

Health Information Technology Advisory Committee

Annual Report Workgroup Virtual Meeting

Transcript | April 27, 2026, 3 – 4:30 PM ET

Attendance

Members

Eliel Oliveira, Connexus, Texas HIE, Co-Chair
Hans Buitendijk, Oracle Health
Michael Chiang, National Institutes of Health
Bryant Thomas Karras, Washington State Dept. of Health
Rochelle Prosser, Orchid Healthcare Solutions
Steven Eichner, Texas Department of State Health Services
Hannah Galvin, Cambridge Health Alliance
Anna McCollister, Individual
Kikelomo Oshunkentan, Humana
Naresh Sundar Rajan, Neantix.Inc

Members Not in Attendance

Shila Blend, North Dakota Health Information Network, Co-Chair
Mark Sendak, Vega Health

ONC Staff

Tara Porter, Designated Federal Officer
Peter Karras, HITAC Support Team
Maggie Zeng, HITAC Support Team

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

Tara Porter

Good afternoon, everybody, and welcome to today's Annual Report Workgroup meeting. I am Tara Porter with the Office of the National Coordinator for Health Information Technology (ONC) and I will be serving as the Designated Federal Officer for today's meeting. Before we get started, I want to note that all work group meetings are open to the public and public feedback is welcomed. Members of the public can type comments in the Zoom chat feature throughout the duration of today's meeting or can also make verbal comments during the public comment period that we have scheduled towards the end of today's agenda. If you could go to the next slide, please. Thank you. Today's agenda will begin with a quick roll call and then I will transition to our co-chair, Eliel, to lead the continued discussion of draft topics for the HITAC Annual Report for fiscal year 2026 and we will then shift the call to any public comments before adjourning today's meeting. You could go to the next slide, please. I will begin roll call of the work members. When I call your name, if you could just please indicate that you are present starting with our co-chair, Eliel Oliveira.

Eliel Oliveira

I am present. Good afternoon.

Tara Porter

Thank you. Good afternoon. Shila Blend noted that she would be absent today. Hans Buitendijk.

Hans Buitendijk

Good afternoon.

Tara Porter

Good afternoon. Michael Chiang.

Michael Chiang

Hi, Tara. Present.

Tara Porter

Hi. Steve Eichner.

Steven Eichner

Good afternoon. Present.

Tara Porter

Good afternoon. Hannah Galvin noted that she will be joining us about 30 minutes late today. Bryant Thomas Karras.

Bryant Thomas Karras

I am here.

Tara Porter

Good afternoon. Anna McCollister.

Anna McCollister

I am here.

Tara Porter

Good afternoon. Dayo Oshunkentan.

Kikelomo Oshunkentan

I am here. You said that beautifully by the way.

Tara Porter

Thank you. I have been practicing.

Kikelomo Oshunkentan

Super.

Tara Porter

Rochelle Prosser. Mark Sendak and Naresh Sundar Rajan.

Naresh Sundar Rajan

I am here.

Tara Porter

Good afternoon. All right. Thank you. If you could go to the next slide, please. I will now turn it over to today's co-chair, Eliel, for some opening remarks.

Opening Remarks & Validate Topics List for Priority Target Areas (00:02:28)

Eliel Oliveira

Thank you, Tara. Good afternoon, again, everybody. It is so great to see many of you again here. Thank you for your time. We very much appreciate it. I am excited to see most of you, if not all of you, and others next week in the District of Columbia (DC) for the HITAC meeting. It is long overdue to see all of you together again. On that note, I just wanted to highlight here that during the HITAC meeting, we will have reporting from the Annual Report Workgroup. We are probably going to do a five minute overview of the work that we have been doing here, describing where it is at and where it is going and then open up for comments and suggestions from the rest of the committee for about 15 minutes or so. I am looking forward to refine today a bit more what we did last time and then hear from the full HITAC group when we are in DC shortly. With that said, thank you again. Let us go to the next slide. Again, we are going to continue with what we did last week.

We made some updates to the document. If you have not had a chance to review the email that the group sent out where we added additional topics under each target area, I would like to switch to that document now and we could review as a group and further improve it. All right, here it goes. As you guys know, we focus on three areas - interoperability, privacy and security, and patient access to information. As you can see here in red, we had a few additional topics based on the discussions that we had last time. I would like to start again this time, just like last time, let us go by each category area, target area first and open the discussion for all. I will read briefly here that we have seen so far that the topics would include for interoperability to improve interoperability across key data domains like laboratory, pharmacy, imaging, payer, public health and research, improve data quality and standardization, reduce administrative burden, use of artificial intelligence (AI) to support access, exchange and use of Electronic Health Information (EHI), improve patient identification and matching, and improve individual access services implementation.

This is where we are so far, and I would like to hear if folks have had a chance to review and have any additional thoughts on important topics that we need to consider, any adjustments to the current ones on the interoperability.

Steven Eichner

Good afternoon, thank you. Looking at the first bullet point, I think we want to perhaps revisit whether it is key data domains or key user domains or user type domains because those are not the same thing. It also occurs to me, especially if we are talking about user domains, that we might want to include patients as a user domain as well. It kind of ties into the last collection of patient access to information. It is not just about the availability of health data to patients, but it is also about the interoperability component in terms of accessing that data, whether it be an individual access service through the Trusted Exchange Framework and Common Agreement (TEFCA) or whether it be an app or whether it be patient portal through an existing electronic health record (EHR). I think that becomes a good opportunity to put that in. Looking at the second bullet, I think we probably mean use of standards, rather than standardization, just for clarification because I think we mean the ability to exchange information in a meaningful way that is understandable at both ends, not standardize the data so that everybody's blood pressure is the same blood pressure, just for clarification standpoint.

I think we might want to elaborate a little bit on AI and thinking about what does that mean for access and how is the use of AI ensuring that there is good representation of all the individuals in AI utilization, thinking about things like rare diseases or different populations, so that AI is giving the best advice possible for the patients that are being treated or are having recommendations for their treatment under that technology. I will stop.

Eliel Oliveira

Yes, we even complement that. Those are great points that use of AI to me is very much aligned with the second bullet of data quality and standards, right? Otherwise, we cannot predict what AI necessarily can do. Complete data would be very important. Anna, you have your hand up?

Anna McCollister

Yes, I guess one of the things that I think might help is I feel like when it comes to interoperability that we need a reference to the inclusion of patient-generated health data. I know that it is in patient access to information. Personally, I feel like it belongs a little bit more in interoperability, which is important, particularly within the context of AI because one of my really big concerns about the use of AI in a clinical setting is that it is going to be making decisions based off of clinical data, lab data, which is not very granular at all and does not really include a lot of very clinically relevant data sources, particularly, diabetes is the classic use case, high blood pressure, blood pressure, homeostatic blood pressure is another digital scales, which measure fluctuations in weight, which is important for congestive heart failure, kidney functioning. None of that stuff is incorporated into the EHR at this point, and it creates remarkable blind spots for AI. That, to me, is a significant concern. I feel like patient access to information does not feel like the right home for that anymore because patients already have access to this information.

It is whether or not the physicians and the EHR and the tools that work on data from the EHR includes this information.

Eliel Oliveira

Could I summarize or say, Anna, that what you are saying is that we do not have any defined standards for patient-generated data or device-generated data that makes it difficult to then be utilized by providers or any others or devices or AI, like you are saying because any device, any tool may be generating data in a different way, with different metrics, different standards.

Anna McCollister

Well, I am not a standards person, so I will not speak to the standards part, but I would say that as it currently stands, if I go to see my endocrinologist, he can see my Continuous Glucose Monitor (CGM) data, but it is not part of the clinical record, and it definitely is not something that is exchanged from one place to the other. Same with blood pressure, same with digital scale, and I have had all of this data. It has been collecting. I have been collecting it at home, some of it is 24/7, for a very, very long time. None of that is part of the clinical record.

There are lots of places where that would be fairly irrelevant, at least on the face of it, but if we are going to start using AI to draw some conclusions and make recommendations based off of the data in the EHR, that is part of the clinical record set, but it needs to be far more comprehensive than it is, and I submitted this in my comments to ONC, but if I am unconscious, and you make insulin dosing decisions based off of standard guidelines without any understanding of my insulin sensitivity factor, etc., you are probably going to kill me or at least put me into severe hypoglycemic shock. I do not know how long it would take for people to figure that out in the clinical setting because you do not have real-time glucose monitoring in Intensive Care Unit (ICU) or Emergency Room (ER).

Anyway, I just feel like, again, that is just the example that I live with, but I am sure there are others that are equally dire that I am just not aware of.

Eliel Oliveira

Thank you for the clarification, and that makes sense. That access to the providers would be quite important as well. Michael, do you have your hand up?

Michael Chiang

Yes, Eliel, I have a couple comments, one about the first bullet point and one about the second bullet point under interoperability. The first bullet point is improving interoperability across those key domains, and the way I interpret that is laboratory to laboratory, pharmacy to pharmacy, imaging to imaging. Another aspect that I think is really important and sometimes overlooked is multimodal data integration, for example, integrating imaging together with clinical data or with administrative data. I just wonder if that is something that could be considered in scope for this because I see that as a gap, sort of multimodal and broad data integration. My comment about the second bullet point, data quality and standardization, is that my observation is that sometimes standardization is viewed as almost like a structural conformance, like you use the same standard, therefore, you have the same terminology, therefore, you are interoperable.

I feel like underlying that there is a semantic layer of interoperability and sometimes in the real world that that is where things kind of do not really go as well, and so I wonder if the addendum to that might be distinguishing sort of structural conformance with actual semantic interoperability.

Elieil Oliveira

Yes, I think that, Michael, makes a ton of sense, right? Otherwise, you cannot maintain the level of understanding that is necessary. As far as your first point as well, yes, I like that clarification as well because we need better ways where pharmacy information is delivered, for instance, to anyone, right? It is not just between pharmacies, like you are saying, but anyone that is treating an individual, the same for lab results and so on and so forth. That goes for public health as well receiving those lab results, those images and those medication records. Yes, I think it is all in all, like you are saying, the interoperability there that we mean might be between all the different ends and fronts in the healthcare space. I appreciate your comments there. Hans, I see your hands up.

Hans Buitendijk

Yes, thank you, Elieil. Two comments that I would like to make. One relates to the suggestions that Anna made that I agree is that patient generated health data needs to have some presence in interoperability category and in patient access. Starting with the comment on the last part there is that I am wondering that patient access where it is not only about access, but is it actually patient access to and contribution of information. If we look at it that way, and then the second bullet in that box is about improving the availability and use of patient generated data, health data, and in the interoperability part as part of the improving interoperability include patient generated health data as a domain of data that needs to be shared, I am wondering whether that strikes that balance of it is interoperability, we have to share it better when it is there. In patient access, we are missing that contribution part and the use and availability of that data appropriately, whether that is "integrated" into the EHR or available to the user, the clinician, how that is done.

Either way, and I think we can have a discussion there what is appropriate balance there, but either way, we are after availability and use. Perhaps that that might help to strike that balance because the underlying, I completely agree with Anna, it is in both spaces. Then, the second comment is around AI. AI can be used and very widely interpreted and applied inside or with interoperability or totally independent of it. The current way that it is phrased use of AI to support access exchange and use of EHR, particularly the latter part is expanding and well beyond interoperability. I am wondering whether it is that it is really what we are trying to look at there is the use of AI to support sharing the right and complete data for the purpose at hand. An example would be prior auth is an interesting example these days of finding based on what is needed for an authorization, what is the right information, what is the complete set of information to have a more efficient flow and prior authorization. That input into the exchange, AI has interesting opportunities.

On the other side, the evaluation of all of the data received, whether it is for rules in prior auth or whether it is in the integration de-duping, reconciling the data. It is tied around the interop. What can it do better in front of and when it is received? When you go beyond those points, then however the data got there, it does not matter anymore. It is the data at hand that I am applying AI for. I think we want to be careful to expand the scope of AI too widely in the way it is stated and it goes well beyond interoperability.

Elieil Oliveira

That is a terrific point, Hans. As you are speaking about that, it is coming to mind, the fact that this is very generic on AI, right? The example you mentioned, which I think it should be one of the key goals for the year coming up with prior authorization, it is an administrative use, not technical use, not biological use. I think there is probably a place here to differentiate and maybe focus on the support for AI but for different things and not administrative tools like prior authorization and other scheduling, to be honest, is a big issue in a space as well. It could be a good focus, but I will stop there because I am excited to hear what Bryant has to say as well because he noted the same point there on the chat.

Bryant Thomas Karras

Yes, thanks. I think that everybody has made really good points. I would like to acknowledge that I truly do think that patient access to information and patient contribution to information is something that we could highlight. I think that is a great suggestion and I think all of these categories are concentric circles with overlaps with each other. Maybe we call out in a header to this table that there are interoperability components to privacy and security and patient access and there are patient information access issues to interoperability, as noted by the individual access service implementation needing to be highlighted. I put it in the chat that I feel like in the interoperability category, and maybe we can make these sub-dot points of that improve interoperability across key domains and

then call out under that some specific things that we want to focus on or highlight in our report, like individual access services, like prior auth, like provider access, and public health population level access, which some of those issues are called out in the privacy and security, talking about de-identification.

Again, these all overlap and interoperate, if you excuse the pun, and I think that calling them out in the topics will help guide our development of the report forward.

Eliel Oliveira

Thanks, Bryant. That is terrific. I am going to keep moving. Dayo, I see your hand up.

Kikelomo Oshunkentan

Hi there. Did you want to move on to the next topic or do I still have time to throw something in?

Eliel Oliveira

I would still try to focus on the interoperability, but if you want to jump elsewhere, that is fine, too, and we can always come back with other comments from folks.

Kikelomo Oshunkentan

Thank you, Eliel. As a clinician, when I think about the use of patient data, it is helpful. We often ask for logs, whether it be blood sugar or blood pressure or just even daily functioning, right? However, the issue remains is the data integrity of the EHR. The EHR has been, so to speak, a very guarded tool since I began residency over two and a half decades ago, and the protection of the EHR remains the primary focus. Not so much not wanting the patient data, maybe creating a section within the EHR is helpful because there is been so many occasions where the member's machine does not calibrate when we compare it in the office or in the hospital, and having those big gaps within variability of readings is huge. That could lead us to actually overdose or underdose as well. Just like your comment earlier, Anna, if the data is not accurate, it can also have some deleterious consequences on that front as well.

I think there is a need. We always want to have a patient's engaged involvement, but we have got to maintain a way where we keep the integrity of the EHR as we incorporate that data into the system. That is my two cents.

Eliel Oliveira

Thank you. I think I am hearing what you are saying might be somehow on the data quality standard and the precision of the data that is being used.

Kikelomo Oshunkentan

That is right.

Eliel Oliveira

Yes. Maybe that is the bucket where this would be a best fit, but I agree with you, and there is a lot that we can talk about, like making changes to those EHR records, which are quite difficult, and we do not have a way to do it today, but it is a streamlined way. Thank you for that. Michael?

Michael Chiang

Eliel, I am sorry to raise my hand again. Something about this conversation reminded me that in one of the previous meetings, we had spoken with JaWanna, ONC JaWanna, about TEFCA and research exchange as a use case, and I just wanted to put that out there. I do not know if that is going to rise to the level of the annual working group, but I sensed that there was some enthusiasm about prioritizing a specific research exchange purpose to facilitate cross-institutional dataset integration. Just one other thing to consider there. I mean, that is from a little bit of a self-serving perspective because I am from the National Institutes of Health (NIH) and we do research, but I sense that might be a potential way for the groups to collaborate.

Eliel Oliveira

Yes, I think that is a great point, Michael. I mentioned in a previous meeting where we see what is going on with the Centers for Medicare & Medicaid Services (CMS) with the tech ecosystem, and we cannot just walk in HITAC, in my opinion at least, without considering what is taking place there. The example that Bryant just brought up and with Hans about prioritization is a good example. Same of what you are saying with TEFCA. There are certain things there of TEFCA that I think would be important, and on that note, I have been thinking about throwing this to the group here as a point of discussion to see what everybody thinks. I personally feel that this interoperability

target area, there is a space here to provide some direction, understanding as this being a critical national infrastructure that if not protected appropriately, it can have dire consequences. I am speaking that way, I was just talking to colleagues in Louisiana, I used to live in New Orleans, so I went through Katrina, and we know what that meant when everything got destroyed and we had access to nothing, and now they are trying to adopt a mobile technology that can allow patients to carry data, which is kind of like what CMS is working on as well.

I would love to hear from all of you as well because that is not in our list here, but it is critical for infrastructure. If we have a failure in an interoperability ecosystem that we have in place, whether it is TEFCA, whether it is a Health Information Exchange (HIE) or other networks or EHR vendors, it can be catastrophic, you know? Thank you for your comments there. I think the research access is one that I also work a lot in research in data, aspects of research with the Food and Drug Administration (FDA) Sentinel and National Patient-Centered Clinical Research Network (PCORnet) and a few others, so I would love to have answers to that as well. Thank you for bringing that up. Anna, I see your hand back.

Anna McCollister

Yes, and I, too, was going to speak about some issues or things that we might want to think about in terms of providing leadership around TEFCA because I feel like we all know what threats are out there and about the lawsuits that have been filed. Some of the concerns that are flooding out there that I think are there is a lot of validity to the points that are being made in terms of a lack of insight into the sub-participants and the Qualified Health Information Network (QHIN), really understanding how those are embedded and what kind of auditing there is. Toward that end, one of the other things, and I am pretty embedded in the health tech ecosystem stuff as well, and one of the things that I struggle to figure out for both the health tech ecosystem, as well as within the broader context of TEFCA, is how can we get some metrics around what data is actually exchanged? Who might be blocking it, particularly as it relates to Individual Access Services (IAS), but the other treatment exchange purposes as well? I mean, everybody seems to be trying to use treatment because you cannot get anything through IAS.

We need to understand who is blocking IAS? How many times are different providers allowing IAS to go through? At least I have some sort of understanding and metrics around those blockages and what needs to happen. It just feels like the trust to be maintained for TEFCA, you have got to have some of this stuff a little bit more robustly tracked and transparently reported so that we can really have an understanding of what the issues are because right now, people throw their hands up and say, "Well, if you use IAS, there is no data that comes through."

Elie Oliveira

Right.

Anna McCollister

There is a research exchange purpose, too.

Elie Oliveira

Yes. Yes, I think your comments, Anna, and Michael's as well, it is a great segue to the next session of Privacy and Security, the way I am seeing you on the screen, unless if folks still want to talk about interoperability, no problem, jump in, raise your hand. I think what you are saying is TEFCA and other solutions out there for data access, exchange and use need a bit more of governance controls. I think you mentioned some of those lawsuits that we have seen and whatnot. I completely agree. I think we should be able to track data from beginning to end and who is using for what. Within any organization, that is part of the healthcare data ecosystem. We do not have a standard way to generate logs and track those logs so that we know who is accessing what and when. I think you saw it in some of that, that is what CMS is working on, that those logs becomes available. I think maybe there are two pieces here, if I may, folks.

One is under the interoperability standards for data log, logging across the whole set of electronic systems in healthcare because that, to me, is the only way that you can enforce governance is by knowing who is doing what with what data. That, to me, then enabled what Michael was describing, which is if we are going to use this for research, how do we track down when we have an item approved and there is a consent in place for a patient or we do not need a consent. We have a waiver of consent. To me, it all falls under the governance bucket. I would love to hear more from you guys. Steven, I see your hand. Please go ahead.

Steven Eichner

Yes, I think another piece that is tied or related to logs and might be a super category is thinking about accountability. Award might be a component of that accountability. One of the things that we have talked about in

the past in the work groups is looking at making recommendations about updates to Health Insurance Portability and Accountability Act of 1996 (HIPAA), either from a regulatory standpoint or in other spaces, so that disclosures are better communicated to the patient so that the patient can really understand without any special extra efforts about how their data is being used. That becomes kind of an important aspect as well. Again, as Bryant pointed out earlier, that might trace the difference or the gap between privacy, security, and patient interaction with data but I think that is an important cross-cutting component.

Eliel Oliveira

Excellent. Excellent, Ike. Yes, I think towards that point, Ike, and what Anna was saying, and to me, it goes back to like that ability to be able to track who is doing what and when that we still lack. Hans, your hand.

Hans Buitendijk

Yes, I think I believe that gets us a little bit more into that privacy and security topic and having the notion when we talk about transparency, I believe very much goes to the notions of audit logs and tracking what data is going where. There is a part of it that sits in the first bullet a little bit that I am trying to get some clarity on that maybe there may not be there because the fact whether you can share is in part, who are you, and are you using it for the right purpose or not? Is it for treatment? Is it for IAS? Or is it for operations? What is the right place? Improve upon that and that has been identified. There is this interplay between a number of different kinds of rules on who is authorized to get access to it besides the fact whether they are covered entity or not or etc. That depends on privacy rules by jurisdictions that are getting increasingly more granular and varied. There is the patient consent that typically has been more at an all or nothing depending on what you are looking at, opt in, opt out but that is getting more granular in order to address in support of or override privacy rules.

Then, there are these “simpler” permissions that are more in, but still some fashion in which the patient indicates who can get access to what, and that you have patient apps that may or may not get access to everything or to a subset of that. That range of privacy rules, consent rules by the patient, permissions by the patients, but to very specific environments, they all need to play into this. I am not totally sure whether the way it is stated would allow us to cover that or whether we need to adjust the bullet a little bit more, or the headers a little bit more, that we can address the challenges or the needs in each one of those or across those areas because in the end, as a data holder, EHR, payer, registry, whatever, that has a Protected Health Information (PHI) beyond EHI, when as they release that data, or are about to, they have to consider all the rules. It is not just the patient consent, it is not just the privacy rules, etc. They need to review that and how do we advance the ability to consistently do that across the entire ecosystem?

Clearly, that is part of strengthening, what do we need to advise and suggest there, but I want to make sure that the intent of that bullet allows us to get across the entire continuum of rules by whomever they are stated, that are authorized to state them, that we can do that. Privacy granular consent might look at it more from the patient perspective only, but we also have the jurisdictions and then we have the variety of other flavors in there as well. I was just going to say, I would like to suggest that we can take it broad so that we can address those topics there.

Eliel Oliveira

Yes, that is a great comment, if I may add there, Hans, is that I have heard from many, and I believe on this myself, that there is something when the data is being given to the patient and the patient is further sharing with someone else. That process of a covered entity or a network giving the data to the patient, basically, and I am pretty confident that I am not saying the wrong thing here, the data moves from under the umbrella of HIPAA to Federal Trade Commission (FTC) because now it is under the governance of the patient, not of the covered entity anymore. That, to me, raises a question, is this part of our purview here at HITAC in terms of helping also figure out what are the consent controls that patients would have under the umbrella of FTC to share their data with others or not, which is very different than the consent that we talk about here across covered entities in the healthcare space. I will stop there. I would love to hear comments from that, but Ike, you have something up?

Steven Eichner

Yes, I think the other two points to build on what Hans was saying is one, looking at information about providers' access to data, what providers are having access to patient data and how is a patient determining what providers might be accessing the data at a more granular level. Secondly, looking at patient involvement in the usage of data from a payment treatment operations standpoint and things like research, facilitating perhaps the ability for a patient to say, “Yes, please go ahead and use my data for this kind of research but not that kind of research,” or somewhere along those lines where it makes it easy for a patient to consent for the use of data, but also easy for

the patient to understand where their data has actually been used. There is accountability, not just on the healthcare side of it, but looking at the research side of it as well.

Elieil Oliveira

Yes. I do not know if you guys feel differently, but I wanted to ask the ONC and Accel team here that maybe this is something for us to make a determination offline in terms of that line of separation between consent and data sharing as it related to HIPAA and covered entities and consent and data sharing as it relates to patients sharing data under the FTC regulatory oversight and if that is something that we will work on as well as part of the annual report. Ike?

Steven Eichner

Yes, just really fast on that one, to untangle or not tangle that set of complications is looking at patient role or patient perspective and looking at data sharing and access. How do you define the line about authorizing a healthcare provider to share patient data versus passing through a patient hands and disclosing the data? I would guess about a quarter of the time if I am sharing my data, I am sharing it back to a different healthcare provider, so it is getting reinserted back into a HIPAA covered entity perspective. I have got no problem with that, that is my call, but it could be really complicated trying to explain that to a patient just from a broad perspective and what set of rules applies under what kind of disclosure could be complicated.

Elieil Oliveira

Hans?

Hans Buitendijk

The last couple of comments from Steve triggered a thought on the fourth bullet that we had last time, clarify standards for de-identified data, re-identification, and consent. I think it is in that last part that my prior comments would also apply is that to make sure is that we are not just looking at the consent lest we are ending up with managing privacy rules and permissions and other things in a substantially different way. It is still a set of rules of according to the patient or jurisdiction or another party is that data can or cannot be shared with somebody else. There are a variety of different terms that are being used, whether they are called authorizations, permissions, preferences, consent, etc., but it all should be considered holistically. Otherwise, data holders are going to have to deal with it in a variety of different ways, which is not going to be helpful to make it consistent and more reliable.

Elieil Oliveira

I agree. Lots of very intelligent systems these days with AI that can really create a challenge there. Bryant, do you have your hand up?

Bryant Thomas Karras

Just a plus one. I find it almost maddening that when I want to share data that I have in my possession, providers will still ask me to sign consent forms to put it into their system. It is implied consent, or I should not need to consent myself. I feel like we are starting to run into, if we do not figure out how to implement this in a logical way or get the standards to work right seamlessly, we will be in that situation where we have to re-consent the re-sharing of information that we have already shared, per Steve and Hans' comments. Thank you.

Elieil Oliveira

Thank you, Bryant. I will say that maybe on that bucket of re-consenting of data back so the provider should access, Bryant, there should be some discussion around the patient's ability to rectify their own records within a healthcare job. That is a big problem, right?

Bryant Thomas Karras

Yes, that is a whole different can of worms we might need its own annual report on. Ues, I was wondering if maybe something to call out is differentiating, providing that consent or that data access, sharing from the primary provider's source information versus an intermediary like a health information exchange or data passing through a QHIN. I think that is where some of this complexity and some of these lawsuits, frankly, have come from. In our annual report, may want to address and call out these new layers of interoperability and data exchange. Do we need to add a consent to the target area, privacy and security, or is that term constrained by our task order? Anyway, just musing, sorry.

Elieil Oliveira

Yes, I think the target areas are defined by law, right?

Bryant Thomas Karras

We cannot edit that. That is fine.

Eliel Oliveira

Yes. Anna?

Anna McCollister

Editing the law would be super fun.

Eliel Oliveira

That is it.

Anna McCollister

One thing that kind of comes to mind as we think about privacy and security, and I say this as somebody, I think I talked about this last time, I do not know, I had a data breach. I will not name specific names, but a major hospital system in the DC area, they had a breach, security breach, and all of my personal identifiers, along with medical data, was linked to the dark web. I got all these notifications from my credit reporting company for three months before I actually heard from the health system, which I think is not appropriate. Then, they offered me credit monitoring services for two years, which I already had that. I think that is the wimpiest accountability possible. The credit monitoring services, it is a joke that we are letting anybody get away with that. I do not want to target hospitals because private companies do it all the time, too. Toward that end, particularly within the context of the limited release or targeted release of the Claude Methos, which is the concern there is they released it to different tech companies and government agencies so that they could figure it out.

This model so strong that they are afraid that it is going to be used on a widespread basis by hackers to be able to hack very cleverly into systems. I do not get the sense, and I have no idea what is going on in this area, but I do not get the sense that our hospitals are particularly secure at the moment based off of personal experience and all the reports that you hear about systems being hacked and taken over or the ransom stuff. I feel like there needs to be some sort of a concerted effort, if there is not one already, to help hospitals and health systems and companies prepare for this because this is serious stuff. If Anthropic releases this to the broad public, then it is just going to put the hacking stuff on steroids, and it is going to put all of us at risk and not just our data, but actually our healthcare that relies on the data.

Eliel Oliveira

That is a great point, and that is why I was bringing up the critical infrastructure aspect a minute ago because I feel like that in addition to the individual risk that you are describing, I can see a national risk on some targeted disruption of the healthcare ecosystem across the country could be very detrimental from a financial, monetary way, but from impact in the lives of everyone. I think an example that came to mind here as you are speaking was during 9/11, emergency responders could not communicate because the primary infrastructure for communication was overwhelmed so that today, there is an alternative form of technology for that emergency system. It is called FirstNet. That is completely separated from the base cell phone communication so that for emergency responders. My point is, it is critical infrastructure that we have in healthcare that when are we going to protect it, after a major event like that? We have seen what you are describing happening for the last, I do not know, decade or two quite a bit and continues to grow in with sophistication of AI, there is more risk involved. Thank you for those comments.

Anna McCollister

Yes, it is just not realistic to expect hospitals to be able to hire AI experts and engineers that know how to protect it. It is not. That needs to be something that is rolled out as some sort of a critical infrastructure piece by the government in some way, shape, or form.

Eliel Oliveira

Yes. Yes. I can give you an example here that I think has been terrific in Texas is that the state government has basically funded the SOC or the Security Operations Center for the university to basically provide the same tools that they use to protect the government to protect the hospitals in the state that are non-profit. Everybody gets access to those tools at no cost. That is a terrific asset to get started. I think hospitals should have some sort of support as well on that front, like you are describing. Thank you. Michael.

Michael Chiang

I just wanted to compliment the discussion on consent by mentioning that a few weeks ago, there was a group from NIH, sort of data science leadership from NIH that had a meeting with the ONC team. Brett, Avinash, Sean Bogg, and Alex Baker, I recall being in that meeting from ONC. The topic was consent and the United States Core Data for Interoperability (USCDI) plus as a potential mechanism for getting consent that, essentially, traveled with the patient and traveled with the data rather than being local based. I just want to make sure that you knew that that conversation happened in case it ties in a potential way to go further with this conversation. That is the first thing. The second is I am reading Hans's comment in the chat box about share or not share. I think that what we lack is often clear frameworks for when is data access acceptable or how to use it responsibly. That gets into all these issues with definitions of de-identification, which I think are evolving in the real world so much quicker than the legal and HIPAA sort of safe harbor definitions are. I just wanted to call that out as well, really those two points, informed consent and governance models.

Eliei Oliveira

Thanks, Michael. Yes, I think some of the work that CMS is also pursuing in terms of that patient access to data could tie in very nicely with the consent because you are right, if the patient are the ones that control that and the logs are available, then we can see when there is a misuse. That is why I was talking a bit about logs and some standard for every application system to have a way to track it down because that, I cannot consent today, but I can change my mind tomorrow. If there was an appropriate access in between the times that are allowed and disallowed a specific use how do we track that? It becomes very difficult if you do not have the logs. I think where CMS is headed is in that direction.

Michael Chiang

Eliei, I really appreciate that. I think that would be really exciting. Just to follow up on one comment that I heard like make about consenting for A but not B, I personally think that is a cumbersome model to consent for different things and not others because it is very confusing to operationalize. I wonder if an alternative model might be you either consent for reuse or you do not consent for reuse for secondary use or not, but then there would be some, Eliei, as you mentioned, log for when your data got used for something because I could argue that there are some scenarios where if your data was used for something that benefited other people, well, maybe you should know about it if you could have benefited from data that was relevant, your research that was relevant to your data or something that was relevant to you. Or maybe there is a future where people should be reimbursed or something for contributing to that ecosystem. That is way more than what I think this working group can tackle this year. I think that is a potential future state.

Eliei Oliveira

Yes, I think, Michael, that you are describing more or less what I understand was the situation in some of these lawsuits that we have seen. There was sharing that took place for one purpose, but then there was a secondary purpose that was being utilized and folks deduced that that was the case. Then, the lawsuits came about. There will be a better setup that we have the tracking logs of all these uses, so that we can actually see clearly that was a misuse or not. Anna, you are on mute.

Anna McCollister

My apologies. I think we got into some of this last year because this has been one of my hot button issues for many years is just making patients aware. I was thinking about it in the context of HIPAA, and all of what is allowed under once the thing has been stripped of the identifiers under HIPAA, you can do anything you want with the data, basically. Nobody knows what happens with it. I have always felt strongly that there should be a compensatory requirement to let people know how their data has been used. I think that would actually help build trust, if there were more transparency around it, and people could see that their data is actually being used for helpful research. I convinced one of my clients a few years ago to do this. They are a little nervous about it, but committed to the concept of doing an annual report around use of de-identified data. In this case, it was a genetic testing company, so it was genetic data.

The patients absolutely loved it. They were super excited to see how their data had been used to support research. Whereas some of those same patients that I knew personally, were sort of like, "What do they do? What are the scary things that are happening with the data?" Actually, when they saw all of the uses, it was like, "Oh, well, this is really good. I am glad that is happening." That may be something that requires a HIPAA update, but I think it is something that is important.

Eliei Oliveira

That is a great point, Anna. Yes, I can relate to many projects as well, that folks were very excited to contribute to science. There is not necessarily an all-in, everybody is going to stop things from happening. They just want to be part of it and be well-informed.

Anna McCollister

Not have some sort of creepy sense that data is being used in a way that you do not really understand and it is sort of shadowy. We have given people a lot of latitude with HIPAA to use the identified data, and there should be some requirement in return for that.

Eliel Oliveira

Thank you. All right, folks, I am going to do a final read here just to make sure that everybody has one chance more to think through the privacy and security before we jump on patient access. Strengthen privacy, granular consent, and patient control health data. It is one topic. Increase transparency, accountability, and disclosure of secondary users of healthcare data. Improve governance of AI and emergency technologies. Clarify standards for de-identified data, re-identification risk, and consent. Improved public trust, which is what Anna was just talking about a bit in some ways, accountability, and appropriate access exchange use of health data. We addressed several other things here. I think that we are going to provide those edits later, but anything else that we did not talk that we want to still mention on the privacy and security? All right. Hearing none, let us jump on patient access. We have here improved usability of health data. Improve the use and sharing of patient-generated health data, which we talked a bit about. Improve price transparency and consumer-driven affordability.

Address information blocking and enforcement. Improve access to health-related data, and increase patient participation in health IT and AI policy development. Rochelle, I see your hand up.

Rochelle Prosser

Yes. I am in the clinical setting, so I cannot have my video on. For me, it is looking at the automated machine learning and what are they collecting and how is it being used for the modeling because we know through evidence-based research with the NIH that some models, when left to their own devices to learn on their own, become negatives to certain populations just based on what their presentations are. Even though the data that they are using is de-identified, the machine learning has been able to find out the identities of the individuals, including race, sex, characteristics, etc., and create exclusionary rules that become very catastrophic to patient care if they are not found out and determined looking at what the biases that are presented within the modeling. I do not know where that fits in, but it fits in somewhere. We do need to look on how they are using these rules, creating trust with TEFCA, the interoperability, and sharing of data and making sure patients are consented or have the ability to consent positively or negatively with their use.

Eliel Oliveira

Great, Rochelle. Ike?

Steven Eichner

Yes, thank you. I think the category might want to be relabeled a little bit, perhaps. If we look at the things that are currently listed, the ones that are listed right now are really largely about other entities accessing data about patients, not patients accessing their own data or accessing other services. What happens if we recast it as something like patient involvement in healthcare via health IT or something in that space and look at patient involvement or patient improving patient usability of health data, looking at patient sharing or patient sharing patient-generated data, and looking at transparency and consumer-driven affordability, again, from the patient end of it or the consumer end of it? Does that make sense?

Eliel Oliveira

I think it does, Ike, but at the same time, I am thinking, if I am understanding well, is you are saying that the target area, patient access to information is talking about the patient access. I am trying to still reconcile that.

Steven Eichner

Yes, and as we have laid out, improved usability of health data, it is not really clear to me that we are talking about improving the usability of health data by the patient, or is it looking at improving the usability of patient-generated health data by somebody else? Looking at the use and sharing of patient-generated data, again, seems to me to be looking at outward data rather than looking at improving patient access to health information.

Eliel Oliveira

Yes, here is my thinking. I would love to hear from others but in my mind, improved usability of health data, to me, from a patient perspective, well, there is not a lot today. We still have portals all over the place. I think that is one of the things CMS is trying to do with the Cure the Clipboard app. To me, once the data is actually available to patients, then yes, how do we control how data is summarized so that patients can leverage because some of that data is complex, as you know, a lot of it, by the way? The usability, I think, becomes an important aspect. That is how I am understanding that line.

Steven Eichner

It might be helpful to add by patients at the end, or by patients and their family, just to clarify who the audience and the user is. To your point, it may go beyond just looking at the availability of health data, but how do I improve the full usability? What interpretive services are available to help patients understand the data so they are not looking at a list of Current Procedural Terminology (CPT®) codes or blood pressure numbers without a context, without tools to help them understand and use it in improving their healthcare? That probably is one of the objectives, or should be the objectives, in patient involvement with their health data, is to help improve their healthcare, either directly or through collaboration with their healthcare provider team.

Eliel Oliveira

That makes sense. Bryant, I saw you off mute. Did you have a point to add?

Bryant Thomas Karras

Just a plus one in the chat.

Eliel Oliveira

Great. Thank you. Anna?

Anna McCollister

Yes, I have a couple of thoughts. I am sure that surprises everyone. As it relates to patient access to information, I think it makes sense for us to specifically call out imaging. I think I have shared with some, if not most of you, some of the information blocking issue that I ran into in accessing my ophthalmology issues when I was on the verge of losing my vision. The issue there is several fold. 1.) Is that it is really hard to get access to your images through the EHR period or patient portals. 2.) Ophthalmology issues, and Michael can speak to specifics of this far better than I, but ophthalmology images and other types of specialty data is not incorporated into the EHR. They are saved on specialized systems that do not connect to the HER and particularly, it is impossible to access, it is impossible for doctors to really share them.

They can share basically a Portable Document Format (PDF) or Joint Photographic Experts Group (JPEG) of the image, but it does not include all of the raw image. There are some Intellectual Property (IP) claims from the device manufacturers that I would love to challenge in court at some point. One of my concerns as a patient, particularly when you think about as more and more of us are uploading images into AI to track things over time, we need access to the real images, not just a JPEG or PDF of the image. That is pretty much all you can get. When I finally did get my images, it was on a Universal Serial Bus (USB) drive and it was essentially a bunch of JPEGs. You can see a lot, but there is a lot that is lost as well. I feel like there needs to be some specific focus on ensuring that those images are not stored in some sort of bespoke special server and software only accessible via the device manufacturers, clinician portals, or whatever system they have set up. That needs to be something that can be exchanged.

More specifically, it needs to be something that is being available to patients in a relatively straightforward way. On a related note, and I think Hans mentioned something related to this or at least tangential to this in the chat, one of my concerns, particularly as we are moving into an era where we have direct connections between patient portals and AI systems, is some degree of protection on data that is connected directly from the portal into AI systems. There is none at all. These are not medical device companies. They are specifically not calling themselves medical device companies, but they are opening up different health apps, health offerings. I feel like there needs to be some degree of incumbent requirement around security and privacy protocols and then what happens with that data. How does it get hoovered up into the AI system?

What kind of protections do they have? That is a significant concern that has gotten some attention, but I do not know that it is gotten any regulatory oversight or attention. I do not know if that is what you were getting at, but there was something to that effect, I think.

Elieil Oliveira

One question that I had there was related to the imaging proprietary kind of standards that could create complications, which they exist, and I am wondering if that is something that you wanted to maybe be addressed under the information blocking and enforcement, or you were thinking more about the type of provider that is not usually part of the data sharing that we currently have?

Anna McCollister

Well, again, I will defer to Michael on the specifics because he knows it much better than I, but my understanding is that all of this data is generated by a specific device and that the machines, I think, are owned by the device company and all of the software that enables a doctor to be able to see the stuff is in a separate portal. It is in a separate system that does not connect to the clinical record or EHR and, therefore, is nearly impossible to exchange in any kind of easy way. It is certainly nearly impossible for patients to be able to get access to it in any kind of practical way.

Elieil Oliveira

Right. Great. Thank you for clarifying. Michael?

Michael Chiang

Yes, Elieil, I thought I would raise my hand because you mentioned my name in the comments. No, this is great. I just, for one, want to give a shout out that, Anna, I know that you mentioned I may know the field better because I am an eye doctor. I also think that I love listening to your comments because you have been a patient in ways that not all of us have. I think that that is extremely useful as a perspective so just to call that out. I would say some of the background, Elieil, in terms of I think that often when ONC, for example, or most people think about imaging, they think of Radiology Departments. These are enormous devices that then send images to Picture Archiving and Communication System (PACS) that is in hospitals and they think of the PACS as the image repository. I guess to Anna's point, there is a ton of imaging out there that occurs outside the PACS. My historical piece of the world was eye imaging. Of course, there is dermatologists, cardiologists, everybody has got their own many things that do not end up in the PACS.

I think that, to me, has been the challenge, what happens with those images because I think for most of these, these are not \$1 million, enormous devices that take up half of the room. They are \$10,000.00 or \$50,000.00 devices that kind of fly under the radar. We struggle with this in ophthalmology because often they are small vendors. Sometimes the vendors have monopolies or virtual monopolies and so there is really no pressure to do things like have interoperability. In fact, they are sometimes perfectly happy not to because they own the market anyway. A few years ago, we engaged the ONC team to look at this for ocular imaging. It was how can we promote interoperability because it just was not happening spontaneously over a few decades. The people on that team included, at the time, Micky Tripathi was the National Coordinator and Tom Keane was in the group as well. One thing I learned from them is that PACS and non-radiology PACS and stuff does not fall under ONC purview because they are not considered EHRs.

The ONC team's feeling at the time was that patient access to information, in other words, this row in the spreadsheet here, may be a way to engage the vendors because if there is a requirement that patients have to have access to that information and you need to adopt standards to give patients access to information, then that may be a way to enforce conformance with standards without having purview over the specialty-specific image repository. That was some background that I thought may be useful to share with the group. I definitely agree with Anna's point that this is something that is a problem, not just for eye doctors and eye patients, but I assume for other people who have images taken that are not in a Radiology Department. That is my first comment. The second one is that I think there is a few discussion points that were really important that were raised.

Things like giving patients access to medical records that may not be in lay language, or how do you convert them to lay language, or other issues along those lines. Bryant wrote improving usability of health data. Some of those, there may not be off-the-shelf solutions to how to do that because, technically, somebody may have to figure out how to do that. If you feel like there is an avenue for NIH to support research that solves those questions and then gets that in, I would love to get that into the report, action items for somebody else to do. I will stop there, but really thank you for giving a chance.

Elieil Oliveira

Yes, thank you so much, both of you because that is exactly why we have a committee with members that have that specific knowledge that you do to bring up these specific details about imaging. Whether it is ONC's purview

or not, it is still a challenge. I think the report can still in some capacity address that and how that is going to be taken to the right agency to be resolved because I believe that we have a problem here with the imaging sharing.

Anna McCollister

It is very much electronic health information, so therefore, it is covered by the 21st Century Cures Act.

Eliei Oliveira

Yes, well thank you so much, both of you. I wanted to pause for a second, folks. We need to turn to public comment for a bit, and after public comment, we have a bit more time, possibly, to discuss a little bit more. Accel team, I think I will turn it to you.

Public Comments (01:18:16)

Tara Porter

Perfect. Thanks, Eliei. We would now like to open today's meeting for public comment. If you are on Zoom and would like to make a comment, please use the raise hand function, which is located on the Zoom toolbar at the bottom of your screen. If you are just dialed in on the phone only, you can press star nine to raise your hand, and then once called upon, you can press star six to mute and unmute your line. I am not seeing any raised hands. Accel, can you confirm if anyone from the phone has a comment?

Accel Solutions

No comments at this time.

Tara Porter

Thank you. Eliei, I will turn it back to you. You have about nine minutes remaining for discussion before you close out for today. Thank you.

Eliei Oliveira

Thank you all. Well, thank you, everyone. I mean, we had some great discussions today, but we still have some additional time here, and I am wondering if anyone else had any other comments, especially on the last topic area of patient access. Hans, Bryant, I see your hands up.

Bryant Thomas Karras

Yes, Hans put a really great question in the chat. I wonder if we had time to discuss it, and I am curious does that mean that if EHRs are the limited scope, does that mean payer systems are out of scope, in which case do we have to retract the payer-to-payer Application Programming Interface (API) advancement from our recommendation? I do not think that is the intent, so I would like to kind of push back on that, and maybe we can get imaging systems to be defined as a EHR adjacent.

Eliei Oliveira

Hans?

Hans Buitendijk

Yes, I put in the question a little bit as a rhetorical, and based on how we have been understanding it, is that the remit of ONC is HIT. Based on funding and CMS programs, other programs, etc., adoption is that has been focused initially on EHR, remains highly focused on EHR. We see that in a way that USCDI is defined, but at the same point in time, depending on what you hear, is that there was at some point in time, if you go back to HDI, I am going to miss some numbers now, I think it was three or two, somewhere in there, HDI2, that there was the proposal to have the respective payer APIs on their side part of certification as well. That can happen if another program, let us say CMS, would require that systems be certified, and if other programs, whether CMS or anybody else, is not requiring that, then ONC has no authority to require that.

It only requires that if you are certified, and you want to remain certified, you have to continue to re-up with that. I think from that perspective, it is always this interesting focus that many might have heard in different meetings, so can you replace EHR with HIT, please, because we want to make sure that it works in HIT? ONC cannot get always there because other parties cannot get there. We have to keep that in mind. That means that certain areas are not going to advance as quickly, even though there is still HIT, they still capture the same data to some extent, and they still need to work with the same standards on both sides of the equation. I think we are seeing some

movement there in what is happening in the payer space, perhaps, but it is not a single party agency, that is the right word. It is not a single agency initiative.

It is multi-agencies to make it happen, and ONC can only go so far. The charter is HIT, has been from the start, and I am actually looking at the website right now where it states, "National Coordinator for Health Information Technology."

Eliel Oliveira

Thank you, Hans. I agree with both of you. I think there is a little bit of clarification because yes, even though it is very clearly spelled out that way, it seems like a lot related to EHRs, and we know that EHRs are not HIT necessarily, it is just a piece of it. It might be helpful for us to have a discussion with ONC to nail that fully.

Bryant Thomas Karras

Yes, especially given Tom explicitly called out imaging as part of his charge when he did our introduction. We really should get some clarification on that, and it seems like there is an implied scope allowance.

Hans Buitendijk

Yes, and if you talk about specifically imaging, that has its challenges that today we probably cannot look at that, but imaging in certain areas is "relatively straightforward," and that it could be and is part of simple images in EHRs, but when they get 10,000 slices worth of studies or more, then that is typically not stored or going to be stored in the EHR, but in systems and otherwise. How do you manage the range and enable access to that is not just a question of put a copy in the EHR, and therefore, then it is within the purview of ONC. Now, there is a bit more technology behind it to get access to 10,000 plus studies over slices of study.

Bryant Thomas Karras

Anna, can I pull you into the conversation a little bit? Do you really want raw access to your images or the ability to share those images with others? I do not want to have to take out a cloud account to store that image record of 10,000 slices that just mentioned.

Anna McCollister

When you say you do not want to take out a cloud account, you mean what?

Bryant Thomas Karras

Gone are the days where they can put it on a Compact Disc Read-Only Memory (CD-ROM). It is a terabyte of image information. What is the average patient going to do with that?

Anna McCollister

Right. Well, I do not know if we want to design for the average patient, but to answer your question, I am not completely sure what I mean by raw data. I am not going to pretend to be an expert on the specifics of what that means in terms of space required to store something like that.

Bryant Thomas Karras

Or the software needed to view it. Yes.

Anna McCollister

I would say that particularly within the context of Large Language Models (LLMs) and some of these consumer focused applications of AI, imaging has long been a great case study for how AI is even better than humans. I personally have had some humans looking at data and drawing wrong conclusions that had consequential impact on my vision. It would be nice to be able to get access to that data and to be able to do my own analysis of it using the assistance of AI.

Eliel Oliveira

We have already run out of time pretty quick, folks, a minute. I wanted to give Rochelle the chance to voice her thoughts because she had her hand up for a minute or two.

Rochelle Prosser

Thank you very much, Eliel. I agree with Anna. Patients need those data, those images, to be able to compare, contrast, and see if there is advances in their own health or in the other way, detriments to their own health. You can only see that through the comparative over time. I agree there are certain language learning models. Before,

we used to share these images and still do on CD-ROMs and Digital Versatile Disc (DVD) discs. This older technology is not sustainable over time because you have compatibility issues between the different facilities, compatibility issues between different radiology, imaging technologies, and then third parties, etc. I have actually built one of these systems where you would be able to create one of these EHR and radiology repositories. It is not that hard. The issue is the use of the API and the sharing of data. If we are able to do that effectively and have like use, we are choosing one or two or three models that we would be able to share these APIs so that we have compatibilities.

I think that falls under interoperability. Yes, I do think that patients do want to have access to all 10,000 images if it means life or death or changes in their course of treatment.

Eliei Oliveira

Thank you so much, Rochelle. Thank you, everyone. I know we have run out of time, but this was a terrific discussion. I think back to where Michael started, maybe there was some misunderstanding that we need to clarify, but seeing Dr. Keane and Mark Cuban the other day discussing prior authorization, I think there is a case to be made here that we cover a bit more than just EHR. I hope to get that answer for us all. I look forward to seeing you guys again soon.

Bryant Thomas Karras

Yes, either that or we need to buy stock in fax machine companies.

Eliei Oliveira

That, too. Take care.

Anna McCollister

Thank you.

Bryant Thomas Karras

Thanks, everybody.

Adjourn (01:29:04)

Questions and Comments Received Via Zoom Webinar Chat

Steven Eichner: Use of patient-generated data is important. It ties both to interoperability and to the last section (which probably should be renamed/recast to something like "patient involvement in health care via health IT" or something along those lines.

Bryant Thomas Karras: if we call out IAS should we mention: Prior Authorization 0057-f as-well-as Provider Access API and Payer-to-Payer API

Rochelle Prosser: I agree Bryant

Rochelle Prosser: I agree with Hans. As we look at prior Authorization this can amount to information blocking if the AML is not trained properly

Eliei Oliveira (Connxus, TX HIE): +1 Rochelle

Rochelle Prosser: Agree with Bryant

Rochelle Prosser: Definitely agree. Mismatched data can also prevent billing and proper patient follow up.

Steven Eichner: The availability of patient-created data to all of the patient's providers also needs to be addressed- how is gatekeeping addressed?

Rochelle Prosser: I agree with Steve

Bryant Thomas Karras: Interoperability • Improve interoperability across key data domains (i.e., laboratory, pharmacy, imaging, payer, public health, and research)

- Individual Access Services (IAS) implementation
- Prior Authorization 0057-f
- Provider Access API
- Public Health use case
- Improve data quality and standardization
- Reduce administrative burden
- Use of AI to support access, exchange, and use of EHI
- Improve patient identification and matching

Eliel Oliveira (Connxus, TX HIE): Thanks, Bryant!

Rochelle Prosser: Hans +1

Rochelle Prosser: I am concerned what modeling AML's use and collect during research and in patient reported data. We already know AML can use de identified data to not only find identity but create exclusion rules that prevent care. These models should be accessible to the public for review.

Hans Buitendijk: AI needs standards to understand how to share or not share data in accordance with privacy/consent/permission rules.

Rochelle Prosser: +1 Bryant

Hans Buitendijk: Consent traveling with the patient can be conceived as tags on transactions, or virtual access to all of a patient's consent rules whether maintained centrally (patient focused in a location of a patient's choice) or decentralized (with every data holder, or some federated flavor inbetween. HL7 Scalable Consent Management aims to enable either virtual flavor focusing on how to share and keeping all relevant PHI data holders in sync.

Rochelle Prosser: I disagree. Just as in paper use, you should have electronic choice to make available or not

Rochelle Prosser: Just because it was a benefit use, doesn't make it right to use

Eliel Oliveira (Connxus, TX HIE): exactly!

Rochelle Prosser: +1 Ana

Bryant Thomas Karras: i agree lke.

Rochelle Prosser: Steve +1, Ike + 1

Bryant Thomas Karras: edit

- Improve usability of health data by patients, parents/guardians

Eliel Oliveira (Connxus, TX HIE): Great, Bryant.

Steven Eichner: + Bryant

Bryant Thomas Karras: there is some great review by Network for PH Law on State regulations protecting Pt data in 3rd party apps

Rochelle Prosser: +1Ana

Rochelle Prosser: Michael+1

Hans Buitendijk: Is it that non-EHR HIT does not fall under ONC's remit or that other programs do not incent adoption and interoperability? ONC is the Office of the National Coordinator for Health Information Technology, not just EHR.

Eliel Oliveira (Connxus, TX HIE): Agree, Hans.

Rochelle Prosser: That was my question Hans

Eliel Oliveira (Connxus, TX HIE): The HITAC will recommend to the National Coordinator for Health IT policies, standards, implementation specifications, and certification criteria relating to the implementation of a health information technology infrastructure, nationally and locally, that advances the electronic access, exchange, and use of health information.

Rochelle Prosser: I would love to answer this.

Hans Buitendijk: To view the data (or share the actual image) a shareable, accessible link needs to be in place. The standards to such a link have not been established (technical issue) and the distribution of cost to enable the sharing and accessing such links to the right authorized parties (patient, provider, etc.) has not been resolved.

Eliel Oliveira (Connxus, TX HIE): +1 Hans

Questions and Comments Received Via Email

No comments were received via email.

Resources

[AR WG Webpage](#)

[AR WG - April 27, 2026, Meeting Webpage](#)

Transcript approved by Tara Porter, HITAC DFO, on May 15, 2026.