Transcript

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

December 18, 2023, 3:00 – 4:30 PM ET

VIRTUAL

MEMBERS IN ATTENDANCE

Aaron Miri, Baptist Health, Co-Chair
Hans Buitendijk, Oracle Health
Hannah Galvin, Cambridge Health Alliance
Anna McCollister, Individual
Eliel Oliveira, Harvard Medical School & Harvard Pilgrim Health Care Institute

MEMBERS NOT IN ATTENDANCE

Medell Briggs-Malonson, UCLA Health, Co-Chair
Jim Jirjis, Centers for Disease Control and Prevention

ONC STAFF

Wendy Noboa, Acting Designated Federal Officer, ONC
Michelle Murray, Senior Health Policy Analyst, ONC

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

Wendy Noboa
Hello everyone and thank you for joining the HITAC Annual Report Workgroup. I am Wendy Noboa with ONC. And I am pleased to welcome our co-chair, Aaron Miri. Also joining us today are our work group members, Hans Buitendijk, Hannah Galvin, and Eliel Oliveira. Unfortunately, Medell Briggs-Malonson is not able to join us today. We are expecting Jim Jirjis and Anna McCollister to join us shortly. But in the meantime, just a reminder that public comments are welcomed and can be typed in the Zoom chat or made verbally during public comment. And now, I will turn it over to Aaron for opening remarks.

Opening Remarks, Meeting Schedules, and Next Steps & Discussion of Draft HITAC Annual Report for FY23 Including the Illustrative Stories (00:00:36)

Aaron Miri
All right. December 18, just a few days before the holiday festivities. Hopefully, you are all in the final swing of things and getting ready for it. We have a full agenda today so I look forward to chatting and talking about all things as we wrap up this Annual Report Workgroup for this term. This is a joy to close the year strong. It is my final meeting so it really is sort of bittersweet for me but I look forward to talking to you all when we put a bow on this as a present and move on for next year. As you see here for our agenda today, we are going to talk about the schedule as we are wrapping up for the year. What we really want to focus on today, one of the most important things, is to put a pen in the illustrative stories. I hope you all saw the note from Michelle and team earlier in the week. Hi, Hannah. We see you. Thank you for being here. And we really want to look at those stories and make sure that they make sense.

As a reminder, those illustrative stories are going to try to put into plain English what all of the various nuances of items that we are recommending, what people could expect, what would that look like in the real world if all of these things were able to come together. Stories are very important as cascading down what we envision as the net positives for the industry. We are going to go through talking about the draft supplement background research document. We really want to look at that and make sure it makes sense, are there any glaring omissions. At this point, it is probably too late to do any serious modifications or edits.

It does not mean that it cannot go into the backlog. But we will want to talk about that document and make sure that we are on the same page. We will go to public comment and then, the next step is to adjourn. We are here at December 18. We are very close to the very end.

The annual report will go to the HITAC for approval January 31. And then, in the February/March timeframe, it will be transmitted. It is always an exciting moment with this is voted on. And I hope you all enjoy that fruit of your labor there. I appreciate the ONC team, Michelle, your team, Accel, everybody. It is something every year to behold that document. And it truly becomes a work product of love from this committee and the HITAC takes a lot of pride in it. For the new members on this group, enjoy the moment when it is approved and voted on. Draft report, January 18 and then, of course, the approval will happen February 8 thereafter. The next steps are development of the HITAC report. We are going to review the draft annual report today and supplemental background and then, of course, present that for full approval and discussion at the upcoming HITAC meetings. I will say there will be a lot of new members joining this year, obviously, with a lot of committee members rolling off.

It is incumbent on you all to tell the story of why the annual report matters. There will be a lot of new faces voting for the very first time on something that they just joined a committee on. It is very, very important to make sure folks understand the voracity of the document, to understand the depth of knowledge, and understand the importance of each of the topics and help the new folks also feel contributory towards the next session so that when the FY24 annual report is put together, they give their input. As we have always said and it is very important, every single opinion on the HITAC matters. It does not matter how farfetched the idea is, it matters. It matters to be heard. It matters to be respected. And it matters to be engaged in a way that people want to be engaged.

I think the next slide should be the stories. Here we go. Outline, of course, on report. You guys have seen this before. The report as you look at it, it is sort of an orientation slide here, you have got the landscape, which has the illustrative stories, which we are going to talk about here in a minute, health IT infrastructure gaps, opportunities and recommendations. That is what we have spent the majority of the year really talking about. There is a good progress there on the HITAC progress. What have we worked on? A ton of things. HTI-1, TEFCA, all of these things that we did this past year. Conclusions are right at the end and then, the appendix with some benchmarks, acknowledgements, etc. It is also, I would say, really neat to look at Section 4, the progress, especially for the new members to help them orient on what we have done so they can jump right into the fray. Several of them will be, as you all were when you first joined HITAC trying to feel the waters.

Use the report as a way to get folks engaged quickly on the topics, especially with HTI-2 and others right around the corner, especially with USCDI, cancer, and others starting up. There are some great initiatives that they can get involved with. And the report is a way to galvanize that support. Draft illustrative stories for FY23. Again, I hope you all took a look at the note the other day. Again, we are going to look at the initial set of options here for those brief illustrative stories and then, what we hope the HITAC will be able to help enable and foster for the future. The final part is a single illustrative story will be highlighted as a paragraph in a call out box for each of the target areas. Each target area like cybersecurity or public health have an illustrative story, which, hopefully, you helped contribute towards. Hannah, I really appreciate some of your redline edits. I saw the draft. It was excellent. I appreciate your feedback there and precision around that.

Again, we want us to look at the stories, suggest additional ideas, anything in there, tweak them, help with spelling if there are issues, although Michelle's team does an amazing job with grammar and anything else. But anything you see, this is our chance to really cull that out. Let us go through them. The first target area, use of technologies to promote and advance health equity. I do not want to read this back to you but a lot of the items in the read, I think, Hannah, these are your edits here, take a look at this. I want to read it to you. And Eliel, I know you are driving so please do not read and drive at the same time. That could be dangerous for your health, my friend. But for others on the call, take a look at this. Let us take a minute here. I can read it out loud if that is helpful but I do not want to put you to sleep. Hannah, do you want to talk about your edits? Maybe that will be helpful to the group. And you are on mute.

Hannah Galvin
Am I still on mute?

Aaron Miri
There you are. Now, you are good.

Hannah Galvin
I was trying to pull up my version of my edits because I think I had put some information in comments as well that just had contextual information about it. I think that overall, I thought there may have been some confusion about what the diabetes management coach was asking about. That is where I put that edit in. Here we go just so that I have my comments to reference here. And very specifically, my first comment is that we said due to new SDOH standards and the development of the framework to support implementation, it said the physicians and patients can query records. We have some of that today so, we might want to clarify what we meant by SDOH standards and then, write that in the chart in a structured way so that it can trigger a CDS tool. Previously, we may have been able to see some of this data but now, we can have it in a structured way that triggers a CDS tool because it is not brand new that we can access some information.

But having it in a structured way enables the use then of semantic interoperability. I think that was my main comment there.

Aaron Miri
Are there other comments about it? Eliel, a thought?

Eliel Oliveira
Are we talking about the first one, Aaron?

Aaron Miri
Yes, the first one, yes.

Eliel Oliveira
I think what I had, Aaron, is related to after the red sentence that says, "The physician regularly follows up on the progress made." And usually, what we have seen is that community health workers are the ones that are doing that work, not physicians necessarily. And I think that given now that CMS and others are reimbursing for community health workers that might be an important terminology of staff or individuals that are deeply involved in the coordination of social services to be introduce here.

Aaron Miri
And what if we said practitioner versus physician? That way, it could be whomever is associated with the patient. Is that a fair word that we could use versus physician?

Eliel Oliveira
Yes. You could do that and you could put in parentheses, "physicians, social workers, health workers," to make that broad as you are saying.

Aaron Miri
Yes. I think the goal of this statement, the way I read it and I think it was a great suggestion, and Hannah, I see your hand raised, I think the suggestion was around the standards, especially coming in with USCDI, being able to exchange our data more freely. It is more available and people can use it in whatever the course of care is whomever the provider may be or practitioner. That is the word being used these days. I see your point, Eliel. Anna?

Anna McCollister
I guess I skipped ahead to the second one so maybe I should hold my thoughts until then.

Aaron Miri
If you do not mind just so we can put a pin on the first one and then, we can go to the second bullet. Hold the thought. Are there other ideas around the first No. 1? Hans, I do not know if you are able to read it.

Hans Buitendijk
I am but I have a question about No. 2 after Anna.

Aaron Miri
You guys are eager to jump on. Okay. I think we are all in agreement then for No. 1 just so we can get Michelle's stuff straight here. For No. 1, again, make it a little more broad to practitioner in parentheses of multiple types of provider, etc., so folks get that sense that, basically, it is about the SDOH data being available to be used and it can be used appropriately, especially for folks in the food desert, which we have here in Jacksonville and it is very sad. Let us go to No. 2. An order for a patient with worsening vision needs to see a specialist. I think, Anna, you had your hand raised first and then, we will go to Hans. Anna?

Anna McCollister
Sure. One question that I had is when I look at this as somebody who has diabetes and vision issues, there are tools that are available now that use iPhone technology to actually do retinal scans. And I think it was the first version of this is when the first AI tools were approved by FDA a couple of years ago. I am just wondering if it would make sense for us to include incorporating that into telehealth or is that taking us outside of the realm as a way of pulling in the various data sources and tools that the U.S. government has the ability to encourage implementation of since ONC is ostensibly the gatherer of all things related to this. Or is that completely outside of the scope of what it is we are trying to do?

Aaron Miri
No. It is a fair point. We are trying to paint the picture of what the art of the possible is and what we can materialize if we were to get various dimensions addressed that HITAC is recommending. If there is some

incorporation of leveraging tools like artificial intelligence in the future because now, this data is available, the SDOH data, and can be leveraged, I do not think it hurts to incorporate that, especially given, to your point, ONC is doing an excellent job of convening the AI componentry. I think it is a very fair point, even if it just alludes to the fact that it could be done. I think it is a fair point.

Anna McCollister
One of the biggest barriers and this gets into CMS, but one of the biggest barriers of that is does CMS reimburse for it and I have no idea if CMS is reimbursing for this kind of AI-enabled retinal scan using an iPhone. It seemed like a way of filling out the picture or saying in addition to having broadband XS or whatever using these tools through this platform, there are other tools that other parts of the government are working on that are an essential part of this mix.

Aaron Miri
Even at the very end there to say work with a specialist to devise a treatment plan and perhaps leverage tools like artificial intelligence to look at the data and suggest a course of action or something to that effect.

Anna McCollister
Yes. Those are approved devices.

Aaron Miri
That is a fair statement. Hans?

Hans Buitendijk
Thank you. I have two questions that are relatively minor just from a flow perspective. The first one is that switching where the suggestion was made to change from a senior patient to an older adult but then, subsequent sentences talk about patients. What is the intent? Are we trying to keep it neutral and it is not necessarily a patient? We may need to then use adults a little bit further in as well. It just seemed to be the switch could be adjusted. The larger question with flow is around the reference to SDOH data and the sequence that is in here. It is clear from the first part that somehow it is discovered and understood that the adult is in an area where telehealth broadband access is not readily available. But it is not clear from the way it is stated how SDOH data contributes to either the awareness or otherwise to that. I think it could be adjusted a little bit to clarify that that is how we learned that the patient has neither and based on that and the community initiatives, once we had it established.

It is a little bit of a flow question to understand why we are going from the voice-to-text technology, SDOH and then, suddenly, the broadband arrived.

Aaron Miri
I got it. I see how you got there. Good suggestion, good observations. Thank you for that. Are there any other comments on this one?

Anna McCollister
Is the main crux of this putting the government to this public/private partnership around establishing broadband access? Is that the main thrust of this one? It seems to me that it is and so, I think that is appropriate because there are places not far from where I grew up who have no broadband access.

Aaron Miri
There are places here in Northern Florida that do not have broadband access. I am, literally, on an island.

Anna McCollister
Well, this is in Ohio.

Aaron Miri
I think it is important. Hannah, I know you added the private/public partnership componentry. Do you want to go into your thoughts there of what you were thinking?

Hannah Galvin
I thought that the previous text there had said that, "With the help of the office administrator and some digital literacy education," and my comment had been that the patient not only needs digital literacy education but a means to access the internet. And we should highlight elsewhere that we talk about that they need to access services enabled through some of the public/private partnerships we are talking about to enable access to broadband internet and a secure location. And that is something we are making recommendations about that we are asking ONC to help enable. There are some inequities in the digital landscape, in general. And it is not just about literacy and training and education but it is about actual access. That is where I recommended that we put that in as well.

Aaron Miri
I like that suggestion. I like the addition there. I think it is important to highlight it. Any descension to that? I think it reads pretty well.

Anna McCollister
I think it is an important part of health equity.

Aaron Miri
It is. And a lot of work is being done there, too, so there is a good call out for that. Michelle, anything else on this particular one that you are missing from us?

Michelle Murray
No. I will just make a point, in general, around these that part of the exercise is to come back and then, choose one. We picked one as a default to put in the report just so you can start reviewing. We do need some input on that.

Aaron Miri
Let us do that. Thank you for clarifying. Of the two, do we have a lean towards which one we would put a start beside as 1A. I will go first. I like the first one. That is me. Others?

Eliel Oliveira
You do not or you do?

Aaron Miri

I do. I like the first. I think they are both great but I would go with the first one. They are both good. Are there other thoughts?

Anna McCollister
I think they get at two different issues. Again, maybe I am overfocusing on the broadband access. I feel like that is an incredibly important health equity issue. Whereas food insecurity has historically been the kinds of things that you think about when you think about social drivers of health. Do we have to pick one?

Aaron Miri
We could always use one as a placeholder for next year. Just because we are good with one this year, that could create a narrative for next year I would think.

Eliel Oliveira
The reason I would go for one is because as I was reading the rest of the report, there was a good section talking about how digital access was a major factor impacting health. It was also talking about language flexibility for individuals that need language support. I think that is well addressed elsewhere. I do like the point here on the internet access and broadband access because I know that is a major issue. When I balance the two, yes, food insecurity comes to the top, as Anna was saying. And I think the other one is addressed elsewhere in the report.

Anna McCollister
Is the broadband thing addressed elsewhere in the report?

Eliel Oliveira
I think so. Maybe it is on the special research document. I am trying to search now to see.

Anna McCollister
That was a question from me.

Aaron Miri
Maybe Michelle knows. I do not recall off the top of my head. We will get that answer.

Anna McCollister
It feels to me that the first one is more of an urban issue and the second one is more of a rural issue. I would not like for us to pick sides.

Hans Buitendijk
I am reacting somewhat similarly to Anna as they identified two different drivers and that helps indicate a little bit of the breadth and depth of what SDOH can get into. Do not only think about one kind but think about the other kinds as well. It all adds up one way or the other that it might raise challenges. Actually, in that sense, these do help create a little bit of that spectrum of the variety that you can think about. That is why I have a hard time. If you twist my arm hard enough, I may end up with a choice but until that time, I might not be able to choose.

Aaron Miri

Hans, is that the answer to one of them or are you saying you like both?

Hans Buitendijk
I like both.

Aaron Miri
You have got to choose one, my friend.

Hans Buitendijk
That is why I said if you twist my arm hard enough, and it sounds like that you are starting to twist it hard enough, in that case, I would be inclined to go for No. 2 but that is because it might demonstrate that technical issues can contribute to that. That is as far as I can go and that is not a strong argument. It is, actually, very weak in my mind.

Anna McCollister
Again, part of my reason for **[inaudible] [00:23:34]** is urban versus rural has become a partisan thing sadly. And I think it would be helpful if we could not make this read like it is a partisan thing.

Aaron Miri
Yes. We cannot have partisan show up in HITAC. Confirmation broadband is addressed in the crosswalk and they are reducing the digital divide section, the general section, of that area confirmed by ONC staff. It is called out. It does not mean one or the other. It sounds like we have got two for two here. It is two for No. 1 and two for No. 2. Hannah, you can be the tiebreaker.

Hannah Galvin
Can you remind me which is No. 1 and No. 2?

Aaron Miri
No. 1 is the food desert item and No. 2 is the broadband access.

Hannah Galvin
And which one are we on?

Aaron Miri
It is split down the middle. Eliel and I both said No. 1. Hans and Anna said No. 2.

Hans Buitendijk
You have the choice.

Aaron Miri
You have a choice, Hannah. You have to choose.

Hannah Galvin
I have a choice?

Aaron Miri
Yes. Choose.

Hannah Galvin
Of which one we are going to do?

Aaron Miri
Yes.

Hannah Galvin
I am going to go with broadband access.

Aaron Miri
Broadband access it is. They are both amazing so this is a good problem to have when you have two of them. That will tie nicely then to that section that is also called out in the report. We asked that question. Good. Michelle, does that help?

Michelle Murray
Yes. It is very helpful. Thank you.

Aaron Miri
Perfect. Public health, a near and dear topic to everybody here. The story here is not two to choose from. It is one to choose from here in this case. Sudden surge of gastrointestinal illness. Because of TEFCA, they are able to share data in real time with real time syndromic surveillance. Within hours of conducting a test, we can find the contaminant, issue a boiled water advisory to the neighborhood. This would be amazing if this is going to be pulled off. And then, do you want to speak to what you said here, Hannah, that the department reviewed the transportation and security data? Do you want to give a little comment on that?

Hannah Galvin
Yes. Where is this one? The department reviewed its SDOH data to identify housing and transportational services that could be provided to community partners in the neighborhood. And I think I was wondering what is the purpose of them identifying the housing and the transportation services? Are we using SDOH data to offer additional services just because we have the data? Or should we be a little bit more specific around how we would use the data specific to the use case. For instance, the department reviewed the transportation and security data in order to offer non-emergency transportation services to those affected who needed rehydration therapy at local care centers. There is a difference between saying, “We have this data and how can we use it or how can we use it in this particular crisis.” In the long term solution, it may make sense that they share the de-identified data not to help them remove the source of contamination but how are they addressing the short term emergency with the long term solution?

And I got the sense from the wording that it was very vague. I thought adding a little bit more specific color around it might be helpful.

Aaron Miri
Good thoughts there, Hannah. Thank you for doing that. Hans, you have your hand raised.

Hans Buitendijk
Yes. I have a question on the first part that it may come across that unless they had TEFCA, they were not going to be able to achieve this. And from the feeds that are already going into public health, it seemed like there is already data there that can be done today. What is the unique part that TEFCA brought to it that could not be done today to identify the cluster at this point in time? That is my concern. Are we putting something in there that for the intent of the storyline is not really that critical? It is the fact that the data that was shared and analyzed based on demographic data available was used to identify whether there was a cluster in a particular geographic area or particular neighborhood or whatever it might be. That is what I am trying to understand. Is that reference necessary and is it overreaching for something that it did not really contribute much to? And I am trying to figure out what it is.

Aaron Miri
I believe this question will open for the group here and I have two hands raised here. I perceived it that because public health will be leveraging TEFCA for the agencies like in Austin, Texas where they are allowing fax machines, literally, in public stores with the fax machine being broken and, therefore, COVID-19 tests could not come in positive or negative, they now have an option versus today, there is no option besides fax machines. I read it with that mindset and that lens from my personal experience of the craziness dealing with public health because there was no other option for them. To your point, it does not mean there are not other ways to do it. There are many ways if they so choose to connect, direct connections and others. But I read it as a mechanism that now that TEFCA is up, it is an option for them that they may not have had before. That is how I interpreted it.

Hans Buitendijk
Yes. I understand that. I am just looking at that today is one of the key elements that was providing this kind of information and case reporting was clearly in that vein of what did you have available to do that. It was already expanded substantially without TEFCA in play yet through the **[inaudible] [00:29:42]**. That was my backdrop to say I am trying to figure out what TEFCA is adding. I can think of a lot of areas where TEFCA can enter so, do not get me wrong there. For this particular use case, it struck me as not adding enough information or believing that it could not be done today. And it already can be done and actually is being done with the connections that are available.

Aaron Miri
Yes. For the participatory folks, you are exactly right. Eliel and Anna. Eliel?

Eliel Oliveira
Yes. My comment was a little bit relate to that as well, Aaron, but with a different twist that I think if this is supposed to be forward looking, I think I would imagine that the reason TEFCA would be brought up here would be that we advance from the messaging exchange to an API based TEFCA, which is still up and coming. And I think everyone heard very well in the annual meeting at the ONC how the CDC, ASPR, and NPHI believes that opportunity for implementation centers that are going to exactly try to get the public health organization authorities in to fight API exchange. And that, to me, would be a reason to change these a little bit. But then, it gets too technical to say that that exchange or the monitoring of surveillance would be done through API where you, basically, as an agency would just be parsing that information. That would

be a different way and a reason for TEFCA here. Again, does that get too much in the weeds to envision the future state?

Aaron Miri
Interesting. Anna?

Anna McCollister
I guess my question as it relates to TEFCA exchange and this case study is lab data is not yet part of USCDI so, the data that is being exchanged does not include lab values. And would you need lab values to be able to identify issues and exchange that information related to public health? Is that sufficiently captured in ICD-10 codes? For instance, if the issue was a new lead poisoning like in Flint, Michigan a few years ago, would that have shown up in the data that is currently present in ICD-10 codes? Or would that need to show up in lab values that show the lead levels or some sort of an E-coli contamination or whatever is likely to get into the water system? This is more of a question. But based on the data that I have seen from my healthcare institution, my data that is now available for exchange theoretically, none of the things that I would think you would need to identify this would be included.

I think it is fine if we are saying a future case, we have lab values and that kind of stuff that is being transmitted but I am not sure exactly what it is that we are saying in this. What is the point of this particular thing? What is the thing that we are pushing for?

Aaron Miri
It is a great point, which I bet you is what Hans has his hand raised about because he just wrote something in the chat. Hans?

Hans Buitendijk
Yes. A little bit of that and a combination of reacting to Anna's comments around USCDI. I like where Eliel was going and it triggered a thought for me of what is TEFCA in public health and what is really being talked about right now is the query for additional data I can get from the patient. I can get that additional context that the initial reporting feed might not have included. If you can put it in that context and we can take any data that was missed because data is not always included then, I think the TEFCA context will provide a little bit further. Once I do that, I actually have a better data set. USCDI does not include certain lab data that might be helpful for this but it does not mean that it is not being exchanged. USCDI is substantially covering less data than what the standards and the actual reporting already allows or requires to report. All data is being reported that USCDI has not included yet.

Since there has been a couple of different of occasions, as HITAC has already discussed very widely as well, we have these electronic lab reporting standards. We have this LOI/LRI lab reporting standards already being used, already being deployed. Why not put them into USCDI? We already cover it. It is already there. I think we have to always be careful that using USCDI to understand what is actually being exchanged we have to be careful about because the standards of many cases are well ahead of the USCDI standard. In other cases, they are not. It is a combination of both.

Anna McCollister
And those standards are like the lab value exchange stuff, that is part of the TEFCA standards?

Hans Buitendijk
While that is interesting, they are not today or not proposed because TEFCA is focusing on a very targeted subset. Once you get to the document exchange or what is in CCDA documents particularly, if you look at in what FHIR could get access to through queries, much more is already available there. If you look at what is already in certification programs for EHRs in particular and certain lab systems to communicate to public health that is certainly there for some of the key requirements there. Lab reporting, case reporting now moving forward, syndromic surveillance, vaccination, etc., they are already there and some still to come.

Aaron Miri
Hannah, are there any comments from you?

Hannah Galvin
I do not have any.

Aaron Miri
It looks like we are all leaning towards, Hans, your suggestion in there about focusing a little bit or adding into this paragraph the specificity of follow up data, queries, and the ability to garner more accuracy in the data, more of the data elements because now, the vehicle exists to do so. Not that you could not before, but it was not easily and readily available. And now because of TEFCA, getting that follow up data is accessible, which seems to answer Anna's question about outbreaks and following through on the data so you can do that Sherlock Holmes detective work that is necessary with the right data at hand. That seems to be where we are all leaning towards. Am I hearing that differently from anybody?

Anna McCollister
I am just trying to understand how given the data that is currently being exchanged that the Public Health Department would be able to have enough bulk data to identify a signal for a public health outbreak.

Hannah Galvin
And I think that is not there yet. But we are looking forward thinking with these use cases.

Aaron Miri
That is right.

Anna McCollister
Okay. That is great.

Aaron Miri
Precisely. If we were to implement all of the various suggestions in our document there, what would the ideal world look like? What does utopia look like?

Anna McCollister
Utopia? I think we have the parameters for utopia.

Hannah Galvin

But I think that is why I broke it down between what can you do to help in the emergent situation today and review their SDOH and provide the transportation right now versus also the public health. Do we want to mention both? There are two different data use cases here.

Aaron Miri
Right. And they are all relying on follow up data, all relying on accessibility of data, all relying on the accuracy and the ability and exchange of data.

Hans Buitendijk
For data that was not sent before because it was not deemed relevant. It is missing data maybe today that are not a complete picturing of the follow up and saying, "By the way, can you give this?" But there is also data that until COVID hit, we were not send three or six months' worth of data because we were trying to figure out what was going on. Those are the types of follow ups that TEFCA would allow for much more than just individual feeds that we do today. Individual feeds only get used so much.

Hannah Galvin
And with the question about TEFCA and the public health data is how identifiable or de-identified is it. I do not quite have the answer on that. If you were going to identify the source of the contamination, you would need to have some identifiable data there related to location or address.

Aaron Miri
Or the respective QHIN on the TEFCA would have to be able to get back to the root of where that came from and contact that health system or whatever and say, "Help us query backwards the origin for contact tracing or whatever you are going to do."

Hans Buitendijk
And currently, the reportable results tests just focusing on lab to the public health, they are not aware of anyone that is de-identified. They are all identified that you can follow up. The syndromic surveillance is de-identified is, basically, what is happening. It depends on what you are looking for. You will have more or less identified and de-identified data already available.

Aaron Miri
I got it.

Eliel Oliveira
I would imagine a situation here. Let us say we are getting these gastrointestinal reports coming in through the ECR and you are getting a sense of is there something going on here. But through API queries, you, basically, could ask a whole QHIN or TEFCA and say how many of those cases are really taking place there without ever knowing the individual or the organization but just the region and the zip codes and say this is how many cases are taking place there right now. That becomes very effective, very quick to pool.

Hans Buitendijk
And that is extremely hard to do today. TEFCA with the queries, it will become much easier to do that.

Aaron Miri

That is the point. It is much easier to do. I think that is the whole synthesis of this paragraph. Are we all in agreement then adding in the specificity of the ability of getting that follow up data and interweaving that, sticking your quote there, Hans, but massaging it in Michelle speak to add it to this to give this some more meat? Is everybody in agreement with that? Is there any descent? Michelle, is that clear for you?

Michelle Murray
Yes. I think we have enough information to do that.

Aaron Miri
Perfect. Interoperability. Two use cases. Again, we have to do the vote and select which one we want to double down on. The first one is cardiology practice queried TEFCA to learn about the patient's previous diagnoses, etc. Because of technical framework, prior standardization, use of patient matching, the patient's records are able to be matched through the TEFCA QHIN to QHIN exchange. This is a very true thing and it is a mess today in dealing with patients that go across state lines. You can do certain amounts of look up today. This should be easier in theory with TEFCA. We will focus on the first one first. Are there any issues with the first one? Hannah, you have your hand raised.

Hannah Galvin
Yes. I think my comments here were mostly about how I still do not quite understand why the future state of QHIN to QHIN matching is going to be an better than our current state of patient matching from what I read. And Hans, maybe you or someone else can elucidate me and help me understand this. And I have been asking this question of why is this going to be so much better from what I read in the QHIN technical framework, the QHINs use their own matching principles but they have to match on any demographic features that they have. I would personally just like to understand this better.

Aaron Miri
Yes. Whether it is RLS or others, right? Hans, first up.

Hans Buitendijk
Yes. It is interesting. I would agree with Hannah that some of the fundamentals being addressed are not unique to TEFCA on the actual matching and some of the work that is now being asked on improving the addresses in HDI-1 is going to help advance in that part in combination with TEFCA. It is certainly going to help. The record location service, on the other hand, that aspect of TEFCA is that we can have better opportunities to find all of the locations where the patient has data that is relevant for what I am trying to do. I think it may be more focusing on that aspect. It still requires good matching. Otherwise, I do not know that the patient has been there. But given that advancing regardless of TEFCA as we move forward, it is the record location in my mind that is giving us the opportunity to get access to a more complete record virtually. And if we can good at that and very efficient at that beyond what currently is happening then, that would be a big step forward because I can now tap into the better record. I think that is the promise of TEFCA.

Aaron Miri
Good points. Eliel?

Eliel Oliveira

I am almost going to be making the same points, Aaron. Instead of doing that, I feel like No. 2 might be the best option here for these anyway.

Aaron Miri
Okay. You jumped right ahead to voting. Let us talk about No. 2 then as a group before we go to the vote. SNF recently implemented an EHR system. The new EHR includes interoperability, etc. We will still be able to see more patient information and hospital records, which would be phenomenal. The EHR, the SNF administrators also learned about TEFCA and created a plan to participate. That is beautiful. And including benefits determination. That is an interesting add on there, which would be very important for skilled nursing. Are there ideas about No. 2, thoughts, comments, questions?

Hans Buitendijk
I am with Eliel.

Anna McCollister
This one seems more straightforward.

Hans Buitendijk
No confusion.

Aaron Miri
Hannah, thoughts?

Hannah Galvin
I like the bit including benefits determination just because I thought that was interesting.

Anna McCollister
I like that.

Aaron Miri
I do, too. I think it was a very astute addition. Anna, any thoughts?

Anna McCollister
No. I think if we have to choose one, I think the second one is more straightforward and I love what Hannah added in terms of benefits determination.

Aaron Miri
No. 2 it is. That was easy. No. 2 it is. Michelle, is that good?

Michelle Murray
Yes, perfect.

Aaron Miri
Perfect. Privacy and security, my favorite topic. The patient received behavioral healthcare, received free trainings, not for profit, new data segmentation, DS4P. Based on this training and using open source

consent management, the patient reviews the health record, chooses not to share their behavioral health data with certain other healthcare providers unless there is a medical emergency, which would be wonderful. I am a big fan of granular choice. This is possibly because of collaboration between providers, etc., in use cases. Starting with No. 1, Eliel?

Eliel Oliveira
Yes. I like this. Honestly, I just thought that maybe we could be a bit more specific on the behavioral healthcare provider, meaning I would suggest here adding something like at our incarceration facility because that, to me, says I am being discharged, taken to jail. They had a clinical provider there that took care of me. I am going to be discharged. I do not want my primary care provider to know that I was in jail. That should be my option. But under certified DHI exchange that could happen.

Aaron Miri
Right. Or a substance abuse treatment facility, another example there. That is a common one I see often folks requesting their records be suppressed or remove that data and other types of situations like that. It is a good suggestion, Eliel. Interesting. Hannah?

Hannah Galvin
Just say specifically around the incarceration piece, that shift is doing a lot of work around standards in this area who are specifically excluding incarceration related data in our first pass at this only because that severe data is often not captured in a structured format that are used in certified EHR technology. And I would just be cautious about mentioning it specifically and I think it is incredibly important. It is super important. But I think that we are multiple steps from being able to get to segmenting around data related to incarceration and data related to CBOs, steps away from that. And the ground layer has to be even just structured certified EHR data. My hope is that we get there quickly as well but I see some additional barriers for that type of data.

Eliel Oliveira
It does not have to be that case. I guess that is one that came to mind but something to make this a bit more specific. Why would somebody not want to allow that sharing? And I have seen so many cases here in medical school where young females that do not want their parents to access their records. Since we are talking about behavioral, what would be one behavioral health situation here that would make that person say, “I do not want that to be shared?”

Hannah Galvin
Yes. That is a good point. And if we are not going to add something more for reproductive health, which is, obviously, a big, hot topic right now and if you want to step under behavioral health, we may want to say something about behavioral health hospitalization or an involuntary hospitalization.

Aaron Miri
That is a good point. That is a good one. That is an interesting point.

Hannah Galvin
A section in Massachusetts we call it Section 12 but an involuntary hospitalization. I think if we want to really keep it under behavioral health. Obviously, reproductive health is also a huge topic.

Aaron Miri
It is but it could be too hot right now. The water temperature could be too hot.

Hannah Galvin
Exactly. I think that is why I said maybe keep it with behavioral health. I think if we keep it to involuntary hospitalization that at least keeps it within the certified EHR technology framework as opposed to going out.

Aaron Miri
Interesting suggestion. I like that suggestion. Anna?

Anna McCollister
I guess I just have a question as to why are we changing mental to behavioral because I see those as two different things.

Hannah Galvin
I made that suggestion, Anna. My understanding is that that has become the cultural norm to refer to behavioral healthcare in that capacity as opposed to mental healthcare, which has been a little bit outdated terminology. That was my suggestion.

Aaron Miri
That is what we have done in our health system, too. We have a very large behavioral health program. And we are very clear to say that because it is a multitude of factors, not just mental health. It is a multitude of factors that feed into it.

Anna McCollister
Not all mental health issues have behavioral components. We do not need to adjudicate that here.

Aaron Miri
It is a good observation. I am glad you asked that. Hans?

Hans Buitendijk
I would like to support No. 1. I think it can be very clear and it points to an ideal state. There are a couple of things that still have to be done that are quite substantial in order to be able to have consent management. I think it is good to state what can we do if we address everything in our report. I wholeheartedly support it. And we have not talked about No. 2 yet but I am going to do an Eliel here. It really clarifies a little bit more and it speaks to the challenges that are particularly lived with and identifiable data and less so with de-identified data because you can a lot more already in that space.

Aaron Miri
Let us save some time here. Do we all agree with No. 1 but adding the component of involuntary hospitalization so that gives it that inpatient componentry to it. A patient who was recently involuntarily hospitalized was discharged. Is everybody in agreement with No. 1 being this choice?

Hans Buitendijk

Yes.

Eliel Oliveira
Yes.

Anna McCollister
Again, I do not understand why we have to choose because I see these as two incredibly important elements for privacy and security. And they are distinct.

Aaron Miri
It is because of the way the report is laid out. We try to do one story for each illustrative section so, for each of the sections on the report. I think it is just for brevity of the report. Otherwise, the report gets really long.

Eliel Oliveira
To be honest, on the second one, it is a weak one, in my opinion, because de-identified data release is kind of already well established. And we talked so much recently on how account of disclosures is so hard to do and now, we are adding account of disclosures for de-identified data. It did not make sense to me.

Aaron Miri
I read No. 2, Eliel, as the health system is being very proactive in garnishing trust with the patients, which I think is phenomenally important of simply telling them, "This is, literally, how we use your data, aka, syndromic surveillance de-identified," or something positive so that folks truly understand beyond the consent of their data really what are you doing with my data, identifiable or de-identifiable, aka, are you selling it, which a lot of vendors are being creepy with data these days. That is how I read it was just over the top truly the data is yours. It belongs to you as the patient. And the system is just a custodian, which is exactly what they are.

Anna McCollister
Yes. I feel very strongly about both of these, quite frankly. I have done a lot of work in speaking as well as with clients to begin establishing a transparency and impact reports for how de-identified data is used because I think it is critical to the future of data access interoperability. People have lost trust in institutions to protect them. I think most of the uses that come with data are, generally, beneficial. But if all you know is that you do not know anything about how your data is being used, it breeds mistrust. And I think it is appropriate mistrust. That is why these are two qualitatively different things looking at two different elements of privacy and security. Again, I understand report format, etc.

Aaron Miri
Yes. We have to choose one. I hate it, too. They are both beautiful stories.

Anna McCollister
Can we incorporate the data transparency into the first one then?

Aaron Miri
Can you combine?

Hans Buitendijk
You could perhaps on the first one say, "And the data is subsequently being de-identified and used in," and then, address it. Then, you are really taking two things that you have to explain and to share, identifiable and awareness of its reuse in a de-identified form, which for certain data you might, at some point in time, have some rights to not include it. I am not sure to what extent you can today.

Anna McCollister
Could we say something like, "They received a report of how the de-identified data was used confirming that their choices were respected?"

Aaron Miri
Hannah, you were about to say something?

Hannah Galvin
I am just trying to think through No. 2.

Anna McCollister
I do not know the exact statute and I will ask and find out but I am pretty sure that No. 2 is actually a legal requirement. It is just that the conclusion has been that nobody could figure out how to do it yet but we have moved on since the last time. Aaron, you may remember this. I think it was the HIT policy committee that checked this out. I know Devon and I had some discussions about this when we were working on the HTI-1 stuff.

Hans Buitendijk
And I believe that the first is also a requirement. You have to be able to record and honor consent directives but it is extremely hard to do, particularly when it becomes electronic and entire data classes and groups are being excluded to avoid that conundrum.

Hannah Galvin
Well, No. 1 is only the requirement so much as patients can request the restrictions but the covered entity does not have to right now under HIPAA for HIPAA covered entities. I do not know if you guys saw it but there was language in the final rule saying that in 2025 or 2026, there needs to be an internet based way for patients to request the restrictions. And if they grant the restrictions then, you have to be able to honor them. I think that is very clear and it was made very clear in the HTI-1 rule. You do not have to grant the restriction right now under HIPAA. For the second one, I do not know how much this is actually being done right now.

Anna McCollister
It is not being done.

Hannah Galvin
And I do not know what law actually governs that this has to be done. And I think that would be very helpful if our ONC colleagues can maybe come back to us with that because this is very hard to do. And it is very hard to do in a way that is helpful. I would love to do this. But I would want to understand how we can do this in a helpful way. I think we talked about this.

Aaron Miri
Interesting. Eliel?

Eliel Oliveira
Yes. I was thinking that there may be a good way to connect it to here because it makes sense. We are saying that the person is providing a consent, or in this case declining to consent, to share data. In that case, it is identifiable data. And then, you can also add a sentence or two here, basically, saying in the case of de-identified that the hospital or the health system is providing a report whenever they share because you are saying I do not want my identifiable data to be shared about this specific situation. And if you share the identified, I would like to know. It will be part of that consent as a double edged sword, I guess.

Aaron Miri
Michelle, I am correct that we need to choose one?

Michelle Murray
We can think about ways to integrate them a little better. I do not know how far we can go but I do like that idea. If you want to choose, you can. You still have that option.

Aaron Miri
I am just trying to make sure we help you guys the best we can here. I think we are all agree these are both very important. And I think we are all agreeing that if there is a way to incorporate elements of No. 2 and No. 1 that we do so. We are leaning towards No. 1 but incorporating the key elements of No. 2 into No. 1. Is that what I am hearing the final answer is?

Anna McCollister
Yes. And I am happy to take a crack at combining them if that would be helpful.

Aaron Miri
That would be awesome. Is there any objection to that?

Anna McCollister
Do I have the slides for this to be able to do that? Does anybody know?

Michelle Murray
We sent out a Word document about a week ago that would have that in it or you can make comments on the side using a comment box.

Anna McCollister
I am sorry. I am really bad at homework.

Aaron Miri
I think we are good on this section then. I think we have one more. Endocrinologists looking at health apps in diabetes turns to a new healthcare industry website. The doctor links several of these apps to the patient portal as resources. The doctor can then direct her diabetic patients to practice this patient portal and would,

basically, choose from the embedded apps. Hannah, do you want to talk about how your use of healthcare industry website? When I read this, I was curious about why did you think that, not that I am disagreeing with you. I am just curious about how did that come to be.

Hannah Galvin
Initially, this said an endocrinologist looking for health apps, she turns to a new website. I do not know that I specifically said healthcare industry website. But my comment was is ONC sponsoring this website? We should probably be clear that this is a government website or a professional society website, not just a random website. Are we staying that there is certification that this app certification is for ONC? I think I just wanted to be clear that there is not just some website out there saying like Google has put together guidance for clinicians. Is it an ONC sponsored website? How do we envision this website? I just wanted some detail around that. I do not think I specified the words healthcare industry. There are other organizations like the AMA that may come out with guidance on websites. But I think that was just that it just would not say a new website because that could be anything that I just Googled.

Anna McCollister
Diabetes, specifically, there is an entire community of hackers that I am part of that I would think would do a way better job of vetting diabetes apps for security and privacy than American Diabetes Association or JDRF or AMA. I do not know what we would get out of stipulating healthcare industry.

Aaron Miri
Interesting. Eliel?

Eliel Oliveira
Yes. I think when I read this paragraph, the point that we are trying to make here is that there is some sort of body that is vetting these apps that are available for patients so that they are trustworthy and can be used. And so, if that is the point of the whole sentence or paragraph, yes, having this industry website kind of becomes too loose now as we have to make a decision here that there is some agency, whether it is the government or not that is actually validating this like what the FDA does for drugs. But somebody needs to validate these apps at some point and make sure that they are safe for patients to use. Then, the doctors can link to their portal because they trust somebody has done their job.

Aaron Miri
We need clarity for the FTC to rule on certain things, too, or that jurisdiction and FDA starts and ends.

Anna McCollister
For this We Are Not Waiting movement, which I helped start early on and now, it is this global thing, there are Facebook pages that do provide recommendations for apps that are good, secure, safe, etc. And it is a community developed system. None of that has anything to do with a device manufacturer, medical society, or patient group. That is all just the crowd. But these are all people who have skin in the game so, frankly, I trust them a lot more than I would an AMA or a device manufacturer.

Aaron Miri
Let us skip to No. 2 for a second just because we are getting closer to time here. Let us do No. 2 and we can come back and talk about this. A neurologist encourages a concussion patient to use a clinical decision

support app at home to measure how differing levels change pupil size and then, transmit the data, etc., newly approved standards and meta tags and definitions. A lot of doctors have seen this data collected in the EHR. The doctor can determine the readings, patient generated versus some PGHD versus at a neurologist's office by filtering the meta tags that indicate the pupil size and then, using supplemental data, how to treat the patient's post-concussive symptoms and closely monitor patient's recovery. That is Star Trek type of stuff. It is awesome. Are there thoughts on No. 2? Go, Eliel.

Eliel Oliveira
I think when I read the two, they are completely different.

Aaron Miri
Yes. Very different.

Eliel Oliveira
If we are talking about patient access for No. 2, it is just like more interoperability aspect and the fact that there is an app that talks to the EHR while the first one is more about who validates that this app is actually doing the work that it is supposed to do. I do not know how much the second one really helps patient access. It is really maybe validating that there is an app that can communicate with the EHR and the provider and the patient back and forth. But does that increase patient access to information?

Aaron Miri
Go ahead, Hans.

Hans Buitendijk
Yes. I am building a little bit on Eliel. And I thought of a discussion that we have had around whether the data actually is in the patient's electronic record when it is coming from other apps. When is it, when is it not depends on the source. Is it the patient? Or is it accessible through or next to? To me, the challenging part is that I thought that we had not landed there and, therefore, to use it that it is directly in the patient's electronic medical record, particularly indicating somewhat patient collected data. It seems to be a little bit of a stretch for the purposes of even the fact that we want to go into an ideal state. But that is purely based on the context that I thought we were still not quite clear all together on this external data and where should it actually live. Is it next to or is it part of it?

Aaron Miri
Yes. Anna?

Anna McCollister
Yes. When I think patient access to information, I do not think getting suggestions for an app that I could use. I think more about can I get the data that has already been collected about me, generated by me that is in these systems from my doctors. And the second one, as somebody who has advocated a lot for patient generated health data to be incorporated into EHRs, I feel like the second one really gets more to that issue. And it is cool and great. But I am not sure how that necessarily fits with the target area of patient access to information or does it? Is there something that I am just missing because I have had not enough caffeine or something?

Aaron Miri
What I took away from Paragraph No. 2 was that the patient's ability to leverage their PGHD in a way for clinical decision making and for the doctor to trust that data accurately and rapidly and make clinical diagnoses based upon PGHD, which we all know today is very hard to do because a lot of them do not talk to the EHR. That is what I walked away with, which was rapid, timely ability to treat it using a "consumer app" of some sort that has been vetted.

Anna McCollister
Yes. Which I think is awesome and the same thing that I have been advocating about for quite some time. I just do not see how that is patient access to information. That is like the patient is providing access to information.

Aaron Miri
That is a good nuance. Interesting. Hans?

Hans Buitendijk
No. My hand should be down. Sorry.

Aaron Miri
No problem. Eliel?

Eliel Oliveira
Yes. I do not know if we want to go that route but I think that is where the two could come together where what we were saying on No. 1 was that somebody needs to be vetting this stuff. The second one is talking about a specific use case of one of those apps that then has been vetted by FDA, FTC and reimbursed by CMS. But there could be a possibility of merger here but I think that becomes too hard. But I agree with what Anna was saying that the second one is not as much as about patient record access but providing data. It does go back to the point that I was trying to make before. It is like somebody needs to validate and certify this stuff. And the second one does that with more specificity.

Aaron Miri
Yes. Like a Better Business Bureau kind of thing. Definitely. Forwarding entity for ONC, they do certification of health IT. I do not think they do certification of consumer apps. But there has got to be a consumer app certification body out there like the Better Business Bureau for lack of a better term. But it is not ONC. It is somebody. I can see how leaving it open ended with healthcare industry website going back to No. 1 or something along those lines, use whatever words, allows for that to develop at some point in the future. It eventually will have to come together logically. Somebody will have to own it. Where that somebody is, is it the FTC, is it the FDA, who knows? But it will live somewhere. Are we all leaning towards No. 1 then with a little bit more voracity on it? Is that what we are leaning towards? Is that what I am hearing?

Anna McCollister
I still do not really see how that is patient access to information. I suppose it is information.

Aaron Miri
It is information. How do I trust it as a patient or as a doctor in this case to give to a patient?

Eliel Oliveira
I think that the challenge I see here, Anna, is healthcare data is already complex and voluminous. And just giving patients access to their data does not necessarily help anybody because they can be overwhelmed. But if there are apps that can plot the information in a way that they can understand or organize it in some way that makes good use for patients, that is great. But somebody needs to say, "Yes, this app can be trusted because it is getting the right data hits. It is catching it the right way for you to see it." That is why I feel this one speaks a little bit more in terms of patient access with the caveat that somebody needs to say, "Yes, this is good for you to use."

Anna McCollister
There have been several attempts that I know if in the diabetes space and I know of a couple that were beyond that to do this. They could never keep the funding maintained. And it is such an incredibly difficult thing because there are so many apps that keep appearing that vetting them all is really challenging.

Aaron Miri
And there are a lot of smoke and mirrors when it comes to apps, too. It is such a great market.

Anna McCollister
Yes. FDA regulates a tiny number of them. FDA only gets involved if they actually make specific treatment recommendations for that individual. I have personally been involved with or known of a number of attempts to get something like this started and it is just not sustainable. I am trying to understand what our point is with this.

Aaron Miri
Hans, your hand is raised.

Hans Buitendijk
Yes. I think of the two and needing to make a choice that strengthening No. 1 provides a very clear opportunity and tying different systems in a way that, yes, we still have to figure out and leave it open. No. 2 makes some assumptions about what the right place is that I think we still have discussed and debated and that need to really work through what the better way is. That is why I will be leaning to No. 1 and move that one forward with flushing it out a little bit further.

Aaron Miri
Are we all in agreement that No. 1 is the choice but we need to add some more meat to it so it is a little more clear? Anna, you had been alluding to that, which I agree with you.

Anna McCollister
Yes. I can take a crack at that one, too, if that would be helpful.

Aaron Miri
Yes.

Anna McCollister

Since the diabetes app technology world is one of the reasons I got into this space.

Hannah Galvin
I just think we are closer to No. 1 than we are to No. 2 right now.

Aaron Miri
No. 2 is awesome.

Hannah Galvin
It is awesome. I think there is more. If we are going to choose, I think there is more.

Eliel Oliveira
What I was going to say there is even though it is tough and I do not know how it would be done but I think it has been done. When I look at Apple and the validation that they do for every app that is trying to go to the Apple App Store as well as security and protecting the privacy of individuals, it is limited to that aspect. But they have been able to pull it off. And of course, it is a trillion dollar company. I think that should be a model here where healthcare apps should be validated in some of these models of some kind. And I guess that is where CMS comes in.

Aaron Miri
Something like that, yes, exactly. No. 1 and then, you got it, Anna, to add a little bit more meat to it with Michelle and some specificity there. Is there another slide? I think this is the last one. Yes. We can do this for a couple of minutes here, a discussion of the background. Obviously, this is the document itself. Landscape analysis, etc. Gap analysis and conclusion, appendices. I hope you guys read this. We are not going to be able to go through the whole thing but let us just go over it high level. I am sorry. Can you pull up the background research document? I am sorry. Michelle, do you want us to go through this document or do you want us just to talk about this?

Michelle Murray
We do not have to show that on yet. It is more the report itself that. We read the stories but did not talk yet about the rest of that document. And I will let you know that the supplemental background research document because of the meeting and turnover of staff, we did a quick edit. We are still going back and cleaning a few things up but you can definitely look at that as well in parallel. We really want your input on the core document, the report itself.

Aaron Miri
Given the time constraints, is this something we should do via email? What would you suggest?

Michelle Murray
Right. If there is anything urgent people saw now in either document but especially the main report, you have 10 minutes for that minus the public comment. But then, yes, traditionally, people can go in and edit in the redline tool in the Word document over the next two weeks or so and then, get back to ONC by early January. We will send out another email about that. That is what happens. And then, what happens in January is there is about a week where ONC comes back at a senior level, the national coordinator and deputy and our division directors take a look. And then, it goes back to the co-chairs and then, on to the

HITAC. It is a really tight timeline in January but the work group has a couple of weeks now. I do apologize that it is through the holidays. That is unfortunate but it is how it has evolved over the past few years that we can get this far by mid-January and then, it is on through email and that communication for the next two weeks.

Aaron Miri
Eliel, you have a question?

Eliel Oliveira
Yes. Not a question, Aaron, but based on what Michelle was saying, I started reading and covered quite a bit. And a couple of things that I thought, which aligns with what she was saying was there are likely some additional updates. There is a section talking about the common agreement, TEFCA, that probably could be updated with the ones that are executed and all of that. I think that would be a nice addition. I think because I did not get to the end, I started making some comments about there was a section about language access. And I was like this needs to be a little more emphatic. But then, when I get down to the report, I am like there is a whole section talking about it, which invalidated my comment. Meaning, we probably still need a little more time. There is quite a bit of great stuff in this supplemental document I have seen so far.

Aaron Miri
Yes. I totally agree with you. Holiday reading. This is what you do. While you sip your eggnog, you read the report to get back the feedback to Michelle and the ONC team on those things. I know they do a great job of cataloging your feedback and then, responding to it or incorporating it. They will definitely take a look at that and add in any pieces to it or tweak whatever wording or whatever componentry you come up with. If that sounds agreeable to everybody, we can take that on for the next couple of weeks and get that back to Michelle. When do you need this back? Did you say the beginning of January, Michelle?

Michelle Murray
Yes. It will be around January 4, the first week of January.

Aaron Miri
Let us call it by New Year's. Let us get them done by New Year's. That is a date that we all remember. Great.

Michelle Murray
Feel free to send things earlier if you want to as well.

Aaron Miri
Of course. I like throwing dates out there that everybody can remember. New Year's deadline, guys. Try to get your feedback in to Michelle by New Year's. We are at time for public comment then. ONC team, can we please open up the line?

Public Comment (01:21:20)

Wendy Noboa

Sure. We are going to open up our meeting now for public comments. If you are on Zoom and you would like to make a comment, please use the hand raise function, which is located on the Zoom toolbar at the bottom of your screen. If you are on the phone only, go ahead and press star nine to raise your hand. Once called upon, press star six to mute or unmute your line. We will pause for a moment to see if there are any public comments. And at this time, we do not see anybody raising their hand. I am going to yield the time back to the work group. Go ahead, Aaron.

Next Steps and Adjourn (01:21:54)

Aaron Miri
Wonderful. Thank you all for a great discussion. I think it was fun talking about the art of the possible. Great observations. Again, Anna, I appreciate your willingness to step up and clean up a little bit of the structure of the stuff to make sure that it really resonates with what the industry has to offer. Eliel, you put your hand up.

Eliel Oliveira
Yes. I have a quick question to Michelle and you, Aaron. We said January 1 for all of the supplemental document review and feedback. But is Michelle working on an updated version that will be sent to us and when do we expect to see that one to prepare for that?

Aaron Miri
Good question. Michelle? She may be muted. Michelle, do we have an ETA on when the updated document will be coming out that you mentioned a little while ago? We will find out, Eliel. We will find out.

Eliel Oliveira
Thank you.

Michelle Murray
I am sorry. I was on mute. You do have what you need right now. I did not plan on another version before January. It is probably just version control. It is getting a little out of control here. Right now, you have the latest. The stories might switch out, obviously, but you have those both in slides and another document, which we could resend everything after this meeting so you have it all together in one packet with instructions.

Anna McCollister
Do we just make our comments directly into the Word document individually and then, send it to you and then, you guys marry all of the comments?

Michelle Murray
Right. I have concurrent review going on at ONC for the next two weeks as well. That is one reason I do not want to start another new version right now for them to edit. It is already starting to go out the door.

Aaron Miri
Got it. Thank you for a wonderful day of talking through things. And also thank you for a phenomenal year. It has been an honor being co-chair of the report work group as it was the HITAC itself. You all are excellent additions to the team. And I have no doubt you will carry forward the torch year over year and really blaze

the report to new trails and new heights. I wish you all the best of luck. I will miss you all but I will see you around. And stay in touch if you do not mind. I would love to hear from you.

Anna McCollister
Thank you, Aaron.

Aaron Miri
By all. Have a good one. Happy holidays.

QUESTIONS AND COMMENTS RECEIVED DURING PUBLIC COMMENT

No comments were received during public comment.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT

Hans Buitendijk: Taking Eliel's perspective, perhaps highlighting that the data of interest was obtained through follow-up queries to get a more complete data set to better understand context.

Aaron Miri: I really like that suggestion @Hans

Eliel Oliveira: +1

Hans Buitendijk: +1 on Eliel!

Eliel Oliveira: Great suggestion Hannah!

Eliel Oliveira: #2 would really require FDA or FTC to make sure this App is considered a device

Aaron Miri: And, being totally candid, CMS recognizing the app for reimbursement

Eliel Oliveira: true

Eliel Oliveira: 👍

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

No comments were received via email.

RESOURCES

AR WG Webpage
AR WG - December 18, 2023, Meeting Webpage