Transcript

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

July 22, 2024, 12 – 1:30 PM ET

VIRTUAL

MEMBERS IN ATTENDANCE

Eliel Oliveira, Harvard Medical School & Harvard Pilgrim Health Care Institute, Co-Chair
Shila Blend, North Dakota Health Information Network
Hans Buitendijk, Oracle Health
Steven (Ike) Eichner, Texas Department of State Health Services
Hannah Galvin, Cambridge Health Alliance
Jim Jirjis, Centers for Disease Control and Prevention
Kikelomo Oshunkentan, Pegasystems
Rochelle Prosser, Orchid Healthcare Solutions

MEMBERS NOT IN ATTENDANCE

Medell Briggs-Malonson, UCLA Health, Co-Chair
Sarah DeSilvey, Gravity Project
Anna McCollister, Individual

ONC STAFF

Peter Karras, Acting Designated Federal Officer, ONC
Michelle Murray, Senior Health Policy Analyst, ONC

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

Peter Karras
Good morning, everyone, and welcome to the FY24 cycle of the Annual Report Workgroup. I am Peter Karras with ONC. I would like to thank you for joining us today. I am going to be serving as the designated federal officer for today's call on behalf of Seth Pazinski, and just as a reminder, all workgroup meetings are open to the public and public feedback is welcome. Members of the public can type comments in the Zoom chat feature throughout the meeting or make verbal comments during the public comment period that is scheduled toward the end of the agenda. I will now start the meeting by beginning roll call of workgroup members, so when I do call your name, please indicate that you are present, and we will start with our cochairs, and I will just note that Medell Briggs-Malonson will not be attending today's meeting, so we will first start with Eliel Oliveira.

Eliel Oliveira
Good morning, everyone.

Peter Karras
Good morning. Hans Buitendijk?

Hans Buitendijk
Good morning.

Peter Karras
Good morning. Hannah Galvin?

Hannah Galvin
Good morning.

Peter Karras
Good morning. Jim Jirjis?

Jim Jirjis
Good morning, present.

Peter Karras
Good morning. Anna McCollister? Shila Blend?

Shila Blend
Good morning.

Peter Karras
Good morning. Sarah DeSilvey? Steve Eichner?

Steven Eichner
Good morning.

Peter Karras
Good morning. Kikelomo Oshunkentan?

Kikelomo Oshunkentan
Good morning.

Peter Karras
Good morning. Rochelle Prosser?

Rochelle Prosser
Present, good morning.

Peter Karras
Good morning. Thank you all, and now, I would like to turn it over to Eliel for his opening remarks.

Opening Remarks & Update on Workgroup Plans (00:02:00)

Eliel Oliveira
Thanks again, Peter, and good morning, everyone. It is great to have you here, and I hope you were part of the last HITAC meeting where we presented a little bit of where we are in our work here and we still remember where we are, but if not, do not fret. We are going to cover that in a little bit and provide some details on where we are and what we are doing today, but I am excited that we are on target with our plans. Thank you for joining, and I am looking forward to comments and suggestions from today's discussion. You can see here on the agenda that we are going to provide an update on the plan, then we are going to jump onto the crosswalk to discuss the topics for FY24, and I think specifically, we are going to try to stay with interoperability today as a follow-up from the last meeting. We are going to open for public comments at

the end, and then give next steps and adjourn the meeting. That is our plan for the day. We can go to the next slide.

Here is an update on the workgroup plan. As you can see, we are here on July 22nd to continue to develop the crosswalk of topics. We have another meeting on August 5th to continue, and that is going to be the last meeting before we actually update HITAC again at the August 15th HITAC meeting. Then we will come back, finalize the crosswalk topics, and aim for a first draft of the annual report by September 9, with some review in the October meeting, which, as you all know, will be in person for those who can join us in person. We will update the report in November and be ready for transmittal in December. So, that is where we are today. Next.

This is a timeline of our HITAC meetings. So, the last meeting, in July, we discussed a topic list, as you know, and hopefully, by the 15th, after what we cover today and will cover the next meeting, we will then discuss the crosswalk and the status of the crosswalk at that point. And at the September meeting, we will be providing an update on the report itself. If you recall, Michelle and the team provided us with a new model on how the report is going to be shared, so I am excited to see that coming together well. I think it is going to attract more readers. And then, in October, again, we are going to review the annual report and approve it by the November HITAC meeting. Next.

So, as you know, for the annual report, we are going to work on developing a draft crosswalk of topics with gaps, opportunities, and recommended activities across the target areas and present it to HITAC in August. The workgroup will review the draft report in September and present it to HITAC in October, and after further edits, HITAC is supposed to approve the report and transmit it to the National Coordinator in November. Finally, ONC will forward the final report to the United States Department of Health and Human Services (HHS) Secretary and Congress and post it on healthIT.gov at that point. I hope that makes sense to all, and I am going to proceed from here. Let's go to the next slide, please.

So, we are going to discuss a little bit about the topics and priorities. As you can see here, we have five: The use of technology to promote and advance health equity, the use of technology that supports public health, interoperability, privacy and security, and patient access to information. So, that is our charge in the CURES Act. In the last call, we covered the first two, so, today, we are going to focus on interoperability, but at the same time, we are going to take a look back, and as you have received electronically the comments and edits that we made to the crosswalk as of now, we will continue making progress today with interoperability, and hopefully, maybe we will cover the other two areas in the next call to prepare for the next HITAC meeting. That is where we are, and I think from this point, we just want to go and jump straight in on the crosswalk, if I am not mistaken. Maybe the Accel team can move us to that if that is the case. Okay, great.

Discussion of Draft Crosswalk of Topics for the HITAC Annual Report for FY24 (00:07:09)

Eliel Oliveira

So, before we jump into interoperability, I just want to go back up to the top of the crosswalk to give everyone on the team an idea of where we are. So, as you can see now, we have a box on the top right corner of the crosswalk that basically details how we are making edits to the crosswalk over time. You see here that the red text is all the edits that we discussed and covered under health equity last time we met, and today, we are going to cover a bit more. And those edits are going to be on brown text, including for other areas in

the crosswalk documents, and we will keep doing that and having different color codes here, as you can see, for the different edits so that we can track appropriately. So, I will highly suggest and recommend that all of you, as you receive these electronically, go back and read each one of the topic areas and see if we have anything here that we need to further edit and adjust, make those edits and send them back to us, and we will consider all edits and suggestions, as you all know. But I just want to make sure that everybody knows and is aware of how we are going to continue to make edits going forward.

So, I just wanted to mention that, and if you have any thoughts or questions on this point specifically, I just want to hear if there are any thoughts or questions before we jump into interoperability today. Okay, hearing none, if you do have questions, please raise your hand. Otherwise, Accel team, I think we can go back to the interoperability heading at this point, and we are going to start right here at the top.

I think we have already captured some comments at the end of the interoperability section. We are going to get to that, but Topic No. 1 is supporting interoperability standards for laboratories and pharmacies, a very important one. The gap that we see today is that inconsistent use of standards by laboratories and pharmacies creates a barrier to interoperability. Pharmacies lack integration into the existing data exchange infrastructure that is widely deployed and bidirectional today. The challenge that we see is that laboratories and health systems often use local codes for laboratory tests that then must be mapped to common terminology standards, like Logical Observation Identifiers Names and Codes (LOINC) and Systemized Nomenclature of Medicine (SNOMED). There is a lack of infrastructure to support the connectivity of pharmacy data with the broader health IT ecosystem, so this is a very important challenge to address.

Some opportunities that we highlighted here so far are that we should explore available adoption levers to require laboratories to meet standards, increased pharmacy data transparency requiring drug shortages and availability details to be included. And we even have some proposed recommended HITAC activities, like holding a listening session to identify adoption levers that could be used to incentivize laboratories to support increased use of data standards. But of course, others here are what we are looking for from your recommendations. So, I will stop there and see if there are any thoughts, questions, or suggestions. Hans, I see your hand.

Hans Buitendijk
Yes, Eliel, thank you. I think this has been on the list for a number of years, which is good, although the question is then what progress is being made, so I have a comment about progress and scope. With the Health Data, Technology, and Interoperability: Patient Engagement, Information Sharing, and Public Health Interoperability (HTI-2) Proposed Rule, I think we are seeing proposals that are steps forward to address some of the things that we had indicated. By the time we wrap this up, we do not know whether this will be included or not, so I think we should keep it in, since we do not yet know what HTI-2 is going to do. From a scope perspective, what I am curious about is whether we needed to be clearer to either explicitly include labs that are public health labs, not lab reporting, but the public health labs, when we talk about Electronic Test Orders and Results (ETOR) and like initiatives that are advancing, whether that should be part of it. I would suggest that it would be helpful, unless there is another area where we can call out public health more specifically, but it seems to fit in here, and we want to be consistent across those areas.

My suggestion would be that we clarify that we are not only looking at commercial labs, but at any labs, such as public health, as well. The second part of the scope, if you will, is that labs and pharmacies could

be present inside the organization, in a way, such as a hospital pharmacy system or a pharmacy lab system. I am not convinced that that is the focus of what we do, so, perhaps somewhere in the language or the context that we are aware of in our discussions, we are really talking about those external labs or pharmacies in the community that we communicate with, not as much the ones inside the healthcare system, where this has typically already been addressed or which have some very natural leverages and requirements that they progress and connect because they are inside the same organization.

Eliel Oliveira

Great comments, Hans. On the internal labs and pharmacies, you are right, the data is already there. But my experience has been that they may not necessarily be following the data standards. As an example, when we got data in our Health Information Exchange (HIE), which we did for National Patient-Centered Clinical Research Network (PCORnet) as well, from commercial labs, they would already be using LOINC, so that was great. But when it was from hospitals and internal labs themselves, it was very difficult because they would basically create whatever nomenclature they felt like in their internal labs, and it was very problematic then to match in the duplication of the specific labs that they had over time. I remember we did that for a hospital that had 15,000 labs, and just for A1C, there were a hundred different ways it was being called in their electronic system.

So, that is my perception there, and I do not know if you mean that because the data is already there, we should not be pushing for internal labs and pharmacies to standardize as well, so that is one piece of feedback. But I think on your other comment, it seems to me that what you suggest, maybe under recommendations here, is that we do a look back on what has been the evolution of this specific topic, and it could be informational for HTI-2, but at the same time, it is just to give us a sense of what has happened in the past and why we are still not where we wish to be.

Hans Buitendijk

I would not disagree with you that there are variances there. The question is which variances in this context that we want to focus on the most. Just to highlight two aspects of it, integration with lab systems inside the organization is typically much more limited to the specific information they need, not necessarily all the demographic data of the patient, because a demographic registration system already has it, so, in that sense, it would not be necessary, and we do not want to give the impression that they have to share all that information with the lab because there are different mechanisms in which that can be shared. So, there is an aspect of it that is not as critical as if you communicated with an external lab that may need to further report, etc. But when it comes to the vocabulary being used, such as standards, coding, etc., the question is really what is being used as the source to communicate externally. You still have a similar question where you want to make sure that, externally, there is alignment on industry vocabulary, but is it the Electronic Health Record (EHR) where that is being communicated, or is it the lab that directly communicates out?

So, it is more around if the system itself communicates externally, then it becomes more important whether it is a lab system, an EHR, public health, or whatever. If the way the data is being shared, used, and exchanged is internal, that need may not be as big, but the focus is external. Once you cross that threshold, that is where we want to make sure that you now have those standards, whether they are syntax or vocabulary, because that is where the critical need is. Internally, we do not know why they did it, and there are some good reasons for it and maybe some not-so-good reasons, but there is no one-size-fits-all.

Eliel Oliveira
That is a great point, Hans, and I would say that there may even be an opportunity here for the internal labs to consider what is really important to standardize if there is a requirement. I think that the rule of thumb that we have adopted in the past in our normalization of internal labs in hospitals for research, and with research, you can think of surveillance as well, as it is useful in the same way, was to just normalize the top 10% or 20% of the most-prescribed labs internally, and that count was sufficient to provide the most impact. As an example, where there are thousands and thousands of labs that are created internally, it becomes really hard to normalize all that because you have to have very specialized skills to be able to understand each one of them and what they matched, so I agree with you that walking backwards may not be useful.

Steven Eichner
This is Steve. To Hans's point, I think we need to be very careful about a definition of what is internal versus external because as we are looking at changes in healthcare systems, a physician's healthcare practice used to be something external to a hospital, and now it is "internal," at least in some situations or some naming conventions. I do not think you want to put a limit on what is internal to a system or not. For a public health laboratory system, the laboratory that the Department of Social and Health Services (DSHS) operates, which is the largest public health laboratory in the country, is internal to the Department of Health and Human Services. It does not mean that we serve only DSHS purposes. We certainly serve external parties as well, so I am not sure that you want to draw a line in that sense.

I think it really focuses on the exchange of data between a system that is managing laboratory information and any other system. In many cases, it may be the hospital's EHR that is sending data to public health, and in some other cases, in some situations, it is the laboratory system within the hospital that is sending information directly to public health, so looking at where the data is being sent to becomes more pertinent than whether it is internal or external.

Eliel Oliveira
Thanks, Steve. If I am listening well here on how we are to frame this, if we are going to use levers to enforce standardization used for labs and pharmacy, we probably have to do a stepwise approach because just enforcing that is too much overall across the board for all labs and all medication. It would just be too much, instead of identifying key areas, labs, and medications that should be standardized across the board and make progress over time. That is my summary of what I heard from both of you. I see Jim's hand up as well. Any thoughts, Jim?

Jim Jirjis
Yes. I was just going to go back to the purpose here. So, ONC has a couple roles. One is to develop voluntarily used standards and a certification process for health IT systems, and they are expanding that in HTI-2 with the proposal to expand that into public health, for example, but that does not necessarily imply levers for adoption. ONC also has a coordinating role. I do not know if those on the phone are familiar with the quad squad, so it may be worth calling them out. The quad squad is a multiagency group that Steve Posnack has assembled to look at the specific laboratory space for standards and what agency levers might exist. For example, they looked at Clinical Laboratory Improvement Amendments (CLIA). In the past, attorneys have determined that it was not within the scope of CLIA to require external laboratories to adhere

to content terminology format standards, exchange standards, etc., so it may be worth calling out support of the quad squad work and, if it is appropriate for ONC, to have them actually present to us in some form.

Eliel Oliveira
Thank you, Jim. I am not familiar with them, but that sounds like a great recommendation. Let's leverage whatever that group has done.

Jim Jirjis
Yes. Steve Posnack would be the contact. Thanks.

Eliel Oliveira
Great, thanks. Hans, I see your hand again.

Hans Buitendijk
Just to clarify a prior point, I would agree with Jim about a presentation at some point in time or understanding that. It is not only what we recommend to ONC, but what they can work with on levers. That would be fantastic.

Just building a little bit further on what Steve also brought up, and I put a note in the chat, I think what we do require is that we generally look at external communication, but there are modular aspects to it, and we cannot broad-brush everything to say someone needs to do this or that. It depends on a much more granular purpose. So, as an example, one of the desires that there is that from the moment that a result is created in the device, moving on to the Integrated Laboratory Systems (ILS), moving on to the EHR, moving on to etc., is that from source, the encoding to LOINC is established as soon as possible and then perpetuated throughout. So there are clearly places like that where there might be a need, but that does not mean that it covers all of the lab's reporting requirements.

So, I think the main point is that with some of these statements, we just need to be cautious about what is in scope. Public health labs seem to be in scope, but when we talk about internal labs, we should not imply that everything in an internal lab is necessarily in scope for what we are trying to do here. It is really how you cut across what communications there are beyond their initial systems or within an organization that we really want to focus on. That is the top priority.

Eliel Oliveira
Great point, Hans. I will add to that that the considerations could be also related to incentives to achieve the specific goals of standardization because, again, there is too much here to achieve in these two areas. What I mean by that is that we see Current Procedural Terminology (CPTs) follow along with others that having the best being linked to data is still being linked to reimbursement or payment, so there might be incentive here to provide them to providers and other organizations that can then follow the standardization that they need, so I think that might be an opportunity. We do not always need to enforce and require certifications, but maybe we can provide an incentive because this is going to take staff time and other types of work.

Any other thoughts or questions? I believe the Accel team has captured a lot of the comments and recommendations here, but is there anything else on this specific line? Otherwise, I would love to move to

image interoperability. I do not see any hands. I see a comment here that this needs to be sufficient to support public health surveillance. I totally agree, Steven. I think surveillance might be the most important aspect to address early on. All right, supporting image interoperability. We basically highlighted here that there is a gap, that interoperability of radiological images is increasingly important in medical care. Hans, I see you have another comment.

Hans Buitendijk
No, please wrap up. I was going to put myself in the queue.

Eliel Oliveira
Sorry, you already have a comment. Okay. But, there is significant need to improve the electronic exchange in the storage of radiological images to reduce duplicative testing and better support clinical decision-making. So, this is a very important one, very costly, and there are lots of savings and improvement there. The challenge is that the current adoption of Digital Imaging and Communications in Medicine (DICOM) standards is voluntary, and standardizing interoperable image data has not been a priority. So, an opportunity for us is to identify the current landscape of interoperable imaging data and standards adoption and implement recommendations to improve the adoption.

In some proposed recommendations that we have already identified here, we should expand upon the related recommendations that we identified in the HITAC Interoperability Standards Workgroup, hold a listening session to identify adoption levers that could be used to support interoperable image data exchange. I will just say that there are a lot of organizations that have tried to expand on the exchange of images nationally, and I think the development or enforcement of those standards would help a lot to guarantee that we have an open market for solutions that can exchange images successfully. All right, Hans. I am turning to you now.

Hans Buitendijk
I think this will be another area where we perhaps want to recognize that there are proposals in HTI-2, though we cannot count on it, but somewhere, given where the timing is of the report, that recognition that we brought it up before, it is starting to be proposed. We should see where it ends up and how else we respond in HITAC and other discussions, but that will be helpful. So, when looking at the proposed recommendations, it is going to be a little bit harder to see what the recommendation is here beyond what is already proposed in HTI-2, and maybe we can recognize that, if there is something else, it is currently a non-standards-based reference to images that would enable you to have access.

Interoperability is not necessarily that the image gets exchanged, but that the access to it is exchanged. Perhaps here, we can highlight in the challenge a little bit more that moving from a much more bespoke way of accessing the images, and that is in the context of a little bit more of a real current state. The standards are there, the practice is there, but there is still a lot of tailoring that needs to happen, where we recognize the progress, but focus on that true standards approach that we can adopt and make consistent.

Eliel Oliveira
Great thoughts there, Hans. Yes, we do need to watch quite a bit for HTI-2, and I think we got that task force going, so this is another connection point between the two that is likely going to require us to adjust our recommendations going forward. I think the timing is good in terms of us putting together the report,

and as you all know, once HTI-2 is released, we are going to have 60 days of comments, and many of us are involved in that task force, so many of us are going to inform that specifically and we need to come back later. So, thank you for your thoughts there. Hannah, I see you.

Hannah Galvin
Thanks, Eliel. I think the one thing I wanted to bring up here is that even when DICOM standards are being used, there are some challenges in sharing not just reference-grade imaging, but diagnostic-grade imaging. Even when reference-level imaging is being shared, there is still a need, and I think the industry is very early on in sharing diagnostic-level imaging, which is really, from a clinical perspective, often what is needed in order to prevent reimaging of patients, improve efficiencies, and really have cost savings and improve safety. I am not sure if that is a standards issue or if there is something else related to storage of images, storage size of the data servers, and that kind of thing that we can address there. The standards are a floor, but there are some other pieces on top of them, as Hans referenced as well, that are really needed in order to achieve adequate sharing of images in a way that achieves the clinical utility that we are looking for.

Eliel Oliveira
Thanks, Hannah. Your comments are giving me a thought here in terms of recommendations, that it might be helpful to recommend a study of some sort to evaluate the impact of the different levels of sharing here, especially on cost itself. I think that is a big aspect. I recall looking at Arkansas and the implementation they have put in place there, and the savings were quite large in the state of Arkansas specifically. I think that in itself could allow quite a bit of advancement at this point. It may identify which ones of those results provide the biggest impact for focus as well. Thank you for that. Rochelle, I see your hand.

Rochelle Prosser
Yes, hi. Piggybacking off both of the prior conversations and presentations, when it comes to pediatrics, there are no standards, so I do understand that HTI-2 is coming forward, but there is a whole swath of a population that we have left behind. And it is not even left behind, it is left behind to such a point that they are not even included in the historical record and language of HTI-1 or HTI-2. And so, when we come back and reconvene, I would like us also to consider doing a case study on interoperability and scale, as well as look at cost factors for improvements, but also overall improvement outcomes once this data sharing is occurring. We are looking at population from 0 to 18, 16 to 18 in some cases, depending on what the age limits in some of these facilities are. Children deserve proper care too. So, as we come back and revisit, we must find out what these levers of change will be because we have not even identified them there at this point as a possibility or plausibility on the pediatrics end of the young adult space.

Eliel Oliveira
That is an excellent point, Rochelle, and it connects so many topics that we have here, and even also the discussion that we had in the HITAC meeting related to maternal health and a focus nationally on that front. So, yes, we could make advancements in maternal health, but if we are not also making advancements in pediatric care, that will be a shame. So, that is a great point of connectivity here. For now, there are aspects, and I see you may have some thoughts back.

Rochelle Prosser
Yes. There is some work being done, either through Advanced Research Projects Agency for Health (ARPA-H) or through the Foundation for the National Institute of Health, bringing in public-private partners

to see if we can improve the data-sharing opportunities, and I will turn it over to our government and public health folks to opine or give suggestions on who we might be able to bring in to present to us from some of these outside organizations that are trying to do the work. But more needs to be done. I think that if we think a little bit differently and openly here, we can advance it so that what we are doing in the other sectors can either align, unify, or be strategic about putting health policy around what they are doing.

Eliel Oliveira
Great. On maternal health and pediatric care specifically, I think that is why ARPA-H is focused on that. I do not know how many of you here know about the HEalth care Rewards to Achieve Improved OutcomES (HEROES) program, that they have released $100 million of opportunity to make advancements there, but the reason that is ARPA-H is because we have not made the impact that we need to, and ARPA-H comes in as the innovative hub to try to do something else that we have not been able to achieve elsewhere. And so, I am excited about that work, and I know quite a bit because we are putting in several proposals from Texas.

I read an article this weekend that we have the worst indicators in maternal health nationally. I think that program is specifically starting next year and is going to last for three years, but I think learning from what ARPA-H and the HEROES program in terms of maternal health are going to uncover is going to be quite informative for HITAC. So, thank you for your comments there. They are very much in line with so many other topics that we have. Any other thoughts or questions? I will make one last one here, Rochelle, which is aligned with what you described, but is related to older teenagers, and that is one area where we have seen quite a bit of data missing as well. This is related to mental health with individuals that are over 15 but younger than 19. There are usually a lot of missed pieces of information that we have found in how to care for those individuals that are not adults yet, but are not pediatric patients anymore, for the most part. It is another area that I know needs some attention at some point.

Rochelle Prosser
In that younger population, I find that they are not going to come out and say, “I have a mental health problem.” They are not going to do that, but what they love is IT, what they love are artificial intelligence (AI) bots and apps, and what they love is speaking to entities that are within their technology. Where they can BS around the corners with everybody else, they really are very truthful and forthcoming about what they feel on social media and other AI and IT tools, so it brings two things to mind. One is that they are talking, they are talking a lot, they are talking very loudly, and I think in HITAC, we can help to encourage that, but do it in a way that provides privacy and protection for them so that they are not taken advantage of.

With the social media space, where our larger government entities are not saying how we should or should not act, we can provide some confines within that that still allow them to be connected with the appropriate behavioral health entities, which allows a window of insight to that so we can provide the appropriate care, but still protect the overall space so that when they transition to 19-plus, whatever they have said in their youth is not being used against them.

Eliel Oliveira
Great points. I just put that link in the chat to that great project, the Early Psychosis Intervention Network, which is a national network. It gives you some examples of how teens are really challenged with mental

health, and yes, exactly to your point, Rochelle, they are in a different space of communication than most of us. Thank you for your thoughts there. So, that is another key area of focus.

I want to keep moving, unless there are other comments. We are at the halfway mark, and we still have a few boxes to cover. The next one that we have here is improving long-term care and post-acute care interoperability. The gap that we see is that interoperability needs to be increased across the board in continued care, including Long-Term and Post-Acute Care (LTPAC) providers. I think we know that they were not part of Meaningful Use and do not have certified systems that can communicate with us, so the challenge is that LTPAC providers are less likely to use interoperable health IT systems compared to acute and ambulatory providers.

The opportunity is to increase the availability of LTPAC-focused certified health IT modules that support interoperability across the care continuum, and the proposed recommendation here is to explore certification needs for LTPAC providers and health IT systems to support bidirectional exchange with acute and ambulatory providers that have already adopted certified health IT modules. I just wanted to highlight here how the Leading Edge Acceleration Projects (LEAP) funding that ONC released is not necessarily for LTPAC, it does not call that out, and it is for mental health, but it is along the same lines because mental health providers also face the same challenges with interoperability. Steve, I see your hand up.

Steven Eichner
Yes, Eliel. I think it is important to draw particular attention to some provider groups, including durable medical equipment and homecare, and not just have it be incorporated into the broader LTPAC categorization. As an example, both of those two groups that I mentioned have specific needs, specific opportunities, and integration of their data, and their access to other data would be most helpful for lots of folks.

Eliel Oliveira
That is true, Steve. I think you mentioned durable medical equipment. That just takes my head directly to Houston right now, with the hurricane, the fact of how many people were impacted, and that challenge. Those are great points. There is a lot more here to address on this front.

Steven Eichner
Yes, and again, I am not trying to unwrap all of it, but I do think we should call attention to a few specific provider types that have historically not been included at all or even barely mentioned. Behavioral health certainly needs more integration. It has been mentioned in interoperability fairly frequently previously, but Durable Medical Equipment (DME) much less so, and home health kind of marginally.

Eliel Oliveira
I think maybe what you are saying here is, just like we were talking about under the labs, the recommendation should be incremental to address specific providers and challenges within LTPACs, as opposed to just a broad enforcement activity of any kind.

Steven Eichner
And more specifically, laundry-listing the entities that need to be focused on so that there is absolute clarity of where there needs to be some emphasis or some special attention paid so that it is not caught up in the

tidal wave. We really want to pay attention and make sure specific communities are addressed and are included.

Eliel Oliveira
Correct. Great point. If we do not focus, this is so big that we will spend too much time and not get results. Rochelle, I see your hand up.

Rochelle Prosser
Sorry, I lost my connectivity. Just to go off of what the prior speaker was saying, is there a way in future provisions that we can actually start to line-item some of these larger logistical challenges out in the long-term and post-acute spaces? Because I see that where it becomes a disability issue in the general public, not just in the long-term and post-acute spaces.

Eliel Oliveira
That is a great thought. Rochelle, maybe we could add here to the proposed recommendations that we convene a set of experts to identify those key areas of focus, like you and Ike highlighted, so that then we can have more targeted recommendations to Congress on how to make improvements in this area that is so large. Does that make sense?

Steven Eichner
To flesh that out one step further, one of the things that we could certainly do is invite presentation from something like the National Organization for Rare Disease, which encompasses a wide spectrum of diseases under its umbrella, to serve and present to HITAC or present to other groups, assembling what are some of the issues faced by the disabled communities in terms of coordinating care and access to data, some of the issues they are facing, from a patient-centric perspective. I think that would be an excellent suggestion and an excellent opportunity to take advantage of.

Hannah Galvin
I concur.

Eliel Oliveira
I agree, Steve. I was exposed recently to one of HHS's agencies, though I cannot remember the name right now, but their focus is exactly on what you were describing earlier in terms of DME, basically looking at electricity support for individuals that have durable equipment. In fact, we were trying to work exactly on that front here in Austin with our energy provider to identify and help link individuals with support systems that can prevent challenges on that front. The point is that I think we are on the same page. We could bring in experts in the field to identify the key priorities and entities to make improvements on this front.

Steven Eichner
Eliel, please reach out to me offline about the Austin stuff. I do have some resources and contacts because I am in Austin as well, obviously. But I do think that it is not just disability focused on the DME piece, it is looking at the broad spectrum, and it is not just about access to electricity, it is looking at coordination of services on the medical side. Yes, electricity is a necessary support, but as an example, an hour ago, I was talking with my primary care physician (PCP) about needing to replace a piece of medical equipment that I had gotten from another provider that he had referred me to. He did not have full access to the information

about what medical equipment I was using, even though he gave me the initial referral, so there is not a comprehensive medical record. Now I am stuck chasing stuff around to get things fixed, and having to get another referral and chase myself in circles for a week to get a minor thing resolved.

Eliel Oliveira
Right. Thank you. Those are all great points. Any other thoughts on this line, anyone? Otherwise, maybe we can move to improving behavioral health interoperability. The gap that we see there is that the health IT adoption among behavioral health providers currently lags behind other providers. The lack of access to health IT impacts behavioral health providers' ability to support the interoperable exchange of data across the care continuum. That is the key challenge. I face that often, as our health information exchange has to deal with the limitations of those EHRs used by behavioral health that cannot provide the data that we need, and the opportunity is to examine opportunities that increase the availability of behavioral-health-focused, certified health IT modules that support interoperability across a continuum of care. Again, just to highlight, the ONC LEAP project is funding some experimentation of lightweight systems that can do exactly that. We do not have any proposed recommended activities listed here at this point, but I want to hear your thoughts, and Hans, I see you have your hand up.

Hans Buitendijk
Yes, Eliel. This is a question of how much we need to add consideration that part of improving interoperability with behavioral health is the ability to manage sensitive data, and therefore, recognizing that it is not only a part of the community being able to connect, to have the standards and otherwise just to exchange data, but also the ability, whatever the rules are, like 42 CFR Part 2 related to Health Insurance Portability and Accountability Act (HIPAA), which are closely aligned, but not exactly, to more easily manage that data sharing and exchange in an automated fashion. I think it relates at that point in time to all the other areas of interoperability.

The question is who can I share data with based on what privacy rules and patient consent? So, in here, perhaps as part of recommendations in the to be determined (TBD) space, it is not only to recognize just the fundamental interoperability challenges to advance, but also that that is very much impacted by how I manage and weave the applicable privacy rules and applicable patient consent rules in here, particularly around behavioral health. It is for all interoperability, but with this one, perhaps there are a couple other things of particular consideration that might come up. Without them, I cannot move forward much in some areas. There is still going to be a hesitancy to adopt, even if you can.

Eliel Oliveira
Yes. That is an excellent point, Hans. I cannot help but think of some of the pilots that I think I see at California Advancing and Innovating Medi-Cal (CalAIM) in California related to consent for data sharing for mental and behavioral health, and what I have seen in the health information exchange space is that we usually avoid exchanging behavioral health data because of exactly what you described. I think one of the reasons is, again, Meaningful Use funded the adoption of certified EHRs for that matter at the time, but not these other types of organizations. But also, another limitation there was that the systems that were built for data exchange, like HIEs or others, did not necessarily have the features to address 42 CFR Part 2 exactly.

So, anyone that is trying to that today is trying to patch their systems to be able to understand what to do and what not to do. Because of the risks, everybody just avoids it completely, and then we miss exchanging information that is critical for the mental health crisis that we have.In our case here in our regions, there is a lot related to homelessness where we do not have timely access to the data that we need to manage the population at risk. So, consent is an excellent point to add there. I think there is what you mentioned and other structures that we need to be able to put in place to be able to better manage this more sensitive data that comes from behavioral health. Ike, I see your hand.

Steven Eichner
Building off what Hans said, I think it is important in the sharing of information that it be patient-controlled and patient-managed. It is not just governing data outside of the patient sphere, it is empowering patients in that space to control and manage who has access to the information. Looking at the text that we currently have developed, I think it is important that we reemphasize that it is integration of behavioral health and primary healthcare. It is not solely interoperability within the behavioral health community, although that certainly needs to be advanced as well, but the interconnectedness between primary and behavioral healthcare also needs to be supported. One of the potential opportunities for recommendations we might want to look at is looking at what is the coding scheme currently used by behavioral health assessments, looking at facilitating the exchange of information.

On the primary healthcare side, exchanging test results is generally an open, acceptable, low- or no-cost item for sharing someone's A1C results or whatever. Looking at the behavioral health space, however, there have historically been costs associated not only with administering a behavioral health assessment, but also looking at sharing that assessment data and for a subsequent receiver to then reexamine that data. When we introduce interoperability, how many assessments have actually been codified in a standardized way to facilitate the exchange of that information without a coding support for the information necessary to support behavioral healthcare? Just establishing the connectivity between providers may not be sufficient. This may also be a place where we can tie in very specifically some work around AI to help look at patient records that have not been codified to use some decision support tools to help summarize and facilitate the useful exchange of the data so the receiver has something that they can work with.

Eliel Oliveira
Yes, I totally agree there, and that is where that same link that I shared about Early Psychosis Intervention Network (EPINET) is a good example. The collection of those assessments is quite important for behavioral health, and there are quite a few. Standardization on that front in sharing becomes quite important here, so that is a great recommendation on maybe learning from the community what those assessments could be and how we could standardize them. Some of them may already be ready for that, but maybe it has not been recognized and could be part of the adoption of EHR systems by behavioral health providers, so that is a good note there. Rochelle, I see you have your hand up.

Rochelle Prosser
Although I totally agree with what was just said, there are protections there in terms of true transparency and communication that historically caused great harm to patients. And so, we have put these barriers in place to have degrees of separation, but what we have now is a failure of handoff. So the primary physician will hand off to the mental health or behavioral health entities, or the insurance will start paying for the services and then start denying based on their need to have access to the records. And they put these

transparency barriers and limits up so high that we can no longer even determine if they even attended, if they even showed up. And so, although we want to have a level of transparency that needs to happen to confirm services were given, received, accepted, completed, and that the patient owns those records, we currently have major hurdles in the continuity of care. Maybe we can discuss that, but I know that in asking for that transparency, we are, as a body, going to come up against these very well-deserved hurdles.

Eliel Oliveira
Thanks, Rochelle. I totally agree. I think there is quite a bit of opportunity here to identify and maybe collaborate also with the bodies that regulate access to this level of sensitive information to define these specific steps. Because I believe that, in some cases, software developers are challenged because they cannot even identify what and what not to do in some situations to preserve not only the privacy and sensitive content. But also, like you are saying, the level is so high that we are not exchanging much, and that creates challenges to the protection of privacy.

Great comments. I am going to move on to the next line if there are no additional comments. Accel team, can we scroll? I think we have two or three more lines. As you can see here, we already had some edits from last time, but we might still need to cover these today.

Let's start with further improvement of data quality and sharing. The gap is that data continues to be crucial for clinical care, research population health, and patient engagement. There is a need to evaluate data quality and ease of sharing across the healthcare continuum. The challenge is that when data is shared across healthcare providers, there is often inconsistency in how much data is shared and the quality of the data, which makes it difficult to use. Maternal health data is not consistently collected or standardized in a manner that enables the delivery of high-quality care, so that is a great addition here. The opportunity is that we could support transparency and establish baseline expectations, suggest best practices for how much data should be exchanged over Trusted Exchange Framework and Common Agreement (TEFCA), and increase the standardized collection of maternal health, that specific line, which USCDI Plus Maternal Health can help with.

We have a proposed recommendation here to encourage ONC to conduct an analysis of existing practices over national networks to see how much time the data being sent covers, such as the last visit, 90 days, and so on, and how relevant it is to suggest best practices for what the minimum standard should be for various cases. I think this comment here may be related to something that Jim Jirjis had talked about quite a bit before, that we do not have specific determinations on how C-CDs should or should not be shared, and I may be mixing things up a bit, but that is what comes to mind. Ike, I see you have your hand up. Any thoughts?

Steven Eichner
Really quickly, I think USCDI Plus includes maternal health as a new field or a new collection. I think any recommendation that we make needs to acknowledge its existence and either figure out how we build upon that as a foundation so that we are providing an up-to-date report and not missing something that is emerging or is already in space. I recognize that when we drafted this, the maternal child health stuff may not have been as developed as it is today, so there is a bit of a moving target. It may not be perfect in that space, but I do think we need to make some effort to acknowledge what is in play.

Eliel Oliveira
Right, I totally agree. Jim, I see you have your hand up as well.

Jim Jirjis
Thanks for the call. On this data, I can just see people… If we talk to ONC, for example, and say, "We have to address the content. How much data is shared?", we have the format, the USCDI terminology standards, and even the exchange standards, but there is variation, and people may argue that we should not overly define it because we do not want to remove the flexibility of people sending just what is needed for a use case. The problem is that I do not think the country is set up operationally to do that. People make a request, for example, from TEFCA, and there is not enough granularity within the request yet to necessarily know the subset. It is probably going to come with Fast Healthcare Interoperability Resources (FHIR). Maybe the standard operating procedures (SOPs) will help a little bit, but for general purposes, it is worth it that we all at least know what to expect. If we say that it is 90 days or a year's worth of data, then at least the recipients know what to expect.

So, maybe our recommendation is that we actually create an expectation of the amount of data and how far back it goes. That is what I would recommend. It is more valuable because then people know they may need to use a different path if they want something more than a year old. So, that would be one addition here.

Eliel Oliveira
I completely agree, Jim. In fact, I would even go a step further in being specific about the elements that are packaged in a message. In my experience, for every interface that we work, it is a different story because different vendors are doing different things in different ways, including how much data is being included, so that is an excellent point. Personally, what I wanted to highlight here as well, besides the thoughts from both Ike and Jim, is that just like on the ONC LEAP funding opportunity right now for data quality using AI, I think another proposed recommendation here is to further take advantage of AI, maybe for surveillance purposes in terms of data quality. Because I think one thing that we highlighted in that request for proposal was the ability to monitor and give some sense of how trustworthy the data is based on quality, and that affects safety quite a bit. So, that would be my personal recommendation of something related to AI and data quality for sharing.

Steven Eichner
Eliel, this is Steve. A friendly amendment, perhaps, Jim, is maybe including some kind of qualifier in the data request about timeframe, building off your idea of not trying to set it up from limit, but to provide some guidance about what might be potential windows so you say, "Hey, I am really just looking for the snapshot of the last encounter, or a 1-to-45-day block, or a 1-to-90-day block, or I want everything you have."

Jim Jirjis
I am just trying to figure out how this would play out operationally and technically. So, instead of just saying, "Hey, it is going to be 90 days," and that is it, even in the request, that would mean that the electronic medical records (EMRs) would need the ability to have a default, which could be 90 days. Or, in the operational tool, we require them to have the ability to know that it is 90 days. So, the average doctor has no idea, and some of these have automated automatic data processing (ADP). If someone goes to the Emergency Room (ER), boom, it pings TEFCA. Well, for an ER use case, they may want to know just 30

days, but for the average internist, it may be two years. So, what you are suggesting is recommending, even in pre-FHIR, having the IT capability and operational capability of the requestor to set defaults. So, there could be a default, but in this particular case, I may want to be able to go in and ask for a year's worth of data, even though I am an ER doc, and 90 days is what the default is. Is that the kind of thing you are thinking?

Steven Eichner
Thinking pre-FHIR, we might need to do defined blocks, but in the FHIR world, you could really set it up where part of the request is a time variable. Now, the other part that HITAC might recommend is to the standards development folk, including a time variable in the standard portfolio to support it, because it will take four or five years for the standard to be developed and supported, so if we insert that request up front, it will take some time to realize it. That is okay if that is a necessary or appropriate goal, but I think that creates a short-term solution and a bridge to a more flexible future.

Jim Jirjis
Okay, perfect.

Eliel Oliveira
Those are great thoughts. I appreciate that because I think there is an opportunity here to do exactly what you are describing, to have some standard length that everybody knows, but that there could be some other specific lengths of time that can be requested in the package and be received and returned. Jim, I pasted something in the chat. I think that is what you are looking for, but let me know if not, and I will copy and paste it again.

Jim Jirjis
I do not see it, oddly. Does anybody else see it?

Rochelle Prosser
No, I do not see it.

Jim Jirjis
Did you hit enter?

Eliel Oliveira
I did. It is posted to everyone. You do not see anything about the proposed recommended activities?

Jim Jirjis
Oh, no, just the link, so we can edit the start.

Eliel Oliveira
Oh, I see. I think the Accel team can…

Jim Jirjis
You can email it if you have it handy.

Eliel Oliveira
I do not think it is shared in an editable document, but I will send it by email, Jim. I think we can forward you the email that we sent earlier this morning.

Jim Jirjis
Oh, okay, so it is not a shared Google doc?

Eliel Oliveira
I do not think so. If there are no other thoughts on this question, I want to jump to the next one, hoping that we can still complete our task for today.

So, supporting data standards for diverse abilities. The gap is that we have a lack of standards that support the interoperable exchange of information about patients with diverse abilities. The inability to capture appropriate information/accommodations can prevent patients from getting the care they need during routine care visits or emergent situations. The opportunity is to identify the current state of patient accessibility to data to ensure better care during routine and emergent situations. The proposed recommendation is to evaluate the current landscape of patient accessibility needs data, then identify information and IT systems sharing necessary to standardize to support patients' accessibility needs. Any thoughts, questions, or recommendations?

Steven Eichner
This is Steve. I think one of the pieces we need to emphasize here is clarifying what we mean by routine and emergency situations. I think we need to add on here "in the provision of healthcare" because it is not just in other spaces, it is actually healthcare providers providing healthcare to individuals with challenges or DME. Again, picking on myself by example, I was at my annual physical today in my power wheelchair, and I could not turn my power wheelchair around in the examination room, not because I am not a talented driver, but there was not sufficient space to really turn it around.

Eliel Oliveira
Good point, Steve. Honestly, I do not know this one, but I am wondering if we do have a data element and standards that capture this specific piece of information?

Steven Eichner
Yes, we do, but they are very limited in terms of what measures are actually recorded. It is limited data utility.

Eliel Oliveira
I see.

Jim Jirjis
Steve, my understanding is that there are robust terminology standards and classification systems for different abilities. The problem is whether or not they have made it in to required certified standard use and whether or not people have workflows that actually collect that data in an accurate way.

Steven Eichner

It is kind of a bifold issue. Particular diseases may have very specific measures in their space. There are a few broader standards about ability, but they are not often supported in most EHR systems in terms of looking at, for example, a particular individual's ability to use a power wheelchair, in what capacity, what their needs are, their restricted arm movements, etc. Yes, you might record that there is a mobility impairment, but it does not often go into more detail than that.

Eliel Oliveira
These are excellent points. I am thinking about CDS, clinical decision support, informed by those elements that you describe in intelligent systems, or at least systems that understand when there is an ability that needs to be highlighted in the course of care.

Jim Jirjis
Eliel, the decision support is defined broadly. For example, in the use case that he just mentioned, as part of the check-in and scheduling process, it could be as simple as having a dashboard indicator that there are special logistical considerations. I am not talking about anyone on this call, but when a lot of people think about decision support, they think about alerts.

Eliel Oliveira
Right. That is a great point, Jim.

Jim Jirjis
Nobody on this call would make that mistake, right?

Eliel Oliveira
Right! Hopefully… Thank you. Are there any other comments on this specific line? I know we are running out of time, and we need to allow for public comment as well. Peter, I am wondering if this is a good time to go to public comment, and if we have time left, we can come back to the last point, but I know we are running short.

Peter Karras
We can probably go until 1:25 before starting public comment, so there are nine minutes, and then we can open up the line.

Eliel Oliveira
Okay, let's try not to give up, then. So, the last one that we had, I believe, is provider use of AI in health and healthcare. The gap, as I think we all know, is that AI capability continues to grow, and there is a lack of best practice on where to use AI that is clinically appropriate. The challenge is that problems with data quality, relevance, and usability can contribute to poor safety and incorrect outputs, and the opportunity is to assist in identifying best practices for clinically appropriate uses of AI. The recommended activity that we have here is to explore steps ONC, in collaboration with other agencies, could take to establish best practices of appropriate use of AI in healthcare. I think this aligns well with the LEAP opportunity there, and data quality, and how that can affect safety and other challenges. There is a lot of movement in this space, and with Micky Tripathi taking the lead on AI, I think maybe the recommendation here we have so far would be to bring everybody together because the space is moving so fast that I think we need to get a handle on it. Steve, I saw your hand. I do not know if you still have any comments.

Steven Eichner
I want to give other folks a chance as well, but I do have some comments in this space. Put me in the batter's box for the moment, please.

Eliel Oliveira
Thanks. Rochelle, I see you have your hand up.

Rochelle Prosser
Yes, I think that AI and the use of AI, it has become a nomenclature for "catchall" in everything healthcare, and I think that if we could have some direction from ONC for clear delineation or definition of what it is and what it is not, what it connotates and what it does not for health IT would be extraordinarily helpful in moving forward for recommendations, and again, just to your point, deferring back to them because it is changing so fast.

Eliel Oliveira
Yes. Thanks, Rochelle. My proposed recommended activity here might be to look at what we went through in an AI hearing that we had in person last time we met and devise some next steps on that hearing. One of the things that I got out of this from that and some of the presentations is that there are some models on how to monitor the design of models, testing, and deployment of those AI models in healthcare and in the surveillance of those models. Ike?

Steven Eichner
I have two specific points. One, I think we need to make sure we include equity in the discussion of quality because it is important throughout that the use of AI accounts for the full diversity of the population and not just account for the idea of saying they are not included, but it needs to recognize it from a utility standpoint and point out the exceptions, where there are some, that are outside the norm. Secondly, I think there is some value in including some use case examples about where we would like to see some space. For example, looking at computer decision support and looking at care summary are two potential ideas where we might just want to start, not that those are the exclusive uses of AI, but those are two potential focus areas that might be of interest. As well as perhaps a third one of looking at AI support for patients so that we are looking at if there is a different rule that AI can perform when it is patient-facing rather than looking at provider-facing, and maybe that is worth an exploration unto itself.

Eliel Oliveira
Thanks, Ike. Yes, I think we saw the terms there. Besides "equity," I think there was "bias in AI," as you recall, and I think "trustworthy AI" is another term used to make sure that it is equitable and not biased. Those are great points that we need to highlight here. I know we are running out of time, so I want to hear what Jim has to say as well.

Jim Jirjis
Thank you. On this, one question I have in our annual review and our recommendations going forward is do we have a nice, high-level model for what we think of health equity? What I mean by that is when you say "provider use of AI in healthcare" and we talk about health equity, etc., there is the acquisition of information, and so much of what ONC is doing is around interoperability and standards, and maybe it

already exists, but if it does not, an interoperability model for when we talk about health equity. There are populations who are data deserts, such as those without housing, those that are in prisons, for example, so there is an element of comprehensiveness of data and whether we are leaving anyone out from an equity perspective. Then, are there data standards to capture information about housing status? Are there incentives for and investments into actually collecting that information? And then, there is how we use it.

And so, it may be worth either exploring whether an interoperability and data model already exists for how we think of the health equity landscape, because that might then inform a balanced set of recommendations. It is hard to do much with AI and health equity if you do not have the data needed. Without the data, there is no reliable AI. So, this is just a recommendation to evaluate health equity data interoperability approach as a framework so that we can then sensibly make recommendations going forward based on that framework.

Eliel Oliveira
That is excellent, Jim. I think it goes well under the recommended activities, which could tiptoe into what I was going after, which is that someone at some point is going to have to get a handle on all these solutions that are out there and validate that they are actually doing what they say they are doing, and right now, we do not have any regulation on that front. I guess an assessment or evaluation of what is taking place with a few of those systems would be quite powerful to inform what the next steps should be here. Do we need something like AI surveillance, just like we do drug surveillance, to see if they are not being biased and equitable, or even causing harm? We do not know. So, that might be a great next recommended step there. Okay, great. We would love to have your colleague present to all of us. I think we captured quite a bit here. Does anyone have any thoughts or comments? I think we have a few extra minutes, but I want to make sure we collect any other suggestions on this line. If not, Peter, I think I will turn it over to you.

Public Comment (01:23:26)

Peter Karras
Great. Thanks, Eliel. At this time, we would like to open the meeting for public comment. If you are on Zoom and would like to make a comment, please use the hand raise function, which is located on the Zoom toolbar at the bottom of your screen. If you are on the phone only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. While we are waiting to see if there are any public comments verbally through the Zoom, I will check the chat to see if anything came through in the chat. I do not see anything in the chat, and Accel has notified me that there are no public comments at this time, so, with that, Eliel, I can turn it back to you for closing remarks.

Next Steps and Adjourn (01:24:18)

Eliel Oliveira
Thanks, Peter, and thanks, Accel team. I appreciate everybody's comments today. As you see, this was a long list of interoperability, and there was a lot to cover. I think we did it, but it is not perfect, as you can see. The team is capturing some of your comments and thoughts, but again, we probably do a disservice with the amount of time we have. I highly recommend that the team take a look at the email with the attachment crosswalk as it is right now, make some edits, and send them to us. We will incorporate all the edits and discuss next time if necessary, so that is another key step of being part of this. Just keep in mind how important this is. The annual report goes all the way to Congress, so the more details that you provide

there in the areas where you are interested in seeing improvement, the better for all of us. So, with that said, thank you, everyone. We are going to see you again in a couple of weeks and continue this process at that point. Have a good day.

Jim Jirjis
Thanks for your leadership. I appreciate it.

Eliel Oliveira
Thanks, Jim. I appreciate that.

QUESTIONS AND COMMENTS RECEIVED DURING PUBLIC COMMENT

No comments were received during public comment.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT

Rochelle Prosser: +1 Eliel

Rochelle Prosser: regarding Hospital data standarts

Hans Buitendijk: When we look at SHIELD, the focus is of continuity of vocabulary from device to EHR and beyond, so that may be an area where it is important, yet would not cover all aspects.

Rochelle Prosser: I agree, with Jim. Maybe they should include the quad suad to present to us.

Steven Eichner: There needs to be a sufficient floor to support public health surveillance

Jim Jirjis: Hans is all over it like a fly on honey! :)

Steven Eichner: HTI-2 has some discussion of image exchange. Does the language change what we should include in the annual report?

Eliel Oliveira: more on this front: https://nationalepinet.org/

Eliel Oliveira: Thanks for all of your comments Hans!

Eliel Oliveira: Thanks Hannah!

Jim Jirjis: do you want to edit the sections on the chart or do you want me to take a stab?

Eliel Oliveira: Would love if you can make some of your edits to help our team, Jim!

Jim Jirjis: can someone cut and paste the link into chat again for this shared document

Eliel Oliveira: Encourage ONC to conduct an analysis of existing practices over national networks to see how much time the data being sent covers (e.g., last visit, 90 days) and how relevant it is and suggest best practices for what the minimum standard should be for various use cases.

Eliel Oliveira: 👍

Rochelle Prosser: +1 Steve

Steven Eichner: And also how AI can support public health, including leveraging nontraditional sources of information.

Steven Eichner: +1 Jim

Steven Eichner: Building on Jim's comment- also nderstanding what data is needed.

Jim Jirjis: I have someone on my team who can present a public health framework if ti would be helpful

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

No comments were received via email.

RESOURCES

AR WG Webpage
AR WG - July 22, 2024, Meeting Webpage

Transcript approved by Seth Pazinski, HITAC DFO on 8/6/2024.