Meeting Notes

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) – SPECIAL COVID-19 RESPONSE MEETING

March 26, 2020, 10:30 a.m. – 1:30 p.m. ET

VIRTUAL

EXECUTIVE SUMMARY

Donald Rucker welcomed members and thanked them for joining the special virtual meeting of the HITAC to address the COVID-19 virus outbreak and pandemic. He summarized both the clinical and HHS's responses to the outbreak of the virus and noted that a large subset of responses have health IT aspects. Because HHS's senior leadership team is consumed with a vast array of activities around fighting the virus, he called on the HITAC to share in the decision-making process. **Carolyn Petersen** explained the process for collecting information from members, gave an overview of the meeting agenda, provided an overview of the process she followed when reviewing and collating the input received from members on the topic of a COVID-19 response, and then, briefly elaborated on the range of topics. **Robert Wah** summarized the goals for discussion and facilitated an in-depth discussion by the HITAC members of suggested COVID-19 response activities. **Lauren Richie** reminded members that an additional meeting or series of task force meetings would be held before the HITAC meeting on April 15.

There were several public comments submitted by telephone and in the Adobe meeting chatbox.

AGENDA

10:30 a.m.   Call to Order/Roll Call
10:35 a.m.   Welcome Remarks
10:40 a.m.   Remarks, Review of Agenda, and Meeting Objective
10:45 a.m.   Summary Review of HITAC Feedback on COVID-19 Response
11:00 a.m.   HITAC Discussion of Suggested COVID-19 Activities
1:00 p.m.   Next Steps and Action Items
1:15 p.m.   Public Comment
1:30 p.m.   Closing Remarks and Adjourn

ROLL CALL

Carolyn Petersen, Individual, Co-Chair
Robert Wah, Individual, Co-Chair
Christina Caraballo, Audacious Inquiry
Cynthia A. Fisher, PatientRightsAdvocate.org
Valerie Grey, New York eHealth Collaborative
Anil Jain, IBM Watson Health
Jim Jirjis, Clinical Services Group of Hospital Corporation of America (HCA)
John Kansky, Indiana Health Information Exchange
Ken Kawamoto, University of Utah Health
Steven Lane, Sutter Health
Leslie Lenert, Medical University of South Carolina
Arien Malec, Change Healthcare
Clem McDonald, National Library of Medicine
Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin
Brett Oliver, Baptist Health
Terrence O'Malley, Massachusetts General Hospital
Raj Ratwani, MedStar Health
Abby Sears, OCHIN

Sasha TerMaat, Epic
Sheryl Turney, Anthem Inc.
Denise Webb, Individual

MEMBERS NOT IN ATTENDANCE

Amy Abernethy, Food and Drug Administration (FDA)
Michael Adcock, Magnolia Health
James Ellzy, Defense Health Agency, Department of Defense
Tina Esposito, Advocate Aurora Health
Jonathan Nebeker, Department of Veterans Health Affairs
James Pantelas, Individual
Steve Ready, Norton Healthcare
Alexis Snyder, Individual
Andrew Truscott, Accenture

FEDERAL REPRESENTATIVES

Adi V. Gundlapalli, Centers for Disease Control and Prevention (CDC)
Michelle Schreiber, Centers for Medicare and Medicaid Services (CMS)
Ram Sriram, National Institute of Standards and Technology (NIST)
Nina Hunter, Food and Drug Administration (FDA)

ONC STAFF

Donald Rucker, National Coordinator for Health Information Technology
Steve Posnack, Deputy National Coordinator
Seth Pazinski, Director, Division of Strategic Planning and Coordination
Elise Sweeney Anthony, Executive Director, Office of Policy
Avinash Shanbhag, Acting Executive Director, Office of Technology
Tom Mason, Chief Medical Officer
Lauren Richie, Branch Chief, Coordination, Designated Federal Officer

WELCOME REMARKS

Donald Rucker welcomed members to the virtual meeting of the HITAC and thanked them for joining the special meeting to address the COVID-19 virus outbreak and pandemic on such short notice.

He noted that the Fiscal Year 2019 (FY19) Annual Report had been reviewed and submitted to the Secretary of Health and Human Services (HHS) and Congress. He thanked everyone for their work on the report and commended Carolyn Petersen and Aaron Miri for leading that workgroup.

He summarized both the clinical and HHS's responses to the outbreak of the virus and noted that a large subset of responses have health IT aspects. Because HHS's senior leadership team is consumed with a vast array of activities around fighting the virus, he called on the HITAC to share in the decision-making process. He asked members to consider filtering the ideas they will present during the meeting. He urged them to think about the immediacy of the situation, and to, then, prioritize the actions that will make the biggest impact immediately and that are the most natural topics for ONC. He asked members to keep in

mind that some of the suggestions that have come in are in the realm of marketing activity and some are more of a high priority for fighting the infection.

Steve Posnack shared resources on COVID-19 that were put together by ONC's staff. He noted that ONC has a main coronavirus page on the website, and they have taken an approach to organize the health IT relevant information and guidance that their sister agencies and others have made available, resulting in a range of general guidance from EMS-specific guidance to HHS guidance and OCR-related components to data guidance on standards, and other supporting information. He explained that they published a new section of their interoperability standard advisory (ISA) page specific to COVID-19, and that includes all the relevant terminologies, like SNOMED, ICD-10, LOINC, etc. He asked the audience to share anything relevant to the different value sets or other terminology that was not included. Links to the above mentioned sites, are listed here - healthit.gov/coronavirus and healthit.gov/isa.

REMARKS, REVIEW OF AGENDA, AND MEETING OBJECTIVE

Robert Wah gave an overview of the reason for this meeting, which came only a week after the regularly scheduled meeting of the HITAC, and he thanked everyone who made the meeting possible, especially the ONC team and **Carolyn Petersen.**

He explained the process for collecting information and comments from members, which **Carolyn** will collate after the meeting, and thanked everyone who submitted feedback prior to the meeting. He reminded them that a Word document was sent to the full HITAC membership detailing the previously collected feedback, and he urged members to read it as soon as possible. He noted that the first part of the work will center on identifying what the health IT community can do now to support the COVID-19 response. The second part will examine potential actions with considerations that include:

- Can the item be acted on immediately by ONC?
- Should the item be deferred for future consideration (i.e., shared with Annual Report Workgroup for consideration for future HITAC actions)?

He echoed **Donald Rucker's** request to sort those things that members think are health information technology opportunities in the fight against the coronavirus and to identify their natural owners, whether they are ONC, another operating division of HHS, a sister government agency or the private sector. Finally, he highlighted the need to make a series of determinations regarding the timing of various responses.

The next steps are:
- For items that can be acted on immediately by ONC, ONC will identify a potential charge for a new HITAC Task Force to address.
- For items that address issues managed by other federal partners, ONC will capture the items and share with those partners.

SUMMARY REVIEW OF HITAC FEEDBACK ON COVID-19 RESPONSE

Carolyn Petersen gave an overview of the process she used when reviewing and collating the feedback received from members. She briefly elaborated on the suggested ideas , which were generally divided into the following broad categories:

- Technology
- Telemedicine/Telehealth
- Standards and Data
- Privacy Matters
- Policy
- Patient Matching
- Public Health
- Information Exchange
- Other

She reminded members that the meeting support staff would be taking notes on the topics of interest in Adobe during the meeting.

HITAC DISCUSSION OF SUGGESTED COVID-19 ACTIVITIES

Robert Wah asked members to identify examples of tasks the health IT community can do now to support the COVID-19 response.

Discussion:

- **Clem McDonald** noted that some of the items on list could take two or three years, and would like the HITAC to focus strictly on what can be done immediately or in the next few weeks. He suggested using what Korea did with taking and using contact information as an example. He stressed the importance of moving fast.
    - o **Robert Wah** noted that the HITAC is very focused on the urgency of the situation and is trying to be complete in acquiring suggestions for the list. He emphasized the need to focus on things that are doable in the short term and the natural owner.
    - o **Clem McDonald** suggested relaxing access to data, specifically location data for tracking and following populations who might be exposed. He wondered how this could be done, who could be tracked, and if email data could be used.
- **Aaron Miri** echoed Clem McDonald's comments and covered some examples from specific actions currently being undertaken at UT Austin.
    - o He noted that relaxing licensure and other rules allowed telemedicine, especially social services and those of his psych department, to be deployed en masse, which the Austin area finds beneficial. This is an example of rapid action at work.
    - o He noted that there is a new ICD-10 code for COVID-19 that was published by the World Health Organization (WHO). He explained that a number of electronic medical record (EMR) vendors are reluctant to add that code, because many vendors have paused all new updates. He suggested that they take a look at how they can support the EMR vendor community now, so they can begin using the code as soon as possible.
    - o Next, he emphasized the need for information sharing from the front lines, including data elements from academic medical centers, like the loss of smell and other senses. These might be early indicators of the virus, and are, in fact, often coming up as topics on social media platforms such as Twitter. He said they need to do a better job of capturing real-time aspects like these in the field.
    - o The final issue he raised was the personal protective equipment (PPE) shortage. He asked what they could do to share more information on using N95 mask supplies safely and securely. He also mentioned 3D printing PPE as a way to focus on the shortage

fight.

- **Arien Malec** supported the idea of rolling out terminology to support biosurveillance, disease surveillance, and testing.
  - o He is concerned that there has not been ubiquitous adoption of the rollout of new lung terminology for SNOMED and ICD-10 terminology. He emphasized that they need to make sure that the CDC information in the BioSense Platform that has already been deployed is being updated with the right data and the appropriate terminology.
  - o He noted that the CDC released information that showed age as a risk factor, and he sees an opportunity to leverage the massive amount of data in EHRs to look at disease surveillance and additional risk factors. This data might not be as accessible due to foundational activities that **Aaron Miri** described.
  - o He stated that there is a need for urgent coordinated standards in high priority areas, and he shared the example of a team looking at making access to ICU status available via FHIR based APIs to provide additional information for intake and response and, then, to direct people to available beds. ONC has a role to play in terms of prioritizing standards development for the communities most affected.
  - o In areas with an identified need, he stated that ONC can help coordinate funding and can help stand up location information systems to share information in real-time.
  - o He emphasized that ONC can have a critical role in conveying information and coordinating with sister agencies, like OCR (on guidance for information sharing), instead of only playing the role of regulator.
  - o Finally, he stated that there is an immediate need to make a clear prioritization framework to address the highest priority needs, and other needs, like updating disease surveillance capabilities, can wait for a month or two.
- **Michelle Schreiber** shared that CMS is rolling out as fast as it can to providers to relieve the burden of information sharing from providers, so they are able to focus on patient care. They have waived regulations, including quality reporting rules. She encouraged ONC to think about adding this action to the top of their list. She emphasized the importance of telehealth and how it can be focused towards remote areas of the country. She agreed with the move to standardize terminology. She inquired whether ONC has representatives on the new FEMA committees, and she mentioned that they may be looking at simply using paper for record-keeping instead of EMR. She noted that digital information flow is the most important factor. She emphasized making more data available, including mechanisms for standing up large data sets for clinical trials and more information from situations in which providers are putting patients on clinical trial mediations or off-label drugs. She stated that reporting new drug efficacy is important. Sharing analytics, even to the big vendors who have a lot of clinical information, should be done. Also, she added they have to relieve providers of the burden of some of their regulations, so that they can focus on patient care.
- **Christina Caraballo** echoed **Arien Malec's** comments on fast tracking data that is needed. She suggested that they look at what was done in the prior Federal Advisory Committee work and build upon ZIKA task force findings. She suggested pulling in vendors (Cerner, Epic, etc.) to get software ready to deploy rapidly within the crisis, and she said that their response has been an all-hands on deck mentality with regard to coordination. She echoed other members' statements about the importance of telehealth solutions and noted that it is a critical time to engage patients and capture their data. She thanked the team for deploying the new resources on ONC's website, because the COVID response information for organizations is critical. Easily accessible information for those working on the front lines is important.
- **Denise Webb** also commented on telehealth. Due to shelter-in-place orders, there has been an increased demand on the network, which has strained broadband capabilities. She noted that an industry CIO expressed appreciation for relaxation of telehealth requirements that CMS has provided. However, she noted that some telehealth codes reimburse at a lower rate for telephone only communications vs. consultations with audio and video. Also, she stated that these telehealth calls

and the large number of people working and streaming from home strain broadband infrastructure. Another problem is that many isolated seniors, do not have access to technology or have technical challenges. She suggested that ONC could help coordinate with CMS to lessen the burden on the infrastructure and prioritize certain communities. She noted that some telehealth visits that are only reimbursed if done using video and audio don't need video and could be done with just audio and should receive the same reimbursement (versus a lower reimbursement). **Michelle Schreiber** responded to her inquiries on behalf of CMS and noted that they will be proposing legislation to answer some of her concerns.

- **Steven Lane** noted the importance of getting data quickly and accurately to public health departments. Electronic lab reporting is being used across the country, but electronic case reporting is often still a manual process. He suggested that public health agencies are having a hard time because of HIPAA, and it is challenging to get clinical health data. He suggested that they leverage technology already in place, including the eHealth Exchange, direct transport, the PULSE (Patient Unified Lookup System for Emergencies) system that ONC invested in previously, and the care quality framework. He stated that these groups have an established process for electronic case reporting, and they even have live pilot programs that are tailored to COVID-19 that are already active in some areas. He questioned if there is an opportunity for a HIPAA waiver to support access for public health agencies to getting more clinical data, which would be helpful whether they were using the new PULSE system that is being stood up to support COVID-19 or using care quality more broadly.

- **Brett Oliver** congratulated HHS and CMS for removing some regulations to allow for tremendous expansion in the effort to provide virtual care. He strongly emphasized the need to get a better, more reliable supply of PPE to the front-line workers. He emphasized that ONC should put resources towards ways to get PPE out quicker and suggested a central repository for PPE and/or a national 3D printing resource area. He described his supply chain efforts to try to find available PPE and explained that his organization's incoming shipment of PPE from China was hijacked by the government and redistributed. He explained that he understands their national priorities, but they must have a way that they can successfully order and track PPE. Once China adopted more severe PPE requirements, they had zero healthcare workers infected. He said that what we are currently doing is not working.

- **Anil Jain** agreed with other HITAC members and suggested breaking the list of response activities down into the categories of short-term, intermediate, and long-term. He stated that having access to quality data should be promoted. He noted that the quality of data that is going to inform public health officials and researchers is going to be based on completeness and consistent use of the standards that exist. Some of the data points that they may want to promote, such as contact data, location data, travel history, etc., are going to be critical to get a better handle on this, as well as what may happen next. Also, he emphasized ensuring the quality of data with patient matching aspects. He noted that HIPAA misconceptions should be addressed, and he added that it is often raised inappropriately as a barrier. He emphasized the need for standards and consistency in data collection, while allowing frontline providers to do their work.

- **Carolyn Petersen** noted that her statement reflected her personal views, and not Mayo Clinic, her employer. She noted that privacy and some privacy-related concerns were mentioned on the list that was presented from the slides, and there have been some fairly broad discussions about doing things like relaxing restrictions on patient consent or regulations about sharing. She noted that her view is that taking action towards saving lives should be the highest priority. However, relaxing regulations on patient consent can have long-term implications. In light of the fact that there are efforts to revoke the ACA are ongoing, if the ACA goes away, patients can be subject to pre-existing condition exclusions in health insurance once again. She noted that some people, today, who can be insured, will find they can no longer purchase insurance that provides coverage for the things that they need, like COVID-19 care, but also things like heart disease, cancer, and other conditions that are quite common and require ongoing care. She was concerned about setting patients up to be rejected for coverage in the future. She noted that the HITAC and ONC have had past discussions about DS4P (data segmentation for privacy). She strongly entreated members to be looking at those aspects of health

IT, as well as the things necessary to get the COVID-related information moving, so they can help facilitate patient care immediately and also in the future.

- **Leslie Lenert** emphasized the process of debating pros and cons as a committee, especially with regard to healthcare privacy and privacy of healthcare data. The HITAC should be strategic and intelligent when considering relaxing HIPAA and health privacy regulations to benefit the population. He suggested looking at state laws that inhibit information exchange that may be overridden temporarily. He questioned whether public health should only be given the minimum amount of info needed to respond to an outbreak or if there even is a limit to this amount. He encouraged the HITAC to look at the long-term privacy implications and, possibly, make some intelligent compromises. He noted that if they can get those recommendations to decision-makers to implement through the Stafford Act, they can make a difference in this outbreak.

- **John Kansky** asked to amplify some of the items that **Steven Lane** expressed previously, while also incorporating comments related to HIPAA. He noted that information exchange in the U.S. is working and responding. He gave the example of a state Department of Health that has asked an HIE to serve as a single source of data, and for new sources of data that do not already contribute to the exchange, there has to be legal coverage for them to send data. There is a real need for data use agreements to cover exchanges that are being requested. The HIPAA term "Public Health Authority" (PHA) is important. He suggested temporarily giving electronic health information exchanges (HIEs) the PHA designation.

- **Terrence O'Malley** noted that the comments seem to be falling into two categories: one is moving data around more quickly and the other is quality of the data itself. He asked how can ONC fill the gaps.

- **Robert Wah** noted that he submitted information about COVIDcheck.org and the Common Health Project. He stated that they have four functions they should have the capability to provide and referenced the submitted slides; The functions are:
  1. Assessment of risk based on CDC and WHO guidelines
  2. Guide (help individuals find services)
  3. Subscribe (providers and find information)
  4. Report (better reporting on citizen status, like China, who is using QR codes to help patients identify their status, including symptoms, work status, etc.)

  He noted that these status items would be linked to an identity management system. He thinks the HITAC and ONC could use this as an example of where it can apply expertise, as it is all about the data liquidity issue. If the Common Health project is to work appropriately, it will need persistent API agents. Individuals will be able to hold their information and, in an emergency, take it where needed. He stated that many telehealth organizations are not connected with our normal infrastructure of information, so they, Common Health, are putting it in the hands of the patient. Patients, themselves, can provide their medical health history to a telehealth provider that may not have seen them before. He emphasized the idea that there is a free flow of information happening in these activities.

- **Aaron Miri** gave an overview of real-time issues in the field in Texas:
  - First, he noted issues with cellular bandwidth. He would like to see a partnership with FCC to ensure first responders are getting real-time information and not dropping connections. He noted that a lot of this bandwidth is being used by people working at home.
  - Forms for contact tracing are all different, from the CDC to the state to the local level and have numerous fields. They are trying to normalize these, based on the national level, and The University of Texas at Austin is developing an app.
  - Data sharing is an issue. Discrepancies exist between state and federal sources on who is infected. He would like to synergize data between the various dashboards that are available.

- o Protections for medical students and residents need to be defined. He noted that New York has allowed year four medical students to skip final exams and begin practicing as doctors. ACGME and AAMC should be involved in a partnership on how to keep medical students and residents protected and maintain data integrity in the medical record, while allowing them to chart, prescribe, etc. He would like to see a fast track for residents to perform more expanded roles.

- o He emphasized the topic of research and the creation and distribution of FAQs related to IRBs to speed up human trials or announcements of grants. They should consider a partnership with the AAMC, AHA, and others, and to look what MITRE has done with the coalition they have put together. The question is how to get certification and accreditation relaxation to be able to do this as quickly as possible.

- o Military health system data sharing of information related to COVID-19, including partnerships between military divisions, should be encouraged. He asked how they could leverage DoD and the VA's information-sharing platforms.

- o He shared an idea for turning ASC into oxygen therapy or ICU beds. He asked how it would be possible to get accreditation relaxed to do this.

- o Finally, he asked how to best share information to the public and if they can tap into the amber alert system to dispel incorrect information.

- **Arien Malec** echoed some of **Aaron Miri's** statements, including the roll out of universal terminology. He said that they do not need to relax HIPAA and can use existing HIPAA waivers. Better guidance is needed in the partnership between ONC and OCR, in terms of information sharing (that is allowed under existing authority). He noted that there is a great deal of information flowing through the nation, as other members have mentioned, and he would like to see it deployed and used for better data surveillance. He emphasized that none of this matters without terminology that is universally deployed. ONC has a key role in coordinating and standardizing IRBs and real-world data sourced from EHRs, in collaboration with other organizations. Also, if they are asking for duplicative case tracking, ONC can play a role in standardizing information flows in conjunction with CDC and other organizations. It has a critical role in convening with other organizations at a time like this.

- **Abby Sears** noted that the role of ONC as the convener of these groups has a significant impact. She spoke about the degradation of networks in more rural areas, and she stated that patients do not have access to telehealth and other services described by other members, due to broadband limitations. She also described restrictions around CFR 42 data and data from patients undergoing alcohol and drug treatment. She noted that it is not practical to assume a patient will be addressing only one issue at a time during a visit, and they need to be able to work with their provider for all health-related issues, not multiple providers. She said that clinicians need the full picture of a patient to give them the best treatment possible. She noted that their part of the delivery system does not have as many adaptive possibilities. Providers do not have capacity to implement inoperability rules. She is worried that these providers are serving some of the most vulnerable patients in the country, and any leniency in rules would be most useful because, otherwise, these providers will not make the timelines.

- **Ram Sriram** suggested that AI could address the distribution of misinformation on the internet.

- **Cynthia Fisher** described the patient standpoint of those who are following shelter-in-place guidelines. She asked about shared access among family members to allow them to remotely care for each other during these times. She challenged the HITAC to look at interoperability infrastructure to get to a shared standard to share patient health information to family members. She is interested in more information about a possible app being developed with Apple for this purpose. She raised the question of what standards could open up the APIs to deliver on them and share to a mobile app to move faster.

NEXT STEPS AND ACTION ITEMS

Robert Wah noted that he and **Carolyn Petersen** would examine potential actions and considerations, including the following:

- Can the item be acted on immediately by ONC?
- Should the item be deferred for future consideration (i.e., shared with Annual Report Workgroup for consideration for future HITAC actions)?

He noted that he sees the items discussed at the meeting as falling into four main categories, in the support of public health organizations: Privacy, Data Standards, Data Interoperability, Infrastructure. **Carolyn Petersen** asked for specific actions that could be taken to be submitted with the comments from HITAC members, as well as timelines.

Further Discussion:

- **Aaron Miri** emphasized that time is of the essence. Providers are being exposed and testing positive, so he noted that they should focus on immediate actions. Specifically, they should consider reserving bandwidth for providers, convening with CDC for tracking forms, encouraging the vendor community, and immediately adopting new ICD-10 codes. He stated that clinicians need this now.
- **Terrence O'Malley** stated that he would like ONC to expand the ISA and to centralize information for everyone to use.
- **Donald Rucker** responded to **Aaron Miri** that there is an entire command structure that is already in line with FEMA, so they should consider how to package suggestions to make them operational in the field with actions that are being taken by FEMA and others.
- **Abby Sears** requested that they take action to prioritize bandwidth and networking for healthcare activities and would like the HITAC to request this from the command center.
- **Cynthia Fisher** stated that she has heard that people with no or mild symptoms taking up beds and forcing staff to use unnecessary amounts of PPE when they go to get a test. She suggested data interchange to break out symptoms into categories to free up EDs for critical care and triage.
  - o **Robert Wah** noted that the idea on COVIDcheck.org is to use a specific risk assessment tool with 12 to 19 questions, based on CDC and WHO guidelines. Then, providers can categorize patients based on those guidelines. He addressed the question of how to connect patients to guidance, and he said that they need a telehealth session. COVIDcheck.org is trying to create a mechanism where they can take their responses to the risk assessment tool and give them to medical staff. He noted that they want them to have a richer source of information they can bring to these sessions, like their medications list. By giving citizens a way to display or report their status like "tested negative" or "have antibodies," it becomes an identity management issue as well.
  - o **Cynthia Fisher** suggested that smartphones can be used to provide nation-wide update to citizens to triage.
  - o **Robert Wah** stated that COVIDcheck.org is trying to be a two-way information platform to reduce misinformation, which would go beyond other methods of communication.
- **Abby Sears** emphasized the idea of simplifying and streamlining the IRB process to do clinical trials that are being requested.
- **Leslie Lenert** suggested a new approach of allowing investigators to directly contact patients who have COVID-19, without having an established clinical relationship.
- **Arien Malec** requested more information relative to **Donald Rucker's** comments. He inquired: what is already going on in these areas? What are the needs that have already been met? He stated that it would be useful to get a baseline for what everyone is already doing and what is being covered in the response in order to identify the unmet needs.

- o **Donald Rucker** responded that Quest/Labcorp is already getting information on the spread of disease. In terms of case finding (whether manual or automatic), the manual case finding has overwhelmed areas with high disease rates. He noted that the illness is moving rapidly, and this makes contact tracking difficult. FEMA is getting more involved at the ground level. Vendors are using this as an opportunity to mandate the use of their products. He thanked everyone for their suggestions and noted that they will be examined and collated. Internal prioritization of what can be advanced will performed.
- **Steve Posnack** reiterated Don's comments and noted that internal coordination will be done to put various agencies in touch with proper stakeholders. They will be providing consultative support from a data perspective, and they will also be fielding information like the two website resources mentioned at the beginning of the meeting. ONC can help organize activities that are becoming unclear as things develop.
- **Elise Anthony** noted that activities are underway, and ONC will continue to be a resource to the health IT community. In terms of a specific charge, she reiterated that they want to be focused on something that can be implemented immediately. She noted that, when looking back to the ZIKA response, it is possible to see how ONC coordinated with other federal partners. Though the COVID-19 response is different, it is an example of how ONC can coordinate efforts in the short, medium, and long-term.
- **Steven Lane** asked if there is value in standing up a task force to focus ONC priorities.
  - o **Don Rucker** responded that they are interested in setting up something more frequent to discuss topics, especially to hear what is working and what is not, and to serve as an early warning system. They need to hear from those on front lines, as that is the most unfiltered information.
  - o **Robert Wah** noted that ONC wants to have the conversation today to get all input synthesized, create a task force with appropriate charges, and solicit volunteers to serve.
- **Christina Caraballo** noted that she does not want to pull important resources from their focus, but she would like ONC to look at all groups that are making recommendations and tap the thought leaders to share information. She stated that it is important to remove the silos of information/recommendations/concerns.
- **Sheryl Turney** stated that they should focus on what activities are saving lives, like PPE equipment and monitoring systems that do not currently exist. They should focus on the inability to report COVID-19 codes appropriately.
- **Steve Posnack** noted that they are considering a task force, keeping in mind what actions can make the most impact right now. He noted that certain discussion topics are more long-term issues. ONC can move faster than most advisory groups, but they have their limitations. He reminded members that supply chain management and topics of that nature are not in ONC's purview.
- **Leslie Lenert** noted the opportunity exists to provide financial support to volunteer standards organizations and health information exchanges through ONC.
- **Cynthia Fisher** referred to **Donald Rucker's** earlier front-line provider comments. She asked if ONC could look at implementing a real-time data gathering input from the frontlines. They should focus on what they need to be successful. She noted that first responder and emergency personnel exposure is a significant issue, as well as asymptomatic patients wanting tests/exams and crowding EDs. She inquired about an existing two-way channel of communication that could be used in this case.
  - o **Clem McDonald** noted that it is not correct that there are no standard codes; WHO made and released over 30 codes. He said that it is not just emergency personnel that have to be warned, but they should be using every mechanism they have to publicize contact/transfer information.
- **Elise Anthony** mentioned that, as a follow up to the question about OCR and first responders and referred to relevant links that **Steve Posnack** provided in the Adobe chat window.

PUBLIC COMMENT

Larry Ozeran, with Clinical Informatics offered two suggestions. The first was to start to stem panic by adding additional access to accurate information and resources. He suggested that ONC, either alone or with other federal agencies, create an online ring of trust to ensure that every valid COVID-19 resource links to every other resource. This could be either peer-to-peer or hub-and-spoke. He shared more details through the public chat in Adobe. His second suggestion was to develop an opt-in process for members of the public to share identifiable data for research purposes. He thinks that there is a silver lining in the crisis to examine the communal reluctance to getting consent for research purposes, and it might be a good time to pay for infrastructure upgrades using stimulus package funding. He noted that his second suggestion could take longer than the first, maybe up to a few months, but it would have a lasting value for future crises.

Scott Stuewe, with Direct Trust echoed the comments of Steven Lane and John Kansky, who mentioned the importance of utilizing "on the shelf" resources. He highlighted the point about the importance of focusing on providing tools that are of interest and importance to providers on the front line. He emphasized focusing on things that work without thinking about how they can advance business opportunities.

He highlighted the opportunities that the Direct Trust Network represents, including the ability to utilize it specifically for the problems of care coordination, which he thinks are going to be unique in the coded model. He noted that there will be a need to query for data to find out whether or not the patient is stratified into one or another category. Then there will be a need to push that data to where it needs to go, with regards to the appropriate COVID or non-COVID location. Such a mechanism, he stated, could be deployed with no additional cost, no additional effort for the industry, and with just a little bit of coordination.

He stated that they are already trying to work on that effort by collaborating with others to try to make certain they are not out of step, and so he expressed his desire to stay in step with what the ONC is doing so that they do not get ahead or behind of what the government is proposing to do.

He noted that a bi-directional channel for communication is already in place with direct messaging, so he wanted to make sure that the group does not forget that they have an existing product that he thinks would be useful in the efforts surrounding the crisis.

Seth Blumenthal, from the American Medical Association (**AMA)** suggested that a priority action should be on the ground standards of codes. He noted that code sets are immediately usable, regardless of the data capture method. He stated that, as far as existing business requirements are concerned, for example, there is a consensus that the CDC forms are not easily transferred into electronic form. He suggested that the HITC and ONC could give public guidance in this area and could represent how to code COVID-19 data for future use. He mentioned the ISA as a good technical reference, but ONC could also publish a document that is easy to read and more useable. He suggested that they publish something easy to use so people who want standardized data are able to and will get it. He stated that it will help improve the quality of the data without requiring new infrastructure.

Clem McDonald asked for clarification around what has been relaxed as far as HIPAA regulations and other privacy rules are concerned.

Steve Posnack noted that he will talk offline with Clem McDonald.

Janet Hamilton, with the Council of State and Territorial Epidemiologists (**CSPE)** said that her organization represents epidemiologists in state and local health departments working on the frontlines related to this response. She is glad the HITAC has convened and is working on issues that can be implemented on an immediate basis, and she asked to highlight a couple of things that are confronting CSPE members right now.

One is the quality of electronic laboratory reporting data. There are some specific challenges related to the inbound and outbound data quality, with regards to data. She discussed the topic of Logical Observation Identifiers Names and Codes (LOINC) and noted that they are seeing a very general specimen code respiratory being used. She noted that there are identified issues around the around false negatives related to the different specimen type. The general respiratory utilization of that code does not allow them to evaluate that properly.

Second, she stated that they have received messages from laboratories that many of the specimen types are being left completely blank, though they are still receiving the actual specimens. She emphasized that getting that information updated would be useful.

She noted that, from a number of the commercial laboratory feeds and those non-public health lab feeds, they are seeing that around 40% of the patient demographic information is missing as compared to about 10% for other laboratory tests for other reportable diseases. That means they are missing the critical information to figure out who and where those results are coming from and be able to follow up rapidly to implement those control measures. She noted that they are missing information like the patient's address and phone number in places where containment is still occurring. She emphasized that they are losing days and hours to be able to follow up. Resolving these issues around data quality would be very useful.

Also, she encouraged the HITAC to think about other options, like asking for entry questions with some very basic kinds of information, where that could be quickly and rapidly passed along to public health that would help prioritize the case investigation process. Important information in these questions includes whether or not the person works in healthcare, whether the individual is hospitalized in the ICU, if they're pregnant or not, and if there are symptoms present, yes or no.

Finally, she emphasized that electronic case reporting is critical, and this outbreak, with its speed and intensity, needs electronic case reporting where epidemiologists are actually able to get public health data out of the electronic health record. She hopes that the HITAC can prioritize those actions to support public health surveillance.

Brett Blackman, with HealthSplash noted that he has been working with Scott Stuewe and Direct Trust and CCDA data that is already established inside the industry to be able to communicate between every certified EHR. One of the things that they have worked on is building a real-time pre-authorization diagnosis tool built on those standards. They have the ability to automatically flag particular diagnosis codes, medications, and other items inside standards upon transmission of that patient into any facility.

He stated that they would be able to make sure the endpoints of inbound and outbound request facilities that are verified would allow the data to be transferred in appropriately to the front-line providers. He announced that they are launching the ability for the patient to request that same CCDA data, to hold it, and to be able to deliver to any transmission facility they may visit.

Thirdly, he noted that they have been working with some telehealth companies to give them the access to be able to do what they would consider a pre-authorization. He explained that they are looking for guidance on this, including looking for the COVID-19 check form on the diagnosis codes, add that into a CCDA, and deliver it back into the EHR to complete the care loop.

Robert Wah directed Janet Hamilton to put her contact information in the public comments. He noted that they will take all input and synthesize information to create a task force with specific charges to turn that information back to this committee by Monday or Tuesday, and they will be soliciting volunteers for that task force.

Blackford Middleton asked how to bring measurements to all different locations of care? Platform for clinical computation in the cloud. He gave a summary of his background and stated that he works at a platform for generalized clinical computation in the cloud that has connectivity to over 2600 hospitals with BAAs. They have received multiple CDC research contracts to focus on distributing CDS, and they have architected a solution for case detection and reporting.

He stated that they have discussed ideas around eCase detection and an enhanced eCase report being made available to the CDC. They have a QRDA stream in place from the 2600+ hospitals, and they could add an 802 dot stream or API stream as COVID bundles are defined. Based on discussions he has had, there might be a way to curate a novel stream of these data for the purposes of decision support case detection reporting and quality measurement, which has not been measured, either. He asked how they should think about measuring the response to the COVID pandemic as it unfolds.

Also, he noted that have thought about demand management, and they help with algorithms now being published to identify at-risk patients. These stratify them for population management and assist them with self-management and self-triage, which are two key resources, as appropriate. He posed the question, "How do we help folks decrease their demand of precious hospital resources at this time when they're being overwhelmed by if COVID response?" He noted that they have ideas around improving medication compliance and have an application that is ready to be delivered broadly and quickly.

Finally, he stated that he would be interested in helping with the issue of patient access and patient reported data, including patient reported outcomes and iOS app leveraging the health record data store.

Janet Hamilton, **MPH, Senior Director of Science and Policy at CSTE** (submitted by email): We need clear in-bound requirements on in-bound data quality AT the PATIENT level. Public health (PH) at the state and local level is taking advantage of electronic laboratory reporting (ELR) but there are many gaps now.

We are seeing from state PH departments that ~ 40% of laboratory data they are receiving is missing patient demographic info, including patient address, phone number, age, gender. Geographic location at the PATIENT (not the provider level) to be able to identify and map risk appropriately. Right now there is so much missing information public health is losing precious time (hours and days) trying to get the information they need to follow up on cases.

The testing laboratory does not want to hold up the testing process because of missing information. We need to address this on the in-bound side – with the order having the complete information

When specimens are forwarded from one laboratory to another for testing, the information about the patient is often stripped off. Thus, when results are reported to PH critical information is missing (see above) and significantly DELAYS the PH response.

The new loinc release has some specimen specific loinc codes but the specimen TYPE is very GENERIC (respiratory) so NOT helpful for PH to assess sensitivity of tests by specimen site; and currently there is VARIABILITY in false negative results by specimen type.

We need additional ASK ON ORDER ENTRY (AOE) questions w labs that will support the PH response and be carried along with the laboratory results. These questions below have been agreed upon by CSTE (Council of State and Territorial Epidemiologists) members

Ask on order entry questions to be submitted at the time of laboratory order.

If laboratories could be compelled to change their systems – to collect the following information at the time of test order. These data were prioritized by state and local health departments as priority to assist in prioritizing case investigations:

- Employed in healthcare? Y/N/U
- Symptomatic? Y/N/U
- Hospitalized? Y/N/U (if only one of hospitalized or ICU, one vote for hospitalization status)
- In ICU? Y/N/U
- Pregnant? Y/N/U

Manufactures of point of care (POC) tests should be compelled to collect patient identifiable information and submit that information to public health. I would suggest those POC tests also have the questions above added. POC manufactures need to submit this data electronically to state and local PH.

We need to get electronic case reporting (eCR) to public health; many of the data issues we have right now would be resolved if we had eCR to state and local public health. eCR needs to be PRIORITIZED so we can have data move efficiently from healthcare TO public health

Janet Hamilton, Senior Director of Science and Policy, CSTE – please reach out to CSTE so we can best collaborate with this group

Questions and Comments Received via Adobe Connect

Adi Gundlapalli (CDC): Adi Gundlapalli (CDC) here

Nina Hunter: Sorry, Nina Hunter from FDA is here. Couldn't get microphone to work. Thank you!

Carolyn Petersen: Thanks, Nina. And welcome!

Arunan: Sorry for joining late. This is Arunan from the Bill and Melinda Gates Foundation listening in briefly on shared needs

Al Taylor, ONC: healthit.gov/isa/covid-19

Seth Pazinski: https://www.healthit.gov/coronavirus

Clem McDonald: Correction; LOINC has already released 20-30 codes for testing of SARS-Cov-2 (casue of COVID-19/ in colalboration with WHO, CDC, AHPL and othess already has test scodes from WHO,CDC, Chnia Gemernay . Today they had a webnar with 700+ attendees to publicize this . SNOMED has also definned and released dcodes foor findings and disese.e So please be awaer . all of this information on https://loinc.org/sars-coronavirus-2/

Keith W. Boone: https://github.com/AudaciousInquiry/saner-ig/wiki/About-The-SANER-ProjectAudaciousInquiry/saner-ig

Blackford Middleton: (Difficulty to speak; raised hand lowered by host) WOuld like to mention importance of getting knowledge assets and apps to the front line. We ahve connectivity to > 2600 hospitals that could be used to deliver an app (iFrame or SMART on FHIR) to end users rapidly. An area of investigation for me for a long time, and have piloted iwth CDC. Thanks.

Ram D Sriram: Agree with Denise on the video visits. There are lots of people in under served communities who do not have smart phones

Lauren Richie: If members from the public are interestd in providing comments, you may do via the public chat feature or dial into the public comment period towards the end of the call. Thank you.

Blackford Middleton: Lauren -- yes of course, forgot. thanks.

Lauren Richie: no worries. appreciate your participation.

Clem McDonald: Hear, hear to the issue about personal protection equipment

Steven Lane: +1 for PPE prioritization

Blackford Middleton: (echoing Steven Lane) Given our connectivity with > 2600 hospitals we are aslo considering how we can enable streamlined and enhanced eCase Detection in reporting to CDC.

Leslie Lenert: I am on the line but you are not hearing me?

Steven Lane: Clarification would be valuable from HHS/OCR re how HIPAA's minimum necessary requirement applies to Public Health actors/agencies during this crisis. Apparently CDC is looking at establishing BAAs with providers to get around the existing restrictions. An HHS waiver could obviate this need and streamline the process of providing access to clinical data.

Clem McDonald: No one is suggesting dropping protection. but. We have to knmow who has it to keep those who don't have it from getting it.

Clem McDonald: Hear Hear to Leslie's comments

Blackford Middleton: Steven Lane: we have BAA with the > 2600 hospitals in place; could that streamline with CDC?

Clem McDonald: Mr chairman-- I have to take another call for an hour. Wanted to be surer to correct the comment that coding standards are not in place. That is wrong and i gave the correction in my comment

Robert Wah: Clem-Thanks, do you need to speak to this?

John Kansky: Regarding the notes next to my comment. The HIPAA term "Public Health Authority" is important. The suggestion is to *temporarily give HIEs the PHA designation

Clem McDonald: I willl when I get back on voice to this meeting, am time shifting to another required meeting at nLM. I could switch back with some notice

Janet Hamilton: We need clear in-bound requirements on in-bound data quality AT the PATIENT level. Public health (PH) at the state and local level is taking advantage of electronic laboratory reporting (ELR) but there are many gaps now.1. We are seeing from state PH departments that ~ 40% of laboratory data they are receiving is missing patient demographic info, including patient address, phone number, age, gender. Geographic location at the PATIENT (not the provider level) to be able to identify and map risk appropriately. Right now there is so much missing information public health is losing precious time (hours and days) trying to get the information they need to follow up on cases.--The testing laboratory does not want to hold up the testing process because of missing information. We need to address this on the in-bound side – with the order having the complete information2.   When specimens are forwarded from one laboratory to another for testing, the information about the patient is often stripped off. Thus, when resul

Ram D Sriram: The following URL https://www.kaggle.com/covid-19-contributions might be of interest to some of you. Lots of work going on in using AI techniques, which should be of interest to us.

Clem McDonald: The reason why this is spreading is that people who have it are giving it to others. HAVE To know who was around them and quarantine them. Not sufficient to ask them who they remember. We reaely should be using all of the position information on the big tech companies. That has been off the table because of preivay worries, but we could have a million deaths so time touse the Korean approach

Janet Hamilton: 2.   When specimens are forwarded from one laboratory to another for testing, the information about the patient is often stripped off. Thus, when results are reported to PH critical information is missing (see above) and significantly DELAYS the PH response.3.   The new loinc release has some specimen specific loinc codes but the specimen TYPE is very GENERIC (respiratory) so NOT helpful for PH to assess sensitivity of tests by specimen site; and currently there is VARIABILITY in false negative results by specimen type.

Blackford Middleton: Ram -- error on htat URL

Janet Hamilton: 4.   We need additional ASK ON ORDER ENTRY (AOE) questions w labs that will support the PH response and be carried along with the laboratory results. These questions below have been agreed upon by CSTE (Council of State and Territorial Epidemiologists) membersAsk on order entry questions to be submitted at the time of laboratory order.If laboratories could be compelled to change their systems – to collect the following information at the time of test order. These data were prioritized by state and local health departments as priority to assist in prioritizing case investigations: o   Employed   in healthcare? Y/N/Uo   Symptomatic? Y/N/Uo   Hospitalized? Y/N/U (if only one of hospitalized or ICU, one vote for hospitalization status)o   In ICU? Y/N/Uo Pregnant? Y/N/U

Janet Hamilton: 5.   Manufactures of point of care (POC) tests should be compelled to collect patient identifiable information and submit that information to public health. I would suggest those POC tests also

have the questions above added. POC manufactures need to submit this data electronically to state and local PH.

Blackford Middleton: Robert Wah -- can you please shave a link to COVID-Check.

Carl Johnson: Excellent dialogue, however I don't hear anyone advocating for a systems-analysis assessment of where we are at and where we need to go collectively. Each interestes group seems to have their focus with little discussion about how, where, and when their focus fits with others. All the ideas are good in isolation, however in aggregate how can we design (with flexiblity and agility) to respond and accommodate a very dynamic phenomenon. We need to think SYSTEMS now and align around that!

Janet Hamilton: comments above: Janet Hamilton, Senior Director of Science and Policy, CSTE – please reach out to CSTE so we can best collaborate with this group

Robert Wah: Blackford-In beta right now. some info is at covidcheck.org thanks

Carl Johnson: Excellent points Aaron! YES on standard data elements that are digital!!!

Ram D Sriram: Blackford. May be you can go to www.kaggle.com and click on "Your Contributions" tab.

Janet Hamilton: We need to get electronic case reporting (eCR) to public health; many of the data issues we have right now would be resolved if we had eCR to state and local public health. eCR needs to be PRIORITIZED so we can have data move efficiently from healthcare TO public health

Denise Webb: Related to Aaron's comments, dashboards are not reporting data on number tested that are not positive, i.e., % of population tested and % of these pos and % of these neg

Ram D Sriram: Important to have proper reporting to CDC through proper EHR interfaces. Clem brought out important points regarding traceability of infections

Carl Johnson: Aaron's comments are examples of a systems-thinking approach to this issue. All the moving parts have to work harmonously!!!

Susan Clark: Aaron's comments = awesome.

Brett Blackman: where can the National contact form URL be found?

Susan Clark: especially normalizing contact tracing forms.

Clem McDonald: To aarons point LOINC has lots of LOINC codes for SARA-Cov_2 in place to those are standard.CDC is working to develop other kinds of standards questions/measurement Should bee donson

Clem McDonald: To aarien statement Woul dit allow mining location contact information to find contacts. Mamy experts say that the NONLY way to stop this ssave vaciines are inteense trackgin. Depending on the case to know and remember thir contacts will not do the job. Rembmer that one or two leaks can case a whole city to light up. Think about NY.

Leslie Lenert: Public health needs to adapt to using FHIR queries for case investigations as demonstrated in CDC's PACER project

Steven Lane: +1 to Les' comment. We need to support Public Health in standing up FHIR capabilities ASAP - both query and response.

Leslie Lenert: Yes...public health needs immediate access to cell phone geolocation data for diagnosed patients

Julie Maas: Is identity sufficiently captured somewhere in that list?

Steven Lane: Les, We need to remain mindful of individual privacy and liberty - https://www.nytimes.com/2020/03/23/technology/coronavirus-surveillance-tracking-privacy.html

Leslie Lenert: Yes. Let's debate and reach rationale conclusions on the new risk to benefit balance of privacy vs. public health in the setting of COVID-19

Carl Johnson: Aaron's practical recommendations are system focused!!!

Carolyn Petersen: Agree that reserving bandwidth for providers is critical now

Carl Johnson: Without good bandwidth you will have less effective telemedicine!!!

Michael Wang: +1 to steven and les' comments for expanding FHIR capabilities. Can USCore define implementation guide how to use FHIR for case reporting, or HL7v2 if necessary (off existing adt feeds)

Charles Jaffe: Terry enunciated my wishes perfectly. I would hope that a centralized information center not a command center could be established by ONC.

Leslie Lenert: there are standards that preserve bandwidth for first responders but now with home telehealth, there are new issues and not necesarrily a way to prioritize bandwidth for patients

Leslie Lenert: the problem is this is not an easy fix. priority for first responders on celllular nextworks took years to build in

Al Taylor, ONC: there are many covid symptom screeners that somehow give widely varying results and recommendations.

Leslie Lenert: and, in our health system, screener positive patients are yielding positive results less than 10% of the time. How good are they?

Scott Stuewe: It will be extremely important to support the triage and referral process with appropriate access to both query and the ability to push information to the next care location. We are actively working to support this by identifying the appropriate account at facilities to communicate to acute settings in particular. In addition , Direct is frequently used for public health reporting as well. In a bandwidth constrained Circumstance Direct is very resilient. We are hoping to provide s support for this.

Leslie Lenert: We actually have a huge issue with telehealth systems not communicating well with Epic. As many are cash for service, we use Zipnosis this way, billing codes are an after thought.

Seth Blumenthal: URL for covid check??

Denise Webb: Can't the federal government have cellular network providers push out a national message to individual's phones giving them specific instructions regarding screening/testing of COVID-19. Much of this can be done via phone e-consult and home tests would help take pressure of the health system

Denise Webb: Intermountain Health has one of the better symptom checkers that also provides valuable info to an individual using the checker. https://intermountainhealthcare.org/

Scott Stuewe: Support both Steven Lane and John Kansky's points that we need to use whats available in the environment already. Pulse, the HIEs and the DirectTrust network are available now and non-profits are already working to optimize these.

Brett Blackman: I second Scott - Only thing that has to happen to streamline data using the current network is to verify Endpoints

Brett Blackman: Flag Patients as high risk in real-time using CCDA data and notify facilities upon Transition of care

clem mcdonald: Am back-but only by typing. But regarding Dons comment. Yes the window for contact tracking has probably cvlosed in the hot zones. But they kept doing it in Wuhan More immportant, All of the US is not het a hog zone.

Aaron Miri: I second Steven Lane's Task Force idea! Great suggestion

Leslie Lenert: Brett--that is a great HIE function and argues that HIE's should be considered public health agencies during the pandemic as John suggests

Steven Lane: Let's be sure to leave plenty of time for public comment today.

Leslie Lenert: SEC. 3224. GUIDANCE ON PROTECTED HEALTH INFORMATION in the Senate bill Pandemic bill calls for a review of HIPAA

Leslie Lenert: (thanks to Jeff Smith at AMIA for the reference

Leslie Lenert: Might want to get ahead of this

Robert Wah: I have been asked a couple of times so here is the CovidCheck url:

Robert Wah: CovidCheck.org is the url

steve: OCR guidance on first responders

steve: https://www.hhs.gov/sites/default/files/covid-19-hipaa-and-first-responders-508.pdf

Nathan: My team has been working on a tool similar to CovidCheck and we've collected a few resources as well.

Nathan: humandx.org/covid

Nathan: https://www.nhsdirect.wales.nhs.uk/SelfAssessments/symptomcheckers/default.aspx

Nathan: https://c19check.com/step-1

Nathan: https://my.clevelandclinic.org/landing/preparing-for-coronavirus

Robert Wah: Thanks Nathan, I believe the team is aware and may have been in contact with humandx

Lauren Richie: Public commenters: committee chairs or members may not be able to respond directly to questions or inquiries in real time. Your comments will be captured in the offical record for consideration. Thank you.

Blackford Middleton: I have a comment? did dial 1

Blackford Middleton: abnd *1

Janet Hamilton: I'm also in the question que pressed *1

Blackford Middleton: yes on the phone line...

Janet Hamilton: Yes. I dialed the number on the screen

Carolyn Petersen: Just as a reminder, this is a period for comments from the public, rather than questions to specific individuals of ONC or HITAC.

Brett Blackman: I also have pressed *1

Blackford Middleton: sorry i've been skipped again... will hang up and dial back in...

Robert Wah: Thanks Blackford, keep trying

Katherine Campanale: Blackford: please dial 1-877-407-7192

Blackford Middleton: back in...

Blackford Middleton: sorry i am ad heard tone

Blackford Middleton: ?

Scott Stuewe: Great to hear words from the front line Janet.

Steven Lane: Next steps re a task force??

Blackford Middleton: i'll sehd my notes to onc-hitac@accelsolutiohsllc.com and cc you. Shoot wish I could hve spoken.

Blackford Middleton: thanks for teh important effort

Scott Stuewe: Thanks to ONC for convening this.

Brett Blackman: Thank you everyone

Katherine Campanale: Blackford, to speak please dial 1-877-407-7192 and press *1

Blackford Middleton: Katherine C -- have done 2x.

Blackford Middleton: onc-hitac@accelsolutiohsllc.com is this correct email? thx

Katherine Campanale: onc-hitac@accelsolutionsllc.com

CLOSING REMARKS AND ADJOURN

HITAC co-chairs, **Carolyn Petersen** and **Robert Wah**, thanked members for their input, both verbal and written, and stimulating discussion. They noted that the minutes from the previous HITAC meeting would be brought before the committee for approval at the regularly scheduled meeting on April 15. **Carolyn Petersen** noted that they would continue working with ONC and would get the next steps out to members in a few days. They recognize that this is an important, fast-moving, and evolving situation.

Lauren Richie reminded members to watch for another invite for an additional meeting before the April HITAC meeting. She asked that anyone who did not submit their thoughts, or who may have additional comments, send them to her.

Donald Rucker thanked everyone for their time.

The meeting was adjourned at 1:05 p.m. ET.