The Office of the National Coordinator for Health Information Technology

Transcript

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

June 4, 2020, 4:00 p.m. – 5:00 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Co-Chair
Carolyn Petersen	Individual	Co-Chair
Christina Caraballo	Audacious Inquiry	Member
Brett Oliver	Baptist Health	Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Michelle Murray	Office of the National Coordinator	Staff Lead
Cassandra Hadley	Office of the National Coordinator	HITAC Back Up/ Support

Operator
Thank you. All lines are now bridged.

Lauren Richie
Good afternoon, everyone, and welcome to the Health Information Technology Advisory Committee workgroup for the annual report. We have our small but mighty crew, Carolyn Petersen, Aaron Miri, Christina Caraballo, and Brett Oliver. At this point, I'll turn it over to our co-chairs to get us started.

Carolyn Petersen
Hey, good afternoon, everyone. Things just continue to get more complicated and complex with all of our regularly schedule work, COVID, and the social change we see around us, and I am so glad you were able to come, and I send best wishes for your continued good health and safety.

Aaron Miri
Yes, I echo that, Carolyn. Hello to everybody listening. I'm grateful you guys are here and in good health. Thank you for listening in. We are trucking forward with this committee and all the great progress we've done in health IT, and I will say on a personal note it's been really something to watch – being part of the previous policy committee and now part of the HITAC and this work group – how much work has gone on over the past several years to increase interoperability, get better on privacy and security, and really get health IT going, and I think a lot of that played out during the recent COVID crisis. This is great work, and this committee's work played out in front of the whole world. Patients were able to be seen rapidly and in a timely fashion, and countless lives were saved because of the work that we all do, including what this committee does by bringing these topics forward, so this is really good stuff, and I think everybody is appreciative – I'm appreciative, honored, and humbled to be part of this group, so onward we go.

Carolyn Petersen
So, here's our agenda. It probably looks pretty familiar. We will review our meeting schedules again, go through the potential topics on the list for the annual report for fiscal year '20, we'll have a public comment

period, and then we'll briefly review our next steps and adjourn. Could we have the next slide, please? So, here's our work group schedule. We are done with May 20. Today is June 4, so on July 22, we will get to see a chart like this with two gray boxes. Next, please. And, there will be a review of our progress at the HITAC meeting on June 17, and then we will report back to them in September, October, and November with our goal of going through our draft with the full HITAC in January 2021, and getting approval and transmission in February 2021. Next, please. So, we'll go back to our list that we started on a couple weeks ago. Arien was able to come today, so we're going to start with some of the topics that he had submitted, and then work through the rest of the list.

Aaron Miri
Thank you for that. We're going to start, then, on the first white box there, called "Impact of Information-Blocking on Stark," and then kickback EHR safe harbor and that definition inducement. The description there was all about within the ONC CURES Act rule on information blocking, the HITAC should review the impact of these changes and proposed changes to Stark and any kickback regulation. Some work has already been done on this, as you all know, and I saw some great guidance about if a large health system provides cyber assistance to a small health system, that's not considered inducement, but rather, inciting patient referrals to you. It's good cyber hygiene and whatnot. But, I think given that there is now going to be free-flowing information between various healthcare delivery organizations, does further clarity need to be given? It's kind of like that first pass was done already by CMS and others. Is this important for us to look at? That's a question for this group. Brett, what do you think?

Brett Oliver
I think it's important to keep our eye on that. There are still so many moving parts and definitions that I need to personally understand that I don't know that I can be fully coherent with a reply.

Aaron Miri
So, basically, the whole crux of the issue was – and still is, to some degree – that if you provide services of any sort from one provider group or whatnot to another, does that qualify as you saying, "Hey, I did this for you, now send referrals my way"? They want to make sure patients have full choice to go wherever they want to go for their own care. So, to the degree of it, the question came up – obviously, there are those independent clinics in the community that don't have the ability to protect themselves from cybersecurity threats and whatever else, so if I gave assistance, be it I'm monitoring your email traffic for you, helping you, or whatever, does that qualify? So, there was some great guidance put out several months ago – it was before COVID, so it's all a blur to me, but sometime right before COVID – about how that doesn't qualify against the Stark rule and whatnot. So, the question is does all the work that we've been doing and the finalization of the rules call into account more clarity that needs to be given so people know where the boundaries are for Stark, kickback, and whatnot?

Brett Oliver
I agree because I think there's another level of complexity, too, when you're defining – and, I was thinking about it in our own health system. We don't have any Epic Community Connect clients right now, but it's certainly something that gets revisited every so often. Well, with the final rule, if we are deemed a software developer, which we never thought we would be, if we extend an instance of our EHR work to be declared a software developer, that clouds the whole information-blocking rules for us as a healthcare organization, or at least, some of the potential fines are very different as a "software developer" than as a

healthcare organization. That's just one side tangent to the whole piece you just said, Aaron. I guess the point is that we should continue to keep an eye on it because I think there are some complexities coming out that will need some definition. At our organization, we're trying to figure this out. We may not go down the road of offering up some of those things because of those definitions.

Aaron Miri
Good point.

Carolyn Petersen
Considering the discussion around CDS and FDA looking at regulating/managing how CDS, and particularly the type that teaches itself things in ways that humans don't necessarily observe or understand, there are a lot of people who don't think they're going to be in the software business who could wind up being in the software business using their own internal data sets with no intention of selling anything, so it sounds like a good thing to keep our eye on, even if we don't address it in the report here.

Christina Caraballo
I agree, and based on this discussion, I think it would be really helpful if HITAC could – we could potentially recommend that we do some guidance and recommendations to support and educate providers on this gray area because the last thing we want is providers that would otherwise help others in the community with the technology and tools that they have to stop just because of fear, so some guidance on that would be really helpful, as well as highlighting to ONC areas where providers might want to help, but otherwise not because of fears. I think that would be a good use of our time.

Aaron Miri
That's a great point, Christina. So, are we as a group saying that we want to watch this topic as the mark – because the environment – COVID really messed up everything in terms of keeping our eye on the ball and the focus of the healthcare system, so is this something that we want to watch for the remainder of this year as COVID eventually, hopefully, is resolved, and people are back to healthy again, and we're back to some level of normal, or is this something that we should address in this year's report?

Brett Oliver
I think we're going to have to address it because of, if nothing else, the financial implications for organizations. I suppose we can watch and see what happens – if healthcare organizations actually get fined $1 million per incident – but I don't know, Aaron. I totally get your point – there's so much that's up in the air and atypical right now – but I don't feel strongly either way. I feel like it would be helpful, back to what Christina was saying, if we could alleviate some fears or accentuate them to bring some clarity to organizations that – and, Carolyn, your point was great in terms of not even realize you're doing it. I would realize that I was giving that software to somebody else, but I wouldn't know it defined me as a developer because we weren't changing anything, but if you look at the details and even some of the specific responses to comment in the text of the final rule, it appears that we would be defined as a software developer. I don't know if it's defined that way if you have your own internal AI that's changing things, but what do you all think? It feels like we shouldn't wait on that, but…

Christina Caraballo
I'm wondering if, as co-chairs, you guys can ask if ONC could do an evaluation. Maybe Elise's team could look at the rules and identify areas where health IT is going to be impacted, and then HITAC could come up with some recommendations and guidance to address some of the issues that we're going to see. My fear is we're going to have the whole – we don't share – it's like déjà vu. HIPAA made it so that we didn't want to share patient records or electronic access to records with patients because of fear, and I don't want that to happen again, so this isn't a topic that I followed closely, but I feel like it's one that we need to get in front of and understand.

Aaron Miri
Okay. Carolyn, what do you think? I think it's a fair question we can ask.

Carolyn Petersen
I agree.

Aaron Miri
All right, that's a great point, Christina. I do want to give credit that I know that ONC – HHS in general, across all of its divisions – has been looking at this, and they did put out some guidance right before the COVID storm hit, so they were looking at this and doing some great work trying to clarify – probably to all of our points – to make sure that people don't try to hide behind any misnomers, which, again, impacted us during COVID. I can't tell you how many times I heard from health systems that thought they couldn't share public health data because of HIPAA, and I'm like, "No, telling me how many positive tests you have does not qualify as HIPAA. Come on." Anyways, I see all of your points. All right, we'll go that route. Next item on here is… Let me pull up my screen again. I just minimized it for whatever reason. So, organ transplants and health IT – is that correct, Carolyn? Yeah, it's gray. Next one.

Michelle Murray
Sorry, let me clarify something. This is Michelle. There is a light gray that was applied to the table to differentiate the rows, and I'm sorry, it was my fault for putting dark gray as an option for a row that the group decided not to pursue further, so there are different colors of gray. So, if it's like gray, we haven't talked about it yet. I'm sorry.

Aaron Miri
Got it. That's what I needed. Thank you, Michelle. It's okay. All right, information exchange for research. I want to say that we heard from several of the HITAC members during one of our COVID calls about this issue and how to hyperaccelerate research – in that case, it was around COVID, and I want to say it was Clem and others that were talking through this. So, to the degree of it, this continues to be an issue in the research domain of what specific data can and can't be shared, what kind of consent you actually need for human subjects, and what kind of consent qualifies, and I've seen a ton of debate between IRBs, academics, professionals, and patients asking questions for clarity, and with COVID, it all came up again about what that is.

So, the question is how do we get to some common rubric standard of what is needed? Maybe it could be, again, clarity on what the minimum criteria are for successful informed consent for research, and therefore, also some parameters around what type of data should be shared, can be shared, will be

shared, and how it will be shared. So, you would then also remain cognizant of things like the California Consumer Protection Act, GDPR, or others that tend to come around more often in research than they do in normal patient care activities. So, this is around that – trying to figure out if we can begin to standardize those data elements. Like I said, I believe we began to have this discussion already in the HITAC because of COVID. What are your thoughts?

Christina Caraballo
Yeah, I think so.

Michelle Murray
I agree.

Aaron Miri
Okay. Carolyn? Brett?

Carolyn Petersen
I agree as well.

Aaron Miri
All right.

Brett Oliver
Yes, sir.

Aaron Miri
All right. So, should we present this one as an item just to ask for folks to weigh in on during the HITAC meeting? Maybe we won't take time during the meeting, but they can synthesize their thoughts and send them back to us so we can begin to look into them.

Carolyn Petersen
I think that's a good plan. I don't expect that we'll have a lot of time for our presentation in June, and we don't want to get into deep discussions about anything. I think we can give them a list of things to send us comments on as we refine the list and look at this landscape.

Aaron Miri
Perfect. Good. All right. Next on here: Organ transplant and health IT. So, because of the executive order on advancing American kidney health, a transplant organ use case for USCDI data exchange quality measures to align incentives and improve efficiency – basically, what this boils down to is the need for all the various data exchanges and registries that you need for transplant, and really, it goes down to how – what are we supposed to be measuring, when are we measuring it, and how are we exchanging data? This goes back to data standards; it goes back to systems that are used in communicating across those various registries and simplifying the ability for folks to get on a national registry, to qualify to be on a registry, and then, obviously, get an organ donated. And, it's for donors – donor and recipient – both sides of it.

It is a very convoluted process. I put it on the list because it's something that's sometimes overlooked unless you're standing up a transplant program or you run a transplant program like we do, but there's a lot of opportunity here to really streamline and simplify this versus where it is today. Today, it's very robust for obvious safety reasons, but there could be opportunity here, and I'd be curious to hear your thoughts. Brett, maybe we can start with you and get the provider perspective.

Brett Oliver
Yeah, I was going to ask you – to your knowledge, is there a clinical standard data set? I don't want to start down the road of what we need to do technically speaking if it hasn't been defined. This feels like it could be "Well, the University of Cincinnati wants this, and UT Austin wants this." Has there been a general consensus on the data that's needed?

Aaron Miri
There is for quality purposes, but it's interesting how many different registries and reports and whatnot you have to provide to have a successful transplant program. Again, you know subsequent application and transplant application – it's all standardized in terms of how you get on the list, how you become a donor, how you become a recipient, and all those kinds of things, but it's arduous as all get-out, and there's a lot of opportunity for error, although you usually have small armies looking over things and triple-checking things for high-quality programs, but it's an opportunity. Does it meet the criteria of being more important than something else? I think that's for us to talk about.

Carolyn Petersen
I would say that it's a good thing to look at just because there has been some discussion about changing the protocols for putting people on the list in terms of who gets organs, how they prioritize people, how organs are allocated, and whatnot. I think that's still in flux to some degree, and that could potentially affect the kinds of data elements that you need or some of the technical stuff in terms of how they're integrated into the EHR based on what you need to extract and send to the national coordinating group, so I would say it's probably good to keep it on the radar, even though it's not going to seem like something that is really mainstream in our usual thinking about what's mainstream. It could have a significant impact because the need for organs is only going up, not going down.

Brett Oliver
So, Carolyn, you think that the data exchange that's necessary is going to go well beyond simply expanding USCDI elements?

Carolyn Petersen
I think transplant is different from other types of practice, and I think there is a potential for that to happen. I haven't sat down, looked at a chart, and compared what they take and what is already suggested to be in the USCDI, but I know in some places, for example, they have very specific protocols about people moving to the town where they're listed for a transplant, so you've got multiple addresses, for example, multiple phone numbers, because it's not just your home phone, it's the phone of the transplant lodge, hotel, or wherever you're staying, and potentially all other sorts of data that you don't normally think about collecting, like if you just need to go into the hospital for some sort of surgery, even when you're traveling. And then, there is data about tracking outcomes because I think the programs have to report 30-day, one-year, and three-year survival metrics of it, so it's not just the individual, it's being able to pull and analyze

all different kinds of data from people's charts, and typically, you would also be checking donors at some point as well, although I don't think they do that a lot right now.

Aaron Miri
It's just a huge – I won't say a gap – a huge opportunity area that, to Carolyn's point, could be really looked at and talked through. So, are we recommending that we bring this topic forward for solicitation of input from the HITAC?

Carolyn Petersen
I think so, yeah.

Aaron Miri
Okay.

Brett Oliver
I agree with bringing it forward for the discussion. The only thing I struggle with is it's sort of like IT driving the train, whereas I really feel like it's more of an operational issue so that the kidney transplant folks all agree across the country – or, at least, whatever governing body there is – to say, "This is the data that we need to exchange," and lung transplant and cardiac transplant, et cetera. Because we try to do that in our own organization, what I want to avoid is IT coming and saying, "Here's what you're going to do." We tend to be more of a support function, and I think you all would agree with that, so that's my hesitation. Maybe there is, and I'm just not aware of it, but I don't feel like there's an overriding operational organized fashion to say, "Here's what we need. Make it happen, IT." Does that make sense?

Carolyn Petersen
It does. I was just thinking of if the whole transplant listing system gets reoriented and changed and they put in new metrics, it may be that organizations are in the position of going back to their IT and saying, "Okay, we need this. This is what you have to…"

Aaron Miri
Yeah.

Brett Oliver
Maybe there needs to be federal oversight saying, "This is the data you're going to use, and I know you want their third address, but we're going to give you two and move it forward, or it just bogs down and never moves forward."

Aaron Miri
Yeah, it's just interesting. I've learned so much about south and central Texas over the past two years I've been here at UT Austin – I'm just blessed to be in this part of the country – it's amazing the high amount of transplants that occur. People usually go south, more towards the border, and the amount of data disparity that occurs, especially as you begin to get into more rural parts of Texas south of San Antonio, it's very interesting how disparate some of those data systems are in what you're collecting and how you're collecting it, and there's desperate community need, so you start looking at it like, "Wow, this

is something that really has an opportunity to be a high-impact, high-value exercise." That's how this even gelled up for me in my mind because I can see it play out in front of me how much of a need there is here.

Brett Oliver
Makes sense.

Aaron Miri
All right, next item, then. Info blocking – Brett, I think this is yours.

Brett Oliver
Yeah. Gosh, it's been a long time. We see that especially in the PDMP market. That's where I've seen potential information blocking where you've got some private companies that have either legislation at a state level or arrangements with different information exchange, whether they're state or private, and it makes it more difficult to obtain that data. In my particular example of PDMP, it's gotten a little bit better since I solicited that comment because of RxCheck and Department of Justice standing that up as a hub. That put a little bit more pressure on states, but for instance, I couldn't get Indiana to even talk with me about connecting to the hub we already had because they had legislation with APRIS that essentially, the state would fund APRIS to connect with anyone in Indiana. The problem is that right over the river in Kentucky, they're not funding us, but we're stuck with that business relationship. It's just a practice that appeared a bit shady that had me thinking about that with information blocking and barriers. I'm not sure if there are other examples of that that you all want to talk about. I didn't know if you could do a more global understanding in business practices that were out there analogous to the PDMP market.

Aaron Miri
PDMP continues to be one of those states things where they either do it or they don't, and the organizations within a state either do it on their own or don't, and it's very interesting. I have seen a lot of chatter on the various news outlets and whatever else about PDMP access or lack of access that's even inhibited the COVID response and trying to get access to the over-the-counter prescriptions and whatever else, and the belief that PDMP access or not having access to PDMP either sped that up or slowed that down. So, I think there's opportunity here. I don't have a sense of how bad or how egregious the situation is, but I think you're right. I think there is a lot of information blocking, and there was that recent very public lawsuit between Surescripts and somebody about this, right?

Brett Oliver
Yeah, maybe we could keep it on the radar. I don't know that we need the committee to address it unless they want to add more detail to our examples.

Aaron Miri
I don't know. Carolyn and Christina, what do you think?

Carolyn Petersen
I think it's an issue of concern, but I'm not sure how far up it really will float this year, given all the other things. It may be something – maybe we need an additional list, like we have the parking lot, we have what's in the report, and we have the "under observation" list, which is sort of like keeping an eye on it, but not acting right this minute.

Aaron Miri
I like that.

Christina Caraballo
I like that too.

Aaron Miri
Yeah, because it is important, but I don't have a sense of… We know it's a problem; I just don't have a sense of how on fire it is.

Brett Oliver
It makes sense to see what the actual – now that the final rule is written – what impact that's going to have, so maybe we'll have a better position to take with us next year.

Aaron Miri
You're right. I would just be happy if folks got the ADT notification component right in the final rule, much less this. Start small, people.

Christina Caraballo
Hey guys, before we move on, can we move back up to TEFCA and patient access? I know it's red, and if we want to move on, that's fine. Michelle, I'm not sure what you said the red meant, but I don't know how much more discussion this needs. This came up as the very last item on our last call with negative minutes left. Basically, what I'm thinking here is that an essential thing that we've identified as a task force, that ONC has identified, and that the whole industry has identified is the patient's ability to aggregate and interact with their data should be flexible and enable consumers to choose and manage their health and their family's health, and I think that's a really simple way of looking at this, but it doesn't exist now.

So, when I think about patient access and TEFCA, I think our recommendation here should be for the HITAC or potentially a spinoff of the TEFCA work group to look at patient access and where it fits within the TEFCA. I've been an advocate for the concept of a consumer QHIN, and maybe we're not ready for that, but I do want to start laying a foundation to meet the goal that a patient consumer can come in and ask us their information from everywhere really easily and not have to go into multiple portals, multiple places, and not have their selection of applications that they can engage with tied to certain organizations, and I know that's a lot of work, and I understand that that's not where we are today, but unless we start talking about it and building a framework within the framework that we have now to have a road map to get there, we're just not going to. So, even if it doesn't happen tomorrow, I would like us to put recommendations together on how we can start taking baby steps to get there and hopefully get there more quickly.

Aaron Miri
I think that's a fabulous point, Christina, and I would add a component that we had to look at very closely because we did a tremendous amount of contract tracing and home monitoring on behalf of Austin Public Health, so we put out a number of apps to do home monitoring as well as to assist with contact tracing and whatever else, and it's amazing – when you look at the different disparities of patients and

consumers out there and what their ability is to access – we had people who were of low socioeconomic status who had a smartphone, but didn't have access to the Google store or Apple store because they just didn't have the ability to do so, so it was very interesting that you would think, "Oh, just download an app on your phone" – no, they didn't know how to do that, or they were afraid to, or whatever else.

There were these inequalities, so health equity became an issue, and how to level that playing field to make sure that data is consumable for all in all, and in my case, 60% of my patients speak or read Spanish only, so making sure that stuff was available in Spanish and English – all of that, in whatever digestible format, and that it didn't require them to jump through a bunch of hoops. So, I completely commend and agree with your comments. I saw it play out firsthand, and it's important.

Christina Caraballo
That's an excellent point, Aaron.

Aaron Miri
Brett, Christina, any objections? I think it's a fair one to recommend forward.

Brett Oliver
None.

Christina Caraballo
I just really want to add the health equity as well. I think that's a really important point that you bring up in this.

Aaron Miri
Awesome. Okay. Michelle, is it clear what we're doing with that one?

Michelle Murray
Yes, I think we can change it to blue and add some more text.

Aaron Miri
Sweet, all right. Safety of mobile health applications. Brett?

Brett Oliver
Maybe this is an information gathering. I have concern – what's the process for someone to place an app on Apple or wherever that's not prescribed by a healthcare provider or clinician? Is there some kind of safety net – or, maybe not even safety as much as effectiveness grid or filter that these things are taken through? They're going to explode as we provide more data to patients. As they're accessing the discrete data from their health records all over the place, people are going to want to monetize that on an individual patient level. Is there someone looking out for the patient to say, "Yeah, this app has validity. When it's saying it can help you with something, there are studies behind it and it's safe"?

There are some things that may not be effective, but they're going to be dangerous. There are other things that, if they're telling them how to manage their insulin, could be really dangerous. Who's monitoring that if it's patient-centric and they're initiating that response? It's one thing if you're in my office

and I say, “Use this app to help you with your blood sugars. We vetted it as an organization.” Is there anybody out there looking at the safety and effectiveness of these mobile health applications? Does that make sense?

Aaron Miri
It does.

Carolyn Petersen
Yes.

Brett Oliver
It’s probably more of just an understanding. Maybe there is something out there. Maybe you can’t post on that or you can’t present it to Apple or Google and say, “Here, put this on there,” and they don’t check it out at all – as long as you pay the bill, they don’t care. I don’t know how the system works.

Aaron Miri
I like it, Brett. I think it’s important. I’m wondering – is that also part of patient access and health equity? Is there a component of safety with that? That’s a question for Christina as well. I don’t want to convolute the topics. I think you brought up a great point, Christina, but I’m wondering if this had some element of that.

Brett Oliver
Well, it certainly happens because of patient access. Traditionally, you wouldn’t be able to – well, I guess you could, but some of the information – I supposed I should say it expanded. Now, you’ll be able to see all your blood sugars – maybe your A1C – that you didn’t have access to. Now they can get funneled into an app or **[inaudible] [00:34:21]** and whatever the lab test may be.

Christina Caraballo
I agree with that 100% because when you’re looking at the patient access and the QHINs and where they live, I think that mobile health safety is going to be an important piece of that evaluation, so I would put it as almost a line item under the patient access and TEFCA.

Aaron Miri
And health equity, yeah. Got it. Carolyn, are you good with that?

Carolyn Petersen
Yes.

Aaron Miri
Okay. Michelle, is that clear?

Michelle Murray
Yes, and also, I want to circle back to last year’s report and make sure there’s alignment there because it was mentioned last year, but as sort of a line item in passing rather than a separate section.

Aaron Miri
Okay, good. All right. Third-party access to health data – this is a fun one that I tend to get passionate about. So, there is a whole lot of – I think we saw this highlighted with some of the comments that came back before the final rule – concern about patient privacy and whether they're able to control access to their data. There's been a whole lot of work done from the days of Blue Button 1.0, 2.0, and informed consent, and phenomenal work by the ONC, the OCR, and every group out there to try to get more definition around how you can access what data, and even in our 2016 – I believe it was 2016 – API FACA under the old Policy and Standards Committee at the time, Lucia Savage did a phenomenal job working with her team to lay out exactly who is responsible for what under HIPAA, third-party access to data, and whatever else.

All that being said and done, I still feel like there is a tremendous misunderstanding in the industry between developers, patients, and health systems about who can access what data, when, and how. It ties back into my earlier comments about research, consent, and everything else. It is amazing to me – and, I think again, COVID just highlighted it – what the liquidity is for healthcare data, for patients' data, and for what people believe they can or cannot do with data once they receive consent. I always personally err on the side of being very conservative and just ask for consent a million times.

Case in point: When we were doing contact tracing, we must have asked consent at least 10 different times for 10 different things. "Before we call the hair salon and ask if you were there, can we call the hair salon? Can we ask this before we do that?" We made sure we received informed consent every time and spelled it out very clearly, and that's just for contact tracing for a public health emergency. I don't think many organizations – provider, developer, whatever – go through that diligence, and to me, my concern is even though it's wonderful with TEFCA to have information shared, it's just going to be magnified. My question is whether there is a role here to play to look at and really clean up and double down on the responsibilities of third-party developers, and I think some has been done recently, but I just wanted to ask a question.

Christina Caraballo
I think this is a great topic. Is this another one that can be bundled under TEFCA and patient access?

Aaron Miri
I think so. It could be. It's definitely part of that safety component. Carolyn, what do you think?

Carolyn Petersen
[Inaudible – crosstalk] [00:38:15]

Brett Oliver
There's a privacy aspect to it as well, Aaron.

Aaron Miri
Say what?

Brett Oliver
I just said there's definitely a privacy aspect to it as well.

Christina Caraballo
I think that in the evaluation we do on how patients are going to access information via TEFCA, privacy and security is going to be a huge piece of that, and how third-party apps connect in order for patients to interact with the data in a more user-friendly fashion is going to be a big part of that, so as we build the ecosystem, a lot of these concerns have overlapped, but there are all of these consumer-facing technologies, so I think pulling out a bundle of things we've identified and putting this in a larger evaluation of how consumers are able to – how we enable consumers to interact via TEFCA is the overarching goal that I see, but I'm open to others' thoughts. That includes other players coming into the health ecosystem, like the **[inaudible – crosstalk] [00:39:41]**.

Aaron Miri
Yeah. I recall one of our HITAC conversations where there was a very large vendor that asked whether, if information flowed over a QHIN that they didn't have before, they could monetize that data in a deidentified manner, and it really startled me. "Wait a minute – you got access to data because you were part of a QHIN. That doesn't mean you can take it, ingest it, download it, and sell it." At least, I don't think that's what's allowed. It's interesting to see the rules of the road. All I'm asking for is if we need speed limits on the highways. I think it definitely plays into patient access on TEFCA. To me, it's a fair sub-bullet.

Christina Caraballo
I also think it ties into the research in patients' ability to share their data with research easily.

Aaron Miri
Okay. So, we will also combine this one under that bullet. That's going to be a big bullet, Christina. That's good. That's important. Okay, vaccine tracking. Are we ready to go there? Let's do that one. Brett, that's you and Christina.

Brett Oliver
I cannot remember what we were talking about there, Christina.

Christina Caraballo
Let's see. Let me read it.

Carolyn Petersen
Did this have to do perhaps with some of the stuff that was covered in the pediatric requirements, in particular because with COVID, so many kids are missing vaccinations because their parents don't want to take them into a healthcare facility?

Christina Caraballo
Yeah, and we've also talked about access to immunization information as well.

Brett Oliver
I remember part of that was if we could preemptively understand that in southern Utah, their MMR rate is just plummeting for some reason now – obviously, COVID is easy to understand, but we don't know why. At least if it plunges below what's necessary for herd immunity, you can really put focus on things if you

understand it at least at a national or state level. At least in our state, it's still so fragmented. It's tough to get a full picture of the patient, at least electronically.

Aaron Miri
Okay. So, from my perspective, I think this is an issue that has come up – it's especially coming up now as we plan to resume classes here at UT Austin – and I think it's… I don't think this is going to go away as an issue. I think this is just going to get worse. That's my personal take.

Carolyn Petersen
Well, you don't really know how bad it is at this point because people can so easily falsify stuff.

Aaron Miri
True, or you have states that mandate it – as we saw with the pediatric task force – mandate paper, a check box. It's ridiculous as a state law, so what are you going to do with that? Yeah, that's exactly what that was. So, with that one, are we recommending to bring that one forward, then – back to the table for further topics, further consideration for the HITAC?

Carolyn Petersen
I think we should.

Christina Caraballo
I agree.

Aaron Miri
All right. Next topic there. Can you scroll down a little bit, please? All right, health IT response to COVID-19 – all right, that's great. Let's look at these fun ones. It says the adoption of updated standardized code and data terminology to document COVID-19 – yes, okay. So, basically, there are a couple things here. This goes back to electronic case reporting, which is something that not just Arien, but also Steven Lane – Steven Lane and I have been talking tremendously about ECR and trying to push this faster and get it here to Austin – as well as utilization of the correct ICD-10 codes for COVID-19 and standardization.

I can tell you that this is a major bugaboo for public health. I think there was even a *New York Times* article documenting the difficulty the CDC had, as well as public health, because of this, and even granular data such as race and ethnicity that wasn't mandated to be gathered, so there were a lot of discrepancies in trying to figure out where health inequity was occurring to try to get help to those communities, so there are a lot of issues here that played out. My question is whether this is something that is part of either the USCDI task force or some of those standards task forces to be a subgroup underneath those major bodies that already exist or it should be its own topic to talk about.

Christina Caraballo
So, I know AI has been leading some work, and I've been working closely with my colleague Keith Boone, who's been leading an initiative within HL7, and it's the SANER Project, which stands for Situation Awareness for Novel Ethic Response, and they're basically – it's been amazing to watch. I don't know how many of you guys are familiar with the project, but they've basically gotten an implementation guide to address COVID and future pandemics up and running in a very short amount of time. They recently

tested it at the HL7 Connectathon, have gotten on an informal acceleration track, and have been able to convene a ton of the top industry thought leaders and tech groups. It's been amazing to see a lot of EHR vendors and others come together to solve a problem that needed to be solved really quickly by the health IT industry, so that's been happening over the last two months, and they're looking to hopefully ballot the new implementation guide in September, and this is through HL7. So, that's happening now.

I do think a next step is going to be how we get this ready for national deployment, so figuring out a fast track through the USCDI will be really beneficial. I don't know if that's under HITAC. I'll go back to the whole process that has been put in place for data elements to be submitted to ONC through the data element submission process within the USCDI, and to be reviewed based on readiness in all the criteria we put together and submitted as a committee last year. So, I'm not sure what the ask of HITAC is.

I think there are already natural procedures in place where, should this go into USCDI, it can end up teed up that we're going to evaluate it anyway in our review cycle, so I'm not sure what the ask is on data standards and what we could do based upon what I know is happening now, but it's definitely a topic that I think is interesting, and I do think that as I'm thinking out loud in real time, we are going to need to put ecosystems in place to enable this data to be shared on a broader scale. So, once we have the standard to share the data, that's one thing, but then being able to share it across our different systems that may or may not talk could be a recommendation for HITAC to look at. It's kind of like the interoperability plumbing.

Aaron Miri
So, do you want to put this on the one to watch right now – that list that we talked about earlier – while the natural synergies play out? If there's already work going on around this, there's no reason to do dual work, especially if it's already going to go in front of those standards for consideration in the appropriate manner.

Christina Caraballo
Yeah. Maybe watch and see what support is needed next, but I do know that as – we've obviously seen this as a high priority, so I hesitate for us to just make a decision too quickly on that. Isn't ONC coming up with some tasks for the HITAC to help with COVID/future pandemics? I think we were waiting for that, so I'm curious what they're putting together for us. Lauren, is that correct? That was the takeaway I got after our full-day meeting.

Lauren Richie
Yeah, it's still TBD at this point – a work in progress – but understandably just taking a while because we mostly need to connect with CDC, but I would say stay tuned, and hopefully we'll be able to announce something at the HITAC meeting or sometime thereafter.

Aaron Miri
Okay. Maybe we'll just hang onto that one. I know we're getting close to time here. Maybe we can quickly go to the last one.

Carolyn Petersen
I think we have to go to public comment.

Aaron Miri
You're right, public comment time. Almost there. All right.

Carolyn Petersen
We have another meeting to do the next one.

Aaron Miri
That's right. Okay.

Lauren Richie
All right, at this time, we'll ask the operator to open the public line.

Operator
If you would like to make a public comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 if you would like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing *.

Lauren Richie
And, any comments in the queue?

Operator
There are no public comments at this time.

Lauren Richie
Okay. Carolyn, Aaron, or Michelle, anything else before we adjourn?

Carolyn Petersen
I just want to thank everyone for some good discussion today. It's pleasing to see that we're making progress on this list. We're putting ourselves in a good place for the fall, when the writing work starts.

Aaron Miri
Yeah, they're good topics, and what's interesting to me is a lot of these that we had talked about have reared their heads in full flight during COVID, so it helped to talk through it because so many times, you come back to, "Oh yeah, here's an example of this, here's an example of this," so I like these talks because we all talk about our war stories, and that's important.

Michelle Murray
I have one question for the group, and I have time to talk to the co-chairs soon ahead of the full HITAC committee meeting. How does the group feel about presenting topics? Because there are things that our group has talked about before and have been brought up by HITAC members. Or, do we want to stop with the ones that we've discussed through this month that we've already discussed as far as presenting the list to the HITAC?

Christina Caraballo
When is our next meeting? Do we have one before the HITAC meeting?

Michelle Murray
No, not until July 22nd. Sorry, I'm getting a little worried about time to cover everything. I want to point out that some of the next section was going to be things in which we already went in depth in last year's report and can follow through on with updates for this year. I didn't think that would take a lot of time anyway for the work group to discuss. It's more the next few items that were Pages 5 and 6 in this document. There are a couple that are related to COVID-19, and then, one that's more of a process issue that we can get through in a different forum, and then there were two that were emerging-issue types of concerns. So, we have options of going offline or semi-online through email to follow up on these few things or carving out time in July to come back to them.

Aaron Miri
I don't have an opinion one way or the other. Carolyn, I don't know if you do.

Carolyn Petersen
No, not really.

Aaron Miri
Michelle, I think we'll just move forward with what we have, and we'll just keep talking through it.

Michelle Murray
Okay.

Aaron Miri
All right, awesome. Well, if that's there, then I appreciate everybody's time today. Great discussion.

Christina Caraballo
Thanks, everyone. Have a great day.

Aaron Miri
You too.

Carolyn Petersen
Thank you.

Christina Caraballo
Bye, thanks.

Brett Oliver
Bye.