Report Workgroup to do. We are trying to still go through the rest of the crosswalk, and please, if you all can definitely go through the rest of the crosswalk, if there are any minor revisions, tweaks, or small additions that you have, please send that to Aaron and me as well as to the ONC team by October 9th, and we will send out an email reminder about this, but in addition, as you are going through, there is that column on the far right-hand side because we do have to start thinking about the prioritization of some of these different topics.

Already, as we have already seen, there may be some areas that we can collapse into one; there may be some areas that we want to bump up in priority or deprioritize. Please go through this crosswalk, add your revisions, and start thinking about the priorities because we want to continue to move on through so that the rest of our ONC team can start to take all these items after we present this crosswalk to the full committee and start to develop some of the draft. So, that is just a bit of homework between now and October 9th so that we can wrap up all this amazing work and all these great ideas and recommendations that the workgroup has presented. Aaron, any other comments? It looks like Hans has a question.

Aaron Miri

Hans, go for it. You may be double muted again.

Hans Buitendijk
Yes, we know the story. The only question on the last column is how you would like us to mark that if we believe that a priority should be higher. Should we indicate to go up or down, or just use one, two, three?

Medell Briggs-Malonson
Great question. Can we go back to the crosswalk so we can all see the crosswalk together? We will leave the public comment slide and go back to the crosswalk. Excellent. So, if we scroll to the very bottom, there is a legend that we have used historically, and you see the legend there. We have the legend for the immediate tier, meaning we absolutely need to include this now in terms of our annual report, and then there is the longer-term tier, which means we can table this for another year or so. One of the things for the tiers, at least, and Michelle and Aaron, correct me if I am wrong in explaining this, but if we think this is an immediate aspect or topic we need to address, we can just put an I, and if we think it is more longer-term, we can put an LT.

Hans Buitendijk
Should we then put our name with it so we can make some sort of an effort or consensus?

Aaron Miri
You got it, Hans.

Medell Briggs-Malonson
That sounds perfect. And then, just feel free to send it back to us and we can get some of the balls rolling in terms of understanding where each one of the members feel in terms of the topics and their priorities for right now. Excellent question. Any more questions about our homework assignment? Hannah?

Hannah Galvin
So, are we going to each send you back a version of the Excel spreadsheet as opposed to putting it in a Google sheet and working on it together?

Aaron Miri
Yes.

Medell Briggs-Malonson
So, take this direct crosswalk, which is in Excel, and whichever version it is, track your changes in case you have any other revisions to any of these topics, and then, in that far-right column, put I for “immediate,” which means we should include it in this report, or LT, meaning it is okay if we table this for another year or so.

Aaron Miri
All right, I will just close it out. Thank you all for a great discussion over all the topics. We got through the crosswalk and through some groupings here. I look forward to prioritization. Have a great afternoon, and we will see you soon.

Medell Briggs-Malonson
Thanks, everyone. Bye-bye.

Hans Buitendijk
Take care.

QUESTIONS AND COMMENTS RECEIVED DURING PUBLIC COMMENT
No comments were received during public comment.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT
Eliel Oliveira: https://cds.ahrq.gov/

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL
No comments were received via email.

RESOURCES
AR WG Webpage
AR WG - September 25, 2023, Meeting Webpage