Transcript

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

October 16, 2023, 2:30 – 4:00 PM ET

VIRTUAL

MEMBERS IN ATTENDANCE

Medell Briggs-Malonson, UCLA Health, Co-Chair
Aaron Miri, Baptist Health, Co-Chair
Hannah Galvin, Cambridge Health Alliance
Anna McCollister, Individual
Eliel Oliveira, Harvard Medical School & Harvard Pilgrim Health Care Institute

MEMBERS NOT IN ATTENDANCE

Hans Buitendijk, Oracle Health
Jim Jirjis, Centers for Disease Control and Prevention

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, Hannah Galvin, Anna McCollister, and Eliel Oliveira, who are all with us today. Hans Buitendijk and Jim Jirjis are not able to join us. Public comments are welcomed, which can be typed in the Zoom chat or can be made verbally during the public comment period that will be held later in our meeting. Now, I would like to turn it over to Medell and Aaron to get us started today.

Aaron Miri
Perfect. Medell, do you want to start?

Opening Remarks, Meeting Schedules, and Next Steps (00:00:39)

Medell Briggs-Malonson
Of course. Good afternoon, everyone. It is so great to see you all here for our Annual Workgroup meeting. This is another exciting meeting. We are going to be able to get through so many of the different items, topics, and prioritization today, so we are really happy to see you all, and I will turn it on over to Aaron so we can jump right on in.

Aaron Miri
Absolutely. I look forward to the discussion, and of course, as a preview, again, we have our HITAC this Thursday, so, be there or be square. We have to make sure we are ready for that, and this will help inform that conversation as well, so I look forward to today's talk. Let's get to it. So, in the agenda for today, obviously, we are going through our meeting schedule and next steps. We will have a discussion on draft crosswalks today, looking for the topics in green. We are also going to have a discussion of illustrative story ideas for the HITAC annual report in FY23.

As a reminder, the stories are something we started about two or three cycles ago, and it is meant to put into plain, understandable English, kind of like "Talk to me like I am 8 years old," explaining what the patient experience or clinical experience would be like if we were to get interoperability properly done, or what would help from a cybersecurity perspective, or what we could prevent occurring in very plain English. These stories anchor each of the sections that we are going through here, interoperability, cybersecurity, public health, etc., and just explain to the reader in plain English what that means, so we will start talking about those today. It is a fun process, and we usually brainstorm up some really good ones. For those of you who are brand-new to the committee, it really comes together very strongly at the end. We will then go to public comment, and the next step is to adjourn. Next slide.

So, we are here on the 16th of October, and it is amazing how fast time is flying by. Our next meeting will be the 30th of November, right after Thanksgiving, and of course, in December, we will go into the draft for HITAC review and approval sometime in the January/February timeframe for transmittal then thereafter. Next slide. Like I said, HITAC is this Thursday, 10:00 in the morning Eastern Time. We will update and discuss the crosswalk. This is about the point in the HITAC sessions that we start getting some really good feedback, but I will ask all of you as workgroup members to help pull out comments from your fellow HITAC colleagues that you know folks have on the top of your mind. Maybe they are just hesitating to say something, but we really want to collect all feedback. It is important. This is a collective work effort, so we need any feedback therein. Of course, then, on the 9th, we will do another status update, and again on the 18th, with final approval on the 8th of February. Next slide. Okay, let's go into the draft crosswalk, and then, of course, we will be presenting pieces of this at the main HITAC this Thursday. Michelle or Accel team, from here, I think we go right into the crosswalk, correct?

Michelle Murray
Yes, you can do that.

Aaron Miri
Okay, perfect. Time for the crosswalk.

Medell Briggs-Malonson
Aaron, do you want me to go ahead and kick off the crosswalk?

Aaron Miri
Sure.

Discussion of Draft Crosswalk of Topics for the HITAC Annual Report for FY23: Text Edits and Topic Prioritization (00:03:54)

Medell Briggs-Malonson
We are just going to focus on some of the green topics that we had before, and then, as Aaron mentioned, we wanted to go back and start to prioritize where we want to really list all of these topics. So, we left off here last time, with artificial intelligence, and just to take another step back, these were some of the additional items at the very end of the crosswalk in our meeting last time that we met that we really wanted to synthesize together a bit more and make sure that this is where we wanted to land in terms of a proposal for the annual report.

So, we started off with artificial intelligence, and we then decided to try to combine algorithmic bias and transparency. Just to orient everyone to all the various different colors, the teal text, of course, came from 9/25. The red additional text is from all of the homework that we did have, so, thank you, everyone, for doing your homework and providing all those comments back to the team. The green text will then be what we get from today's workgroup. So, you have all the various different texts from our last meeting on 9/25, and the red is some of the additions we want to go over. Thank you, Hannah, for making sure to add some of those pieces in, and you will see at least some of the various different suggestions that are there. And so, there was one question that came up from Hannah, so maybe we can display that comment or question for us to discuss. Hannah, did you want to just give us this additional context to your question?

Hannah Galvin
Yes, I would be happy to. I am actually trying to pull up the full document myself because I cannot see my comment yet.

Medell Briggs-Malonson
We are displaying it right here.

Hannah Galvin
Okay, perfect. It was not in the view that I had. So, my comment here focuses on the fact that even though we talk about how patients and caregivers can be involved in determining what may constitute FAVES, the providers and developers in healthcare organizations need some additional guidance about how to evaluate AI modules for those FAVES and to understand any potential implications around implementation for any specific patient population, even when there is some transparency around how an algorithm works. So, there is some guidance out there from professional societies, there is some guidance out there from other federal agencies, but I think that could be part of all of this as well, helping to align and coordinate that guidance about how best to evaluate and implement decision support interventions, and having the transparency is part of that, defining the FAVES is part of that, but so is giving that education around what I do with that transparency and what I do with that FAVES information and coordination, and some of those recommendations can be part of that as well.

Medell Briggs-Malonson
Absolutely. I love those different ideas and comments as well, Hannah, and I think that is some of the things we had even discussed last time about the importance of us at least trying to hold some type of listening session where we are bringing all the entities together to understand how we actually apply this, just as you mentioned, or understanding how that is in terms of transparency and getting a clarified, unified understanding of this approach, but also, most importantly, how physicians, other clinicians, and patients should actually use this information as well. Those are all really great points there.

Aaron Miri
I like your comment there, Medell, because I had a meeting with ARC last week, and they are looking forward to this coming out because there is a lot of research work on quality perspective they are waiting for HTI-1 to come out with. So, to your point, that also informs the other agencies as well, so there is a uniform approach. I think it is spot on, accurate, and everybody is excited about this being finalized. Anna, I see your hand raised.

Anna McCollister
Yes, and my apologies for not being able to make the meeting on 9/25. I had an episode of acute neuropathy in both of my feet and was a little out of it. So, anyway, forgive me for just getting up to speed. I have a question about this, and to call it a concern is very much an overstatement, but I am a little hesitant to group this under technologies that advance health equity, just because I think health equity is a significant and very important concern as it relates to AI. I completely understand that health equity, whether it is based off of ethnic issues, geographic locations, or whatever, really needs to be thought through greatly in the context of this.

My concern as a patient advocate who has been very focused on quality measures and outcome measures over the years is that some of the stuff that is not working all that well in our current analog system for developing outcomes measures is going to get transported into AI tools, and what the algorithm is maximizing for as the be-all end-all for outcomes for quality may not actually match what is relevant to the patients, not just from a PRO perspective, but from that of the outcomes that are actually a far more accurate assessment of whether or not somebody is healthy or not, or ill or not. I do not know how that necessarily impacts it, but I think it is something that is inclusive of health equity, but also encompasses other areas of concern that I and others have as it relates to the incorporation of AI into EHR technology and certified health technology.

Medell Briggs-Malonson
Great. And so, Anna, just to make sure we understand, you are saying that AI in general is very broad, and I think there are some other aspects of AI that absolutely need to be addressed, but are you saying not to have it in the health equity section, but in a different section? What are some of those other sections that you are recommending?

Anna McCollister
I do not know that I have thought it through that far, to be completely honest. My apologies for that. I definitely think it is absolutely relevant to health equity. We are all familiar with how things can go badly awry in that situation. I am just looking through some of the other categories, forgive me.

Medell Briggs-Malonson
So, one thing I may say, Anna, which is something that I always love for people to also fully know, is that, for instance, the definition of high-quality care from the Institute of Medicine is based off six primary principles. That care has to be patient-centered, timely, effective, efficient, safe, and equitable, so, by their nature, you cannot have high-quality outcomes if the care not equitable because equity is part of high-quality care. I just wanted to put that out there because you were bringing up the importance of quality outcomes, which I agree with 100%, because it is part of my profession to drive high-quality and safe outcomes, but equity is fully integrated into that because it cannot be high-quality if it does not have that important sixth tenet of equity. So, is that part of what you are saying, like it goes across so many of the different domains we think about in terms of equity, not just to center it here? I am just trying to get full clarification there.

Anna McCollister

I will give you some concrete examples from my personal healthcare issues and frustrations with what the healthcare system was designed to maximize or at least use as a determinant, whether or not healthy or appropriately treated. I like to say hemoglobin A1C is like using the *Farmer's Almanac* to plan your afternoon. If you are maximizing for hemoglobin A1C, there are a lot of things you are missing that could be better captured and more relevantly used as guidance for treatment, such as continuous glucose monitoring. So, if everything that is being maximized in an algorithm, like for diabetes, again, just to use a very crude example and something we all understand, like A1C, that is not going to get you the best outcomes, especially for people with Type 1 diabetes or people not on insulin.

Another example is hemoglobin levels for anemia. That is the bane of my existence because we use that as a way of assessing whether or not people can get access to certain medications, and it is like we are maximizing toward specific hemoglobin levels, and that is all incorporated into a black box algorithm or some sort of an AI system. The outputs it will spit out may not actually be appropriate for a patient. So, as a patient, I would want to know what exactly these algorithms are maximizing for, which is a little different than all of the various and complicated aspects related to health equity and social discrimination or discriminatory patterns. **[Inaudible] [00:14:54]** qualitatively different, if that makes sense.

Medell Briggs-Malonson
Got it. Very clear, Anna. Thank you so much for describing that. I will tell you a couple of different things. First, we do have AI in many of the other sections, but true equity is not just rooted in, for instance, ethno-racial categories, gender identity, sexual orientation, or faith. It is actually also related for unique people with their various different disease states or physiologic conditions. That is what true equity is, and it encompasses it all, so your points are well taken. Maybe as we proceed on, we put that pin exactly as you said, to see if there are any other sections where we can really amplify that understanding and that transparency into how these algorithms are working to ensure that there is no unintentional harm for people that have certain medical conditions or certain other types of characteristics because we want everyone to be supported and thrive in that. So, it makes very clear sense that way.

Anna McCollister
Okay, thank you.

Medell Briggs-Malonson
All right. Any other questions about this topic? Are we all good with this here?

Aaron Miri
We are good.

Medell Briggs-Malonson
All right. Well, it sounds like we will keep moving on. I think what we are doing is just looking at some of the various different additions for some of these areas. Once again, there was missing health IT infrastructure for health equity and social drivers of health data. We see some of the various different additions that we discussed last time in terms of the adding of the public health organizations and social service providers, and then we have some of the proposed activities here. Thank you for moving it over. Are there any other comments there? Thank you. We have Hannah's prioritizations there too. Any other thoughts about this topic? Again, we are just going through some of the additions that were there.

Hannah Galvin
Medell, I made some comments down and to the side as well. I have two comments. One is the wording of the public health organizations, which I know we talked a little bit about last time, and social service providers. Maybe I need to lead back to what we said last time and how we are defining public health organizations because there is some different framing around actual departments of public health versus social service providers and CBOs, and so, I think I wondered whether or not we wanted to group all of those together. And then, there are some others, like schools, that could be public health organizations.

So, I had a question about whether we were including departments of public health as a public health organization in this grouping because I think we tend to put some of the public health reporting below. The other piece that I wanted to attend to in this area was sort of a larger question around… We really need to build out the infrastructure around CBOs and social service providers. Some of the data that is relevant to those organizations includes social drivers, but it also includes a lot of other data, like USCDI Version 1 data, basic PANI data, and basic demographic data, and I wonder whether or not we are confounding a little bit because we think about social drivers, and then, when I get data around a social driver, I refer out to a community-based organization for, say, food insecurity or transportation insecurity, and so, therefore, that is the first data that I will share with them, but I would say that in reality or in clinical practice, that may not be the first or only data that I would share with them. I would share demographic data with them.

And so, the focus on just sharing social driver data as opposed to building out an infrastructure for CBOs and social service providers that shares basic EDT demographic data starting at the beginning of what we built out, certified EHR technology data, is some of my question here and whether or not we are confounding the sharing of social driver data with just building out that infrastructure and the sharing of basic data first in patient-matching and giving that ecosystem their own… Does that make sense, or am I not making sense today?

Medell Briggs-Malonson
No, I think it makes sense. I would love to hear what the group has to say. I have some thoughts, but I would love to hear what the workgroup has to say about Hannah's questions. Any thoughts?

Aaron Miri
Honestly, I could go either way. I am being very candid. Hannah, I see your point, but I also see the way we had it written, too. I can see it both ways. I guess I am struggling with that, trying to reconcile one over the other. You are right, public health data is a little bit different and unique; however, from an interoperability and exchange data perspective, it is still the same types of parameters to make happen, so I guess I am torn, for lack of a better term.

Medell Briggs-Malonson
In terms of the two questions, No. 1, I think when we said "public health organizations," we were really thinking about public health organizations, meaning departments of public health throughout the country. Especially coming out of the pandemic, we know the challenges with interoperability that we had on so many levels, just communicating between our provider organizations, our public health organizations, and our governmental organizations, etc. So, Hannah, I think that is what we were thinking of initially when we included public health organizations, truly those that deliver services for the health of the general public,

but you bring up other important factors, like schools and others, and I think that is an important piece, but that is also another subset of more of our… It is hard to navigate where it is, and I would caution us against getting too narrow when we are still even trying to do some of the high-level work that we know that we need to provide all of the appropriate care to the general public as well.

So, I think that was one of the initial thoughts, and public health organizations are different from social service organizations or community-based organizations based off their scope and what their primary missions and objectives are. In terms of the SDOH data versus all of our basic demographic data, I just took it implicitly that if we have already developed the infrastructure to exchange social driver data, we cannot really exchange social driver data without having the information on who that data is linked to, which patient that is, which would include, of course, all of our various different demographic information and everything that is in USCDI 1. So, I think that is where my perception of that was. It was all inclusive because we are taking a step further.

Hannah Galvin
I think that is why, if you scroll down, I rated the gaps in infrastructure as immediate and this as longer-term because I saw needing to address the gaps in infrastructure first, and then, once we put those gaps in place, this follows on that. I just wanted to make sure that we have the same understanding there. If we think that all of that related to social drivers should be incorporated together in this one, including addressing some of the infrastructure gaps, then perhaps we should address it all together here as opposed to addressing the infrastructure gaps separately. That was my only piece. Down on the next page, where we talk about gaps and infrastructure, is what I thought of as a prerequisite to being able to better support this one.

Medell Briggs-Malonson
Those are all great observations. Again, I think in pyramids. You cannot get to the top of the pyramid without building the foundation, and so, although that may be where your vision is, all that basic information has to be there first in order for an entire system to work appropriately, so those are all very good points about how we should make it more explicit what we are referring to when we talk about improving the interoperability in the space. Any other thoughts or comments on this? Okay, everyone is quietly pondering today. Let's get through these two, and then, Aaron, I am going to turn it over to you, and we will go through them because we want to try and see how much we can get through today, since we have to present to all of HITAC on Thursday. So, reducing the digital divide: This is exactly what we discussed last month, but one of the things that we do have is, of course, looking at the additional data elements about a patient's internet access status, digital literacy status, and health literacy status. Hannah, you added in that additional health literacy status.

Hannah Galvin
I actually asked a question about the health literacy status. I think Michelle added it in. I just added some clarification that it may be… I was back and forth about it because it can just be assessed by different personnel, and we just need to define it a little bit, but I know we talked about whether to include it or not last time. Different people can define health literacy differently, so I was just thinking that if we include it as we discussed last time, we should further define what we mean by that. I agree that it is incredibly important, but I want to make sure we have some clear definitions.

Anna McCollister
Again, my apologies for missing last time, but would that just be a gut-check sense from the medical assistant, nurse, or physician, like we noted in our record, or is there some sort of standardized assessment of health literacy or the smiley faces as it relates to health tech? "Do you like health tech or do you hate health tech? Pick the emoji that works best for you." I do not know how that would be assessed and who would be doing the assessment.

Medell Briggs-Malonson
For health literacy assessments, there is actually functionality in the vast majority of EHRs in order to document one's health literacy status. This is typically performed in some level of intake, whether it is outpatient or inpatient. Is it universal across all of our systems? I am not quite sure it is. However, there is a lot of new push in legislation from both our governmental and our accrediting agencies in which you absolutely need to assess for health literacy status. Now, health literacy status is different from digital literacy status, although they are related. Digital literacy status is normally how one's comfort and understanding of using various different forms of technology, whether it is the technology itself or whether navigating within that technology itself, while health literacy is really also related to your literacy status, but health literacy is how you process all of that health information that is provided to you, and in what types of forms.

So, there is really general literacy, health literacy, and digital literacy. I always like to describe it as a Venn diagram, but each one of them focuses on a different area, but oftentimes, that core between them tends to be the area where, if you do assist somebody in that core, it will also help in some of the other areas, especially when it comes to general literacy and health literacy. Digital literacy is a little different because it still has to deal with the devices and some of the technology itself, but they are related. So, Anna, yes, we do assess it. It is not as consistent as it should be, because even if we assess it, we should be following up on it with additional resources to ensure that patient is receiving all of the information in an appropriate way, but there is a huge push to ensure that this is not only always recorded for every single patient, but also, those release sources are provided. So, Hannah, to your point about if health literacy should be included in the digital divide, it is related, but not 100% the same.

Hannah Galvin
I think it is great to include it. As far as I know, at least, there is not a standard out there for assessing it. It would be great to propose a standard, or at least define it, and maybe suggest that, in the future, there be some type of standard for assessing it, but that was my original comment on that.

Medell Briggs-Malonson
Thank you all for all of those. Any other questions or comments? Okeydoke, let's go on to the last one, then. So, the last one was, again, going back to reducing the digital divide, but increasing access to and accessibility of telehealth services. We just see some of the changes that were made based off our last discussion. Excel team, are you able to unclick that? Was that highlighted for a reason?

Hannah Galvin
I think it is because I put a comment there.

Medell Briggs-Malonson

Oh, okay. So, the comments there were "Explore the benefits and challenges of encouraging the adoption of security and accessibility standards by telehealth providers." Hannah, do you want to go over some of our comments there?

Hannah Galvin
Yes. I just recall that the previous time, we had said something about ONC working in its coordinating capacity with other agencies to ensure that public payers are at least supporting equity in the payment of telehealth. That was my recollection of something that we talked about. I think that would be more immediate, but I rated the other pieces as longer-term. That had been my recollection from the previous conversation that I did not see fully captured there.

Medell Briggs-Malonson
Right, absolutely. There was definitely that mention of that. I think Michelle hit the nail on the head there. Since this does fall so much into CMS's domain, and likely a few others, when it does come to our recommendations on behalf of HITAC to ONC, we are just trying to make sure we are squarely within ONC's jurisdiction, but of course, we are encouraging if there is any other collaboration or discussions to really reinforce not only the continuation of this type of technology, but making sure that equitable in access as well. Any other thoughts here?

Aaron Miri
I think it is straightforward, Medell. I do not have any comments.

Medell Briggs-Malonson
Great, awesome. So, thank you for that, Hannah. Those are really good points there. Okay, we went through these items. Let's go on to the next page.

Aaron Miri
I think the next green slide or cell is Page 6. Is that true, Excel team? All right, streamlining health information exchange. Hannah, do we want to talk about your comments here? It looks like the only addition is the word "the," but Hannah, do you want to talk about your comments or the support data linking target area?

Hannah Galvin
Yes. I do not know why I did not have it proposed here. I am just looking here… Oh, yes. I think it was because we had… I am just looking at Michelle's comments as well. So, we had the support data linking target area above, which I thought encapsulated our recommendations, and we focused on TEFCA. "Over listening sessions with other government agencies…" So, I thought we needed to reconcile the two priority areas, and Michelle clarified that the goal was to identify future standards priorities for consideration. I think I just thought this was similar to what we had in the… Where is the support data linking topic above? It is under priority target area interoperability. So, maybe you guys are able to help me understand that this is a recurring topic that we talked about year after year as opposed to the topic that we have under priority target area interoperability, which is something that we are proposing de novo this year. Is that correct?

Aaron Miri
Point me to the other one you are looking at. I am trying to search the document.

Hannah Galvin
It is at the bottom of Page 3.

Aaron Miri
Okay, got it. Are you looking at this data linking one?

Hannah Galvin
Yes, the supporting data linking. So, we were saying that a national standardized method for linking healthcare data is needed, and we said we would explore possibilities for national data linkage, especially across QHINs, and hold a listening session. And then, in this one down here, we talked about streamlining health information exchange. We have some gaps, we want to explore the development of implementation guidance that enables increased consistency of the data exchange… I am trying to remember what I was thinking here.

Aaron Miri
Maybe what you are going towards, Hannah, is a potential merging of the two topics.

Hannah Galvin
Yes, that is what I was going for. We need data linking in order to streamline the… Again, one is sort of dependent on the other.

Aaron Miri
It is a very fair question, Hannah. What does the group think? I see that. It makes sense.

Medell Briggs-Malonson
I just pulled up the entire document, and I was just looking at those two items that you were referring to, Hannah, and I think it would make sense for us to combine them and not have redundancy there.

Aaron Miri
Yes, that is a good call. You are right, Hannah. One of these has been reoccurring over and over again, so it has been on there, but now we have this other section too, so it is time to reconcile. Good point. All right, let's go to Page 7, Excel team. All right, one of my favorite topics here, cybersecurity events across healthcare infrastructure. This is what keeps me up at night. I see your comments, Hannah. "I am not sure how effective a listening session will be per se," CISA, best practices against agencies… So, are you proposing that we do more than just a listening session?

Hannah Galvin
Yes, I would expand it. Actually, since I made these comments, I watched a listening session that some congressional committee did with University of Vermont and a couple of organizations that had security events, and I actually found it very helpful in thinking about my own organization and cybersecurity readiness, so, after thinking that through, I think a listening session is actually helpful, but I also think we need to work across federal agencies to compile best practices because there are only so many ad hoc examples that you can listen to, and then we need some recommended best practices.

Aaron Miri
Interesting, okay. I love the idea. Any comments or feedback from the group? Is that under ONC's jurisdiction, or is it on CISA to provide that?

Anna McCollister
I feel like it is a thing that would be done with ONC and CISA. There is a specific risk.

Aaron Miri
To healthcare, yes. Fair point. It is a good question for even the ONC staff. Where does this come from, and how do you coordinate that? I do not know the answer to that. It is a great suggestion. We could compile information and put it in one place, like a CHPL of sorts.

Anna McCollister
Again, this is just me, and I am not an expert in cybersecurity, but maybe ONC/HHS could take up work with sites to develop some sort of a hacker-based defense mechanism, like what DARPA has done previously for DOD and the broader infrastructure. I know they have done a ton of work on this, and have been doing it for a long time. I do not get the sense that ONC has had that within their jurisdiction, or that HHS has. I could be completely wrong about that.

Aaron Miri
It would be good to find out. You bring up a great point, Anna.

Medell Briggs-Malonson
Anna, I agree exactly with what you said in terms of what is truly ONC's jurisdiction in this space because this has been a trending topic in terms of cybersecurity, and so, when it comes to, for instance, even our role or ONC's role in this, really helping to define that a bit more, just because as we are coming up with these recommendations here, we also want to make sure there is a piece for us and for our knowledge so that we can be a better group to provide recommendations to ONC, but we also truly need to understand what ONC's role is in these cybersecurity events and management so that we can be even more relevant when it comes to our recommendation. I absolutely agree with exploring a bit more about the jurisdiction of ONC in this space.

Aaron Miri
Agreed, and of course, there is a federal rep, Ram Sriram, who can also help coordinate and get some answers as well, so I think this is a great point to double-click on and just find out some more. It would be great to educate everybody on, to be quite honest with you, so it is a good suggestion. Let's go to the next one, around patient access to information. "Limited guidance for safety and security of mobile health applications." Hannah, your comment here asks if there is a way to combine this with AI tools. Do you want to walk us through your thoughts on that?

Hannah Galvin
I just thought that at a very high level, at the time that we first started saying we needed some guidance around global health tools, the guidance is what mobile health tools providers should recommend and what mobile health tools patients should feel comfortable using. Fast forwarding now to 2023, many, though not all, mobile health technologies, like every technology, are touting some version of AI. Again, the high-level

question we are still asking is how we can be transparent about what data is being used, how you are using my data, and what I am going to get out of this application. My thought was that the question was similar at a high level. How can the public, or how can implementers, who may not have a high degree of technological expertise, understand the pros and cons of utilizing a specific tool, whether it specifically incorporates AI algorithms, rules-based tools, or some other tools? That is why I was wondering if it might make sense to group that together, but Michelle responded and said that we cannot actually do that because of the CURES Act. So, that was my thought there.

Aaron Miri
It is a great suggestion. Michelle is the expert, though, so we have to default to her.

Anna McCollister
Why did she say we cannot do this?

Hannah Galvin
One of them is specified in the CURES Act specifically.

Michelle Murray
Yes, I will clarify a little bit. The CURES Act spells out what the HITAC can deliberate on, and there are three priority target areas, and there are additional target areas, and unfortunately, as it was written a few years ago, AI was not so prominent, so it does not have newer topic areas that we might want to cover. You can go to Congress and make a request to add a target area, at least temporarily, but temporary solutions usually involve lawyers to make that happen, which we do not have a process in place to do easily, and use existing target areas and use AI as a theme, so where it falls into each target area, it overlaps and plays both roles. Does that clarify enough for us?

Aaron Miri
Hannah, does that make sense?

Hannah Galvin
It makes sense to me.

Aaron Miri
Hannah and Anna, I guess both.

Anna McCollister
I think it makes sense. I am trying to get my head around exactly what it is we are trying to do. We certainly do not want to create barriers to mobile health apps, but given that there are basically two places where people download apps, one with Apple and the other with Google, maybe the recommendation would be for ONC to work with the App Store and Google Store folks to create criteria or standards they establish for what makes it into their marketplaces. That might be a way of doing it that would be low-touch regulatory to get to companies the ability to work with government to enforce what does and does not make it into these marketplaces as a way of ensuring their customers are actually accessing data that is substantial and meaningful. They have an interest in incorporating it into their own health kit so that it can be interoperable with other apps on their platforms, as well as with EHRs. That is just a thought.

Medell Briggs-Malonson
The private-public partnership that you are referring to, Anna, is interesting because that is where a lot of marketplaces are leaning towards. I had a quick discussion with a group of innovators about a week and a half ago about this exact aspect, and they are all in the app space, and they are all in the algorithm space, and some are in the device space, and they were saying, "Where is legislation going to lead for us as health technology innovators, especially when we feel like we have solutions that will greatly help people's outcomes, but we also do not want to be Xed out of the marketplace by having to jump through a lot of bureaucracy or various different criteria?"

And so, one of the things that we are discussing is that we have to, again, make sure these apps are rooted in integrity and are truly going to be abiding by what is going to promote greater health and not cause any unintentional harm, but of course, we also want to make sure we bring more of those innovators into the space to help us transform health and healthcare. I do not really know the answer to this at all, but it is something in which I think we are going to continue to see growing interest from both sides because it seems like we do need those safeguards, but yet, this may be an area where we actually do things a little differently than what we have done before in the past in terms of "certification" or whatever that may be in order to benefit the overall public. So, this is a great conversation. I just wanted to bring some of those additional real-world concerns onto the plate as well.

Aaron Miri
Other thoughts or comments from the group? Okeydoke. If not, I think the next phase of this is prioritization. Michelle, keep us honest here. Is that correct?

Michelle Murray
Yes. If there are no other questions on any other topics or content before you move on, then yes, you can go to prioritization.

Medell Briggs-Malonson
Great. And so, Aaron, as Accel is going up to the top, Hannah, thank you, you have already started prioritization, before the entire workgroup, as we mentioned last time, and just to bring everyone up to speed, we always like to go through all the various different topics and think about if they fall into one of two categories. Is this for immediate action, meaning as we define our report, we say this is an immediate recommendation which should hopefully be implemented over the next 12 months, or is this more of a long-term recommendation which will be executed in greater than 12 months? I believe we have a legend of near-term or immediate versus long-term, but if not, that is approximately where that lies. And so, what we always like to do is go through all of the topics and make sure we have a consensus on if this is something we need to immediately address in terms of our recommendations or something that is a long-term action for us.

Aaron Miri
Yes. In the legend at the bottom, it says "immediate/calendar years '24 and '25," and long-term is anything beyond '25. Just think of it that way.

Medell Briggs-Malonson

Excellent. I did not even see that legend on the screen. I knew we had it there somewhere.

Aaron Miri
Yes, it is at the very bottom of Page 8. All right, let's go through this, then.

Medell Briggs-Malonson
Aaron and I are just going to flow with this today.

Aaron Miri
Go for it. Just roll.

Medell Briggs-Malonson
We will start off with our target area for design and use of technologies that advance health equity, going back to the AI bias and transparency. Do we think this is immediate, meaning something we need to provide a recommendation for within '24-25, or could this be longer-term?

Aaron Miri
I do not see how it is not immediate.

Anna McCollister
I would think it is immediate. As these formulas are being developed, this really needs to be thought about proactively. I do not think it can be postponed.

Medell Briggs-Malonson
I agree. Does anyone think that we can postpone? All right, immediate it is. Let's go on to the next one. All right, this is going back to missing health IT infrastructure for health equity and social drivers of health. We had some discussions. At least initially, Hannah, you said it should be longer-term, but we are just going to clean the slate in general. Any thoughts on anywhere anybody wants to state where they are with this?

Aaron Miri
I would also agree with longer-term, just because we are developing the USCDI standards that are coming out, and they include a lot of social-drivers-of-health componentry that should be out by then. We should have some more data. At that point, V.3 should hopefully be nonvoluntary and required, and V.5 should be published by then, in the next two years or so, so we will have some better data to really tackle what is missing per se, in my humble opinion.

Medell Briggs-Malonson
Aaron, you bring up some really good points. Of course, you know me. I was going to say this is immediate, but you were so incredibly right, that there are several actions in play right now which will really incorporate some of this information. What I would say is still to vote for immediate, only because I feel like in the infrastructure, while there are lots of different activities going on, I am not sure they are all coming together, so maybe part of building that new infrastructure or assessing it is ensuring, exactly as you verbalized, Aaron, is that we are all tracking the same way in terms of what we currently have, and then we will be able to identify those gaps there.

Aaron Miri
Interesting. That is a good point. Other thoughts?

Hannah Galvin
I would still say longer-term. Let me jump down one page, where we start talking about public health infrastructure. I would say there are some dependencies here. As Aaron points out, USCDI V.3 is coming out, and I think there are some infrastructure dependencies. When we are talking about longer-term, we are talking about a year or two. We certainly do need to be focusing on this, but I do think that there are some infrastructure dependencies here that I would focus on first. How do we actually get the CBOs to adopt tools? How do we get them funding to adopt those tools before we start driving the actual SDOH data that they are collecting? I did not necessarily see those both as part of this because I saw the infrastructure piece below, so that is why I chose longer-term. If we are specifying that driving and improving infrastructure of CBOs, which I did not fully read in here, is part of this, then I may reevaluate, but I did not see that in here. I saw this as more of the adopting standards, and I am not sure the CBOs are quite ready to do that yet.

Medell Briggs-Malonson
That is a really good point, Hannah. I guess for No. 2, I took it as looking at the framework, like exploring the development of a framework to support the adoption and implementation, so I took that as less of standards, but more of looking at infrastructure. I completely hear your and Aaron's comments.

Aaron Miri
Anna?

Medell Briggs-Malonson
Anna we saw you come off mute, but we do not hear you.

Anna McCollister
I am just grabbing something to drink, sorry.

Aaron Miri
All right, so what I am hearing is we have a split decision here.

Anna McCollister
I just stepped out of the room to grab something to drink, and I apologize, I missed part of the discussion.

Aaron Miri
No worries. So, we are looking at infrastructure for health equity and social drivers of health data, and trying to decide whether it is near-term or not, and the debate goes both ways. One view is that standards are still being developed and rolled out, so there could be an argument to wait until those are rolled out to see what is going on, or, to what Medell said, there is such a grave need for coordination of activities that it could be immediate to help steer those and make sure everybody is rowing in the same direction per se. So, the question is do you have comments from your perspective on the timing of this? It is like the chicken and the egg. What comes first?

Anna McCollister
I do not know that I feel strongly one way or the other, to be honest. I have had very limited work interface with public health centers or community-based organizations that serve people with fewer resources, so I will throw that out as a caveat. To the extent to which I have been involved in discussions, they seem to be so resource-limited. Are they even going to have updated computers that are able to access this kind of information? I could be completely wrong. Maybe that is an assumption based off outdated information, but since most of the funding for those places comes from the states, I believe, is it realistic for ONC to develop standards or to suggest that standards are developed for this? Again, I have remarkably little knowledge about this space, so others who do have better knowledge about it can overrule me or tell me I am completely wrong.

Aaron Miri
One of the important aspects of USCDI's uplifting the EHR vendors and the EHR products is to then be able to exchange discrete SDOH data, and then the CBOs and others leverage those data elements. The thought is if you certify a system that has these criteria and elements, at some point at the far end, the CBO or other entity, which could be state-funded, would need to receive that data or vice versa, and then up the ante with potential carrots and sticks over the years to force the issue, much like Meaningful Use, although it makes me cringe to say those two words nowadays. The reality is those are incentive-based drivers to move forward. The question is, though, is the time right to do that at this very moment or wait a hot minute and then do it once some more standards are rolled out? I think that is to the point of what we are being asked to decide, but correct me if I am wrong, Medell or anyone else.

Medell Briggs-Malonson
No, Aaron, you are absolutely correct. Eliel, I almost feel like I saw you about to say something, but if you are unable, that is completely fine. Let's put it as longer-term for right now, since we are a little bit split on this, but then, when the whole workgroup can take a look at it, we can have an additional discussion. This is going to happen, but the real decision is do we really make this as a recommendation now, or do we wait to see everything else come out, and then move forward with this work?

Aaron Miri
That is a good plan.

Eliel Oliveira
I will try to jump in as well. I am driving, and I am not sure you can hear me okay, but I have a few thoughts. Overall, given the challenges that we faced in the pandemic with services and delivery, which were not limited to pharmacies, but affected everybody, I feel like we cannot wait for another disaster to have a process in place for social services. That is one thought. The second one was the data really has a sense of variability of services out there. I agree with Anna that some of these service providers are really not **[inaudible] [01:00:15]** have data privacy, but that is not the case for many of them, and some of those programs are critical for improving health overall. I will mention two here. Federal programs, especially SNAP and WIC, which are for nutrition, are highly necessary, and we know they directly impact improving health, but if you look at WIC, only 50% of the population even benefits from that, and for SNAP, I think 33 million people could still benefit from it.

In the case of central Texas, the Central Texas Food Bank serves 21 counties. It is a massive operation. It is not a small shop, meaning they are going to have the technology. They are going to have the computers. They distribute food throughout a very large group of the population and work directly with the Medicaid program to get folks signed up for it. What we do not have is a process to actually monitor these referral processes in detail to know exactly where things are falling into the cracks, as I think you saw in my presentation in the face-to-face meeting, and the point I am trying to make is when we talk about SDOH, it is so much, but if we just focus on federal programs and how we can put the systems and standards in place to allow the communications to exist fully, the impact would be tremendous. We do not need to solve every SDOH problem, but we should at least focus on a few key ones. I hope that helps.

Aaron Miri
That is good feedback.

Medell Briggs-Malonson
Thank you, Eliel, and be safe driving. So, we heard you say that you are voting for immediate, then.

Eliel Oliveira
Yes, that would be my position, but again, it needs to be changed a little bit. You cannot just say one thing for everything, because then we really get caught in a challenge, but maybe we should focus on certain specific federal programs that are high-impact, like the ones I mentioned, though there could be others.

Medell Briggs-Malonson
So, we are still a little bit divided. Maybe what we should do is sit on this for a moment and then come back to it because we still have some prioritizations that are coming through, and we can also get feedback from Anna and Jim because we are about two and two, and Anna is also thinking about it, and then we will get Jim. Let's leave it as longer-term right now, and then we will circle back to this so we can get through other areas. So, reducing the digital divide, general: Is this immediate or longer-term?

Aaron Miri
It needs to happen yesterday, in my opinion.

Medell Briggs-Malonson
I agree.

Hannah Galvin
I agree. This needs to be immediate, as you can see in my comments there. This is a prerequisite to everything else that we are trying to do.

Aaron Miri
Everything.

Anna McCollister
I agree.

Medell Briggs-Malonson

Excellent. Thank you, Anna. I think Eliel will agree too. All right, next one: Reducing the digital divide. This is increasing access to accessibility and telehealth services. Immediate or longer-term? I will jump out there. I think this is immediate, and the only reason why I think this is immediate for us to explore is because I think the window for opportunity is closing. So, if this is part of our discussion, especially with the other entities like CMS and others, we know there has been some movement of thinking about what to do in this space, so I would say that, especially for something coming from the HITAC Annual Report, just mentioning the importance of some of this work would be important, and so, I would say it is immediate at this moment.

Hannah Galvin
Medell, I think this is where my comment came into play there. I think that some of this is dependent on parity and how much CMS and others allow for continued payment parity. If audio telehealth services continue to be given payment parity, especially by the public payers, to me, there is not quite as much urgency here as there is around other things. Telehealth is broad. There are ambulatory telehealth visits, and then there are things like remote patient monitoring and hospital at home that fall under telehealth, and I think some of those things and reducing the digital divide to allow for some of those complex functionalities can be longer-term if there is payment parity in the immediate so that populations who do not have as much access can continue to receive remote services in the ways that they can.

So, I think that is why I put it longer-term because not everything can be immediate right now, so how do we triage and phase these approaches? But I agree with you that this falls very well under reducing the digital divide overall, and we have a lot of current examples of the ways in which the digital divide has created inequities, specifically around telehealth, in the past few years, but I do think there are ways in which some of this needs to be addressed more immediately than others.

Medell Briggs-Malonson
Hannah, I think you bring up a lot of good points, and it goes back to what we really want to focus on for this topic because payment parity is a huge piece, especially when it comes to what we are doing, at least, say, with televisits. I think what this one was referring to was at least making sure the design of the telehealth services that were provided was inclusive in nature, especially inclusive in terms of language alignment and ability alignment for all our various different patients that may have diverse abilities or be non-English speakers, and ensuring that we are supporting more of those various different approaches and standards for that before things just continue to grow.

So, you bring up a really good point, and because we have not really discussed payment parity and the use of the various different forms of telehealth in this topic per se. So, that is one of the things we have to look at, so, unless we want to add to this topic or if we feel something… At this moment, I feel we need to either keep to this topic or slightly refine it, but I think this topic is really focused more on increasing the inclusivity of the telehealth services so that all people can benefit from it.

Aaron Miri
Right. That is how I read it, Medell, so I would say this should be immediate. This kind of goes hand in hand with the one above, the digital divide. I do not think we can wait. It is getting worse day by day, the more ambiguity there is in the market, in my humble opinion.

Anna McCollister

I know I already said I agree, but I do think this is immediate. I think it is going to get easier and easier to chip away at the access to telehealth, and I think that greater access has been one of a very few bright spots that came out of the pandemic. It is really important for increasing access to good care, particularly for people who live in remote areas or who have difficulty accessing in-person care, and it has certainly been a huge benefit for patients who have disabilities or parents of patients who have disabilities. So, I think we need to prioritize figuring out how to make this thing that has increased, in my opinion, equity for those who have fewer digital resources.

Medell Briggs-Malonson
Those are all great pieces. So, it sounds like we are going to look at this one as immediate right now, but let's definitely keep in mind every single thing that you said, Hannah, because you were spot on. That is the other piece of all of these services as well. All right, we have a few more minutes. We are going to keep on jamming through to the next one. Aaron, I am going to turn it on over to you for Page 3.

Aaron Miri
All right, gaps in infrastructure and standard to support data sharing. Of course, this is a need for infrastructure support, that data sharing, etc. This is one that we have been talking about and looking at for some time, since public health became an area for the HITAC, so it has been on here for quite a hot minute, and all of us saw the limited gaps who had to email various agencies because there was no interoperability, so we were restricted to email systems and fax machines because that is what we do. So, I am going to go out on a limb, being that I was one of the ones who had to live through it, and propose that it be immediate. We need to deal with this. This is an issue, and knock on wood, if there is another global outbreak, we are going to be right in the same basket of worms because nothing has really been addressed. That is my opinion.

Medell Briggs-Malonson
I agree.

Aaron Miri
Any dissent? No? All right. Next up is interoperability. Support data linking; lack of standardized health data linking has resulted in disparity of interoperability across systems and states. Kind of like I was saying earlier, understanding how we can get that data… To me, it is the same argument as we had before. It is immediate because the need is so great. Does anybody disagree? Okay.

Anna McCollister
That is definitely immediate.

Aaron Miri
Next: Interoperability standards, labs and pharmacies, and testing mapping to LOINC and SNOMED. Pharmacies lack integration, and they also lack a desire to, in some cases, depending on which pharmacy it is, if I am being completely candid. The opportunity is to explore the requirements for reference laboratories to meet USCDI standards, help pharmacies leverage TEFCA for treatment purposes, which would be wonderful, and explore requirements for the provided NDC and RxNorm codes. I will say the pharmacy taskforce is meeting actively with a bunch of recommendations to come out, so we will be hearing that this Thursday. That is sort of a preview, not for anything to vote on, but we will be hearing a lot of the

good work, which will be positive, so it also matches this topic in some way or fashion. So, for a proposed tier, Hannah, you are saying longer-term. Any thoughts or questions from folks?

Medell Briggs-Malonson
I am leaning towards what Hannah is mentioning, too. I would see a bit more of what even our workgroup comes out with and what their recommendations are, and I do not know if we will have time to then come back to this to assess, based off what their recommendations are, how we would like to proceed with the annual report, but I would say longer-term right now to understand their assessment and their recommendations first.

Aaron Miri
I would agree.

Anna McCollister
I feel like laboratories are different than pharmacies. I think laboratories are immediate, and pharmacies… I am on the pharmacy workgroup, and that is a little more complicated, but I do not know why laboratories are not required to do those.

Aaron Miri
You are right, but it interesting, though: If you look at CAP inspections and CAP rules for labs and what they require there, that maze you have to navigate for CAP inspections, as well as for any of the CLIA-certified labs and everything else that folks were spinning up to support the mass COVID testing, like we did in my prior life, it is a very interesting maze that you have to navigate to get that going, so even if we wanted to put it as immediate, I do not know how we would go about that. Maybe we could kick off listening sessions to figure out how to do it and how to navigate, but I do not even know where we would start.

Anna McCollister
I am sure there are an incredible number of details that I just do not understand, but laboratories have been sharing structured data for a long time with doctors, direct to the EHR, and direct to patients and patient portals, so they have the capability and the data structure. We know what it means and where it goes in the EHR. I do not know why they are not included. Pharmacies are more complicated, but I see labs as an immediate. This needs to happen.

Eliel Oliveira
I tend to agree with Anna that labs are different. I agree with everybody as well that the pharmacy taskforce is doing great work there, and we have to wait for that, but on lab, I feel like Clem McDonald would be a good person to reach out to and get some ideas from, given that he has worked there at LOINC, but I think the biggest issue I have seen on this front is related to hospitals that have the internal labs instead of with lab companies and how to fix that. This may not work for everything because it is a big mess, but **[inaudible] [01:15:19]** some priorities. Labs have become a part of the USCDI that hospitals have to comply with as well. I remember going through some of that, where 200 or 300 labs for research were reporting certain disease surveillance activities. That might be what is necessary to physically force a set of labs that need to be harmonized for hospitals.

Aaron Miri

Good points, Eliel. Other thoughts?

Anna McCollister
The lack of interoperability of lab data and lack of sharing has consequences. I was on a panel last December with Steve Posnack, Deven McGraw, and a variety of other people, telling the story of going to my OB/GYN and attempting to merge three different patient portals just to get access to information about a specific organism, like a UTI, and it was impossible. It was a 25-minute attempt to try to get access to the data with different lab values from different portals, and it was just absurd. Again, all of that stuff has been structured and exchanged for quite some time. The issue is why it is not interoperable.

Aaron Miri
Good points.

Medell Briggs-Malonson
So, when we all come together on this, do we think that, with all this wonderful discussion, this is something that is longer-term, which just means within a year, that we would be able to address some of these interoperability challenges and make these recommendations, or is this something now that we need to include?

Hannah Galvin
I would just point out that I do think lab is complicated as well, and I wonder if there should be a lab workgroup in addition to how we have a pharmacy workgroup, and I wonder if that has happened in the past as part of HITAC. I would say from a lab and pathology standpoint, it is not just a matter of mapping to LOINC. I hear from my chief of pathology all the time that they are concerned about us just mapping because they do not trust that reference range on that external instrument, or they do not trust the methodology on that instrument. There are all sorts of business cases around why they are using this or that reference lab, so it does not just come down to being lazy and not mapping appropriately. They have all sorts of opinions about whether or not this lab or that lab is using the appropriate and the most up-to-date techniques, and whether they trust them, and whether they want them in the same record, side by side, with their techniques, whether they actually mean the same thing semantically, and whether the reference ranges should be the same.

I think it becomes a debate, not just “Hey, this should be mapped” and it cannot be mapped, but whether they actually think these are equivalent lab ranges and lab values, and so, I wonder if we should have some listening sessions from pathologists and labs to understand those challenges because I think it is more complicated than we understand. I think some of it is economics and some of it is the science and the clinical state of the field of laboratory medicine and pathology right now as well, and maybe we should better understand that as well, and I wonder if we have done some of that in the past, prior to this year. That is at least the pushback that I get around going through and doing a whole bunch of mapping as reasons why everything cannot just be mapped to the same codes.

Medell Briggs-Malonson
Thank you for those insights.

Aaron Miri

That is good feedback. So, I just want to make sure we land on something here. We are all saying that needs to be done soon, but I am not hearing that it needs to be done tomorrow. It almost seems as if it could be done in a year. Am I hearing that right? I realize it is complicated, but everything is complicated, right? "Who knew healthcare was so hard?" But the reality is I just want to make sure we are landing in the right place here and that I am hearing everybody correctly. Are we saying it should be longer-term, with the focus starting now to ask questions and look at the work plan? Maybe there is something ONC could do to start getting things organized. Is that what we are saying?

Hannah Galvin
I agree with that.

Aaron Miri
Anna, did I hear you right?

Anna McCollister
Again, acknowledging and respecting everything that Hannah said, I am sure there are nuances to different lab tests and lab results that I do not regularly get, so I am sure there are real issues, but I feel like certain lab values should be more readily exchanged. Again, from the perspective of a patient, this seems to me like really low-hanging fruit, and I do not understand why it is not exchangeable at this point, understanding that it is very complicated.

Medell Briggs-Malonson
So, Aaron, listening to both Hannah and Anna, I am wondering if we should just go ahead and put it as immediate because there is so much work that needs to be done to really rectify this area. It sounds like this may be an immediate time for some prework that then continues to lead into some of the longer-term work, so if we just put it as immediate, at least we can recommend some of those initial activities.

Aaron Miri
That makes sense to me. We will gait it appropriately, right?

Medell Briggs-Malonson
Exactly.

Aaron Miri
I know we are running really close to public comment here, so should we go to public comment and then come back so we do not start another subject area? What does this group think we should do.

Medell Briggs-Malonson
Public comment sounds great.

Aaron Miri
Okay. Mike, can we go to public comment, please, sir?

Public Comment (01:22:07)

Mike Berry

Yes, we sure can. 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 happen to be just 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 for a moment to see if any members of the public would like to make a comment. I am not seeing any hands raised yet, so I will turn it back to our co-chairs to finish this out.

Medell Briggs-Malonson
Thank you, Mike. Great. If we go back, we have a couple more minutes. Maybe we can see if we can do one more topic.

Aaron Miri
Let's do it.

Medell Briggs-Malonson
Oh. Well, we will try to go fast. So, going to supporting interoperability standards for long-term and post-acute care providers, once again, this is really focused on interoperability across the broader care continuum to include LTPAC providers. Once again, is this immediate or long-term? Any takers for one of those? Hannah, you say longer-term. I would also say, at least right now, we still have some other work to do, so I would say longer-term until we understand this area a bit more.

Aaron Miri
I agree. Not to take away from LTPACs, which do some great work in the community, but they are much further behind and we need to help them out.

Medell Briggs-Malonson
One hundred percent, and we need to understand where the gaps and needs are so we can be as effective as possible.

Aaron Miri
That is absolutely correct.

Medell Briggs-Malonson
Anna, any concern with long-term?

Anna McCollister
No, it is fine.

Medell Briggs-Malonson
All right, thank you, everyone. Eliel, we know we will get your votes offline. Information-blocking infeasibility exception: This is really looking at all the information-blocking rules and all of the pieces in terms of requests to access, exchange, or use of EHI, and so, Hannah, you put that it should be for immediate use, especially if it is not incorporated into the final rule for HTI-1, which we are not aware of, or into HTI-2. Any other thoughts from the group?

Aaron Miri

Immediate, flat out.

Medell Briggs-Malonson
I agree with that. Hannah?

Hannah Galvin
Just to clarify, clarification is needed now.

Aaron Miri
Oh, yes.

Medell Briggs-Malonson
Wonderful.

Anna McCollister
Clarification for what?

Aaron Miri
What are the get-out-of-jail cards that mean you do not have to meet the criteria? There is a lot of ambiguity in the industry, and to be quite candid, I am hearing a lot of vendors trying to skirt the system of providing data for a lot of reasons and giving a bunch of nonsense, so we need to clear this up.

Anna McCollister
Okay.

Aaron Miri
Immediate availability of data should be the goal of everybody, bottom line, outside of preventing harm and those few allowed things, but clearing that up matters.

Anna McCollister
Yes, I agree.

Medell Briggs-Malonson
We can definitely feel your passion on that, Aaron. I completely agree with you.

Aaron Miri
Absolutely. I have gotten some aggression out with some vendors. “You are breaking the law!”

Medell Briggs-Malonson
Well, let’s keep that passion going with information blocking for registries as well. I will not go into everything, but in terms of the opportunity, it is assisting with the implementation of existing and upcoming federal policies that could affect access to registry data. Going back, this is very connected to other forms of information blocking. Hannah, you already wrote here that you think it is also immediate. I have a feeling about what Aaron thinks as well. Two thumbs up?

Aaron Miri
Two thumbs up.

Medell Briggs-Malonson
Anna, what are your thoughts on this piece in terms of if we should approach it now in our annual report?

Anna McCollister
Honestly, I do not feel that strongly one way or the other about it. I have some concerns about small advocacy groups maintaining registries and whether or not they have the resources to be able to withstand some sort of oversight from ONC, but if the issue is around clarification about what and who would fall under the jurisdiction of information blocking, that probably would be helpful, but I just want to raise the issue that not all registries are created equal, and resources behind registries are not created equally. There is a big diversity there.

Aaron Miri
And the costs for registries are not created equally either. It is a big business.

Medell Briggs-Malonson
Those are such important comments, Anna, and you are absolutely right. I hope that if this recommendation moves forward, of course, that would be the feedback, because the recommendation is just to support the development of guidance of how to appropriately implement these registries and who is considered an actor subject to information-blocking rules, so that would be some additional feedback that would be provided to ONC, so that is all really good information there. I appreciate that. All right, at least we have that done, and it looks like we are at the very end of our meeting. Thank you, everyone. We know we have to do it almost rapid-fire there, but thank you for the wonderful discussion, the thoughtful insights, and the prioritizations. We really appreciate all of this work, and thank you, Michelle and the Accel, for all of your help as well. Aaron?

Aaron Miri
Ditto on that. Have a great one, and we will see you on Thursday.

Anna McCollister
Thank you.

Medell Briggs-Malonson
Bye, everyone.

Aaron Miri
Bye, all.

Next Steps and Adjourn (01:28:17)

QUESTIONS AND COMMENTS RECEIVED DURING PUBLIC COMMENT

No comments were received during public comment.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT

Mike Berry (ONC): Thank you for joining the HITAC Annual Report Workgroup. Please remember to tag "Everyone" when using Zoom chat.

Eliel Oliveira: Note how several agencies have done quite a bit on this front here including ONC, AHRQ (page 71): https://www.hhs.gov/sites/default/files/hhs-trustworthy-ai-playbook.pdf

Hannah K. Galvin: I don't think there is a standard out there for health literacy; it would be great if there was

Hannah K. Galvin: I'm good with immediate!

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

No comments were received via email.

RESOURCES

AR WG Webpage
AR WG - October 16, 2023, Meeting Webpage