# Annual Report Work Group

Transcript
August 24, 2018
Virtual Meeting

---

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**
Good morning everyone, and welcome to the second meeting of the HITAC Annual Report Workgroup. We will call the meeting to order, starting with rollcall.

Carolyn Petersen?

**Carolyn Petersen – Individual – Co-Chair**
I'm here!

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**
Aaron Miri?

**Aaron Miri – Imprivata – Co-Chair**
Present.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**
Christina Caraballo?

**Christina Caraballo – Get Real Health – Annual Report WG Member**
Here.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**
Brett Oliver? Not yet. And Chesley Richards? Okay. We'll see if Brett or Chesley joins in a little bit. At this time, I will turn it over to Carolyn and Aaron.

**Aaron Miri – Imprivata – Co-Chair**

Alright. I'll start. This is Aaron.

So, welcome, everybody, to Meeting No. 2. Pleased to help host this, co-chair it, with my esteemed co-chair, Carolyn Petersen. What we wanted to do today was to talk through what we sort of touched on last meeting, as well as sort of the overview here and structure. As we mentioned in the last discussion, this is the first time this annual report is coming through, so it is a work in progress.

You will see a lot of things that we've spoken about that go on over the next weeks and months and have a better graphic, a better pictorial, a better diagram as this is all put together. I appreciate everybody's attendance today and working through this.

In addition, we also wanted to start some discussion and really talking through some of the meat of the report and any ideas and ideation that will go into the final product as time goes on. We will begin all of those processes today. (Next slide, please.)

So, this is kind of our overall workgroup scope. Again, the workgroup is to inform and contribute to and review the draft and the final versions of the HITAC Annual Report, to submit to the secretary and Congress each year, and of course, really, this becomes our metric, our rubric for how we are doing against the issues that we have been charged to look at, as well as anything that we have eventually sought permission to seek out more information on, and how we are doing against that as time goes on.

Again, this is all part of 21st Century Cures, looking at these priority target areas, about which we will go into detail later on. Again, it's sort of that assessment of health IT infrastructure and advancement; analysis of all the gaps in the policy and the resources of those target areas; and as I said earlier, some ideation for potential HITAC activities that we would go back and ask for permission to look at. (Next slide, please. Keep going.)

Alright. So, as noted in Section 4003 of 21st Century Cures, we are really looking at these four areas, interoperability being really key this day and age, sort of that HIT infrastructures allowing for the seamless exchange, access, and use of health information; a subject that is very near and dear to my heart, private security, and making sure that we promote and emphasize the use and protection of private security; and then, patient access, really making sure that we are helping to look at and work through any roadblocks or ideas or questions around facilitation of secure access by an individual and their caregivers; and then the last slide, as I mentioned earlier, any other target area that we could ask to look at with appropriate notice to Congress. (Next slide.)

Our objectives for 2018: One, we really want to publish proposed regulations for implementation of the health IT provisions to drive access to clinical data by advancing proposals related to APIs. And then, No. 2 is really identifying behaviors that are not considered information blocking, which will help assist the ONC and their enforcement of the Cures Act that prohibits information blocking. The second objective here is looking at the TEF, the Trusted Exchange Framework and really publishing that draft to improve data sharing across disparate health information networks. And in the third bullet here, really to have

consideration of the standards and implementation specifications to support priority uses of health IT, based on HITAC recommendations, and encouraging all stakeholders to implement and use those applicable specific interoperabilities that we seek to address. These are three tremendous objectives for FY 18, that the HITAC has been very busy on, and we are looking to report back how we've been able measure against those. (Next slide.)

So, for Fiscal Year 2018, there are several benchmarks that the ONC has identified that we really want to look at here. One is for a proposed regulation covering APIs, information blocking, and other health IT topics, and the possibility of HITAC activity by the end of the year to be in line with the schedule of the publication of certification interoperability enhancements proposed rule.

Number 2 is the draft TEF, the Trusted Exchange Framework, to have that published. It was released on January 5 for public comment. The HITAC is charged with making recommendations and submitting those recommendations to the national coordinator within this year.

And then, Number 3 is the standards and specifications to support our priority use cases. This is really the USCDI, the Core Data for Interoperability and proposed expansion process. HITAC was charged with the review and feedback of this to the national coordinator in FY 18 and HITAC was charged with making recommendations on priority uses of health IT and associated standards of implementation. For those of you who have been part of previous meetings, you've heard of all the detailed work going into this, so it is exciting to be able to report back the rolling up of the sleeves and the making of the sausage that has been going on for all of this. (Next slide.)

Alright. So, I am going to let Carolyn take it from this point forward.

**Carolyn Petersen – Individual – Co-Chair**

Okay. So, we have here what we're calling the 2-D crosswalk of priority target areas for this fiscal year. If we look at all of these things taken together, it is more than two plans that we're trying to kind of flatten out to make it easier to understand. We have the ONC objectives, that is, publishing the proposed regulation, publishing the draft Trusted Exchange Framework, and looking at standards and specifications. There are the ONC benchmarks. Because of the language of the 21st Century Cares Act, "benchmark" is a term that has to be used, but these are actually more baselines, in practice, because we are in the first year.

So, that is the proposed regulation publishing, the draft Trusted Exchange Framework and publication, and the standards and specifications considered. In effect, have we done our objective?

Then we have the HITAC charges, which are the Trusted Exchange Framework, the US Core Data for Interoperability – that workgroup has also previously worked – and we have the interoperability standards priorities that's underway now, and then any additional initiatives that we have determined. (Can we have the next slide please?)

So, here is a 3-D crosswalk that tries to kind of give you a better visual sense of how all of these things fit together. The Rubik's cube is, I think, a familiar kind of way of thinking about things. It is showing the various groups of priorities and objectives and how they kind of all engage together. There are several interest groups, our key stakeholders, that add another layer to all of this: patients, providers, researchers and public health organizations, and others. It is even more complex than this Rubik's cube image, but hopefully this gives you a better sense of what we are trying to address. (Let me have the next slide, please.)

Now we'll get into the workgroup discussion, having reviewed our charges and where we are going. (Could I have the next slide please?)

The first aspect that we need to consider is how we're structuring this report to help us kind of identify what we need to put in and ensure that we have a checklist we can follow to ensure that we get it all done as we work through it. So, the sections we're looking at will be first, the executive summary; followed by an overview or review of HITAC's progress in Fiscal Year 2018; a landscape analysis of health IT infrastructure; a gap analysis of health IT infrastructure, and some recommendations for addressing the infrastructure gap; some suggestions for additional HITAC initiatives, that perhaps we can look at addressing next year and even in the future further; whatever conclusion or conclusions we have; and then appendices that have any extra information that we can provide to support our analyses and recommendations. (Can I have the next slide, please?)

The landscape analysis structure we're proposing has an overview and some other parts. We look at the legislative requirements and the current ONC and HITAC priorities. Then for each of those priority target areas, some background and the current state. Essentially, we are looking at the recent progress of some of these different topics and showing examples of stakeholder groups. (Could I have the next slide, please?)

The gap analysis structure that we are proposing for each of these priority target areas, the gaps identified as well as the opportunities that can help us plan more for the future year and get a sense of what should be on the agenda coming up, and also, of course, recommendations for addressing those gaps and opportunities. (Next slide.)

So, we have some content ideas for the landscape analysis, some interoperability topics. For example, ONC has proposed regulation covering APIs, information blocking, and other health IT topics. There is a draft Trusted Exchange Framework, the US Core Data for Interoperability, and the standards and implementation specifications to support priority uses of health IT.

We have some thinking to do in terms of what other interoperability topics should be included and what are some examples of progress among stakeholder groups.

Continuing on to the privacy and security topics, we have HL7's Fast Healthcare Interoperability Resources: FHIR standard for transferring electronic medical records and there is the OAuth 2.0 security profiles for authentication; privacy and security protections for patient-generated health data; behavioral health information sharing; health information sharing for research purposes; and of course, we want consider what other privacy and

security topics there might be, and again, examples of progress among the stakeholders.

We have also patient access to information topics that could include things like the blue button initiative including MyHealthEData at CMS. Also, data collection using mobile and wearable devices; use and sharing of patient-generated health data; and emerging platforms for data sharing. Again, do we have other topics and what examples of progress can we mention?

Then, with the gap analysis, looking at some content areas for the report, with interoperability topics, the expansion of priority use cases to meet the needs of additional care settings and stakeholder groups; technology maturity and the timeliness of guidelines and development; data quality, provenance, and usefulness; usability metrics for health information exchange; and incentives for change across stakeholder groups. Of course, we still have interest in other topics that come up and examples of concerns that come up among our stakeholders.

For privacy and security in the gap analysis, we have variability of information-sharing policies across states; HIPAA and confidentiality of substance use disorder patient records; regulations, implications and education; granular levels of consent to share and disclose information; implications of the European Union's GDPR and Privacy Shield; implications of the California Consumer Privacy Act of 2018 and perhaps any others that we become aware of during this timeframe; and widespread adoption of the cybersecurity framework. (Next slide, please.)

With regard to patient access with information topics: the use of API to access available patient data; timeliness of planning activities and operational impact; net neutrality; infrastructure needs for underserved populations; and accessibility and usability of patient portals. Again, we are interested if you have other topics and we are looking for some examples of how this plays out among our stakeholders.

Then, we have some other questions related broadly to stakeholder groups. We are wondering if we should look at the interest of select stakeholder groups that could include patients, providers, researchers, public health, developers, preparers, employers, and policymakers. Should the interest of stakeholder groups become an organizing principle for the report? If that's the case, should the content be categorized primarily by the priority target area or by the stakeholder group?

If we go with that priority target area approach, then we can include examples from stakeholder groups to illustrate the concerns and the progress in each area. If we take the stakeholder approach, then the priority target area can be handled as crosscutting themes throughout. (Next slide, please.)

So, we'll review our work plan and schedule. We are now past the kickoff and today we are starting the outline of our landscape analysis and our gap analysis. We will be updating the HITAC in September and look to have a draft of the landscape analysis to work on in September in about a month.

We are looking to take that final landscape analysis to HITAC in October as we work on the draft of the gap analysis, which we will also take to HITAC in October. So, September and October are going to be a push for us.

We will be working on the draft of the progress report and we will be reporting that to HITAC in November, and then taking the final report out in December and reviewing that for HITAC and moving into January where we will review the final and get that to ONC, so they can present it to Congress. (Next slide, please.)

Here is our meeting schedule. Today, we are at the 24th of August. We have one meeting in September and one in October along with one in November and one in December. We can also consider meeting additionally if we need to do that or if we want to have smaller subgroups that work on specific aspects. I suggest that we consider that today and try to wrap our arms around what we think would be helpful, so we can plan because we will have holidays coming up and meeting schedules and other things that could make it more challenging. Then in the winter, that final annual report will be completed, and in the spring, we will start on the report for fiscal year 2019. (Next slide, please.)

Then, the full committee – this is another way of looking at the thing that we just covered – we have a progress report in September; then in October, we have the final landscape and gap analyses to review; in November, the final progress report; and then in January, the final annual report reviewed. In February, that moves on to ONC and is going to Congress in March. (Next slide, please.)

I think before – Are we going to do the public comment now or do we want to have some discussion, Lauren?

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**

Oh, no. We have that reserved for later in our call so if you want to open it up for discussion now.

**Carolyn Petersen – Individual – Co-Chair**

Oh, okay. That's what I figured, but… I thought I'd better check.

**Aaron Miri – Imprivata – Co-Chair**

I see a few new folks have joined. I see Dr. Oliver. Brett Oliver's joined, I believe, so do we want to do a quick roll call to any of the folks that joined late are here?

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**

Thanks for that catch, Aaron. Do we have Brett on the line?

**Brett Oliver – Baptist Health – Annual Report WG Member**

Yes. I apologize for my late arrival.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**
That's okay. No worries. And Chesley Richards? Not yet? Okay. I think that is it for now. Thanks, Aaron.

**Aaron Miri – Imprivata – Co-Chair**
Okay. No problem.

So, Carolyn, I would propose that perhaps we go back to those few topic areas with the topics and maybe spend five minutes on each of those topics and see if there's any other – like around private security or interoperability, if there is anything else that jumps out to this workgroup that should be on this list. I would say no more than maybe five minutes for each area and let's just talk through it at the start.

**Carolyn Petersen – Individual – Co-Chair**
Yep, that sounds great.

**Aaron Miri – Imprivata – Co-Chair**
And if we could go back in the slides to where we were looking at those lists…

**Carolyn Petersen – Individual – Co-Chair**
How do we feel about the structure of the annual report?

**Brett Oliver – Baptist Health – Annual Report WG Member**
This is Brett. I like the overall structure. I think it makes a lot of sense and **[inaudible] [00:02:08]** talking about just the general scaffolding there, that's on the slide.

**Christina Caraballo – Get Real Health – Annual Report WG Member**
I agree. This is great work that you guys put together all of this, so thank you. It's a lot to digest right now.

**Aaron Miri – Imprivata – Co-Chair**
Yes. It is.

**Carolyn Petersen – Individual – Co-Chair**
We just do it one bit at a time.

**Aaron Miri – Imprivata – Co-Chair**
Exactly. A lot of credit to the ONC team. They are rock stars in helping to synthesize this into things like Rubik's cubes that makes a lot of sense.

**Christina Caraballo – Get Real Health – Annual Report WG Member**

Yes, and as we go through it, I am wondering what – I know the ONC team will support a lot on this, but we have a few meetings, and a lot of writing and work to do. Just kind of thinking about how we are going to break it down and actually start kind of diving into all of this would be great to discuss as well. I like the idea of breaking it into sections and getting some subgroups together.

I'd like to get an idea of what ONC is drafting or putting together for us to see how we can actually start doing this. I know our HITAC meeting is in a week or two, right? September 5?

I'm sure, Aaron and Carolyn, you have thought about this a lot. I'll pause there.

**Aaron Miri – Imprivata – Co-Chair**

Yes. I do think that we do need to break this into chunks. That is why I wanted to spend a few minutes going through some of this, and just sanity check. If you look at the gap analysis; let's look at Section 5 for a second. For each of those subject areas, we just took a stab at topics that we know are front and center that we should look at and so, it is one of those things that I think we need to spend a lot of time with and think it through. Do we bring in subject-matter experts to speak with, or do we talk to folks at HITAC, and we look at all of the kinds of things and to your point, just continue to refine this down to a list that actually makes sense.

For me, I want to make sure that we allow everybody an opportunity to weigh in and think about this, because to your point earlier, a lot of work has been done. And Brett, now I look to you, and I really want to make sure that the topics for sure are clinically impacting – they all are clinically impacting, but the ones that we know for a fact that would be front and center for a physician clinician, you want to make sure that you are able to get those out in front and identify those so that we can make sure that you work to those as appropriate so we have a full, comprehensive picture.

**Brett Oliver – Baptist Health – Annual Report WG Member**

Yeah, I love that approach. I think that's great.

**Aaron Miri – Imprivata – Co-Chair**

Carolyn?

**Carolyn Petersen – Individual – Co-Chair**

Yes, I am just looking at this, trying to think of anything else that I have seen or read about or heard about recently. I mean I think that information blocking is obviously a primary consideration and hopefully we will have some further information from ONC in the next month or two that we can include in this, even if we need to add it after we have done the review with HITAC. I think that's probably something that people on the full committee would approve of, knowing how important information blocking has been to the community.

**Brett Oliver – Baptist Health – Annual Report WG Member**

Carolyn, this is Brett. I have one question. Would our report be an appropriate place to define some of these terms? Sometimes I hear, at least on a real basic provider-provider sort of discussion, interoperability as a term thrown around with different definitions as the different conversation arise. Is this an appropriate place to put in some definitions, like what we're talking about when we say certain terms or is that covered somewhere else?

**Carolyn Petersen – Individual – Co-Chair**

I think it would be a great idea to have an appendix section of all the various terms that we're using throughout the report. Also, where there are, should I say, dueling definitions or multiple definitions that are a bit different and have been used commonly, we can say, "A, B, and C; we're defining it as B for the purpose of this report." I think that could be a helpful standalone section in the health IT community just entirely outside of the annual report.

**Aaron Miri – Imprivata – Co-Chair**

I totally agree. This is Aaron, and you know, Brett, one of the things that we have done in other workgroups was even for terms that are somewhat ambiguous – and I will say this sort of tongue-in-cheek – where we are speaking English but people are hearing Greek, it is helpful to note those things and it would be helpful to come up with a more English term for this so that everybody could truly understand what we are talking about.

So, if there are words or terms that come up that as this goes along that you feel that particularly a clinical audience truly doesn't understand what we are talking about and it would be beneficial to come up with something out, this is the time to say, "Hey, let's make this work for everybody." That's the beauty of these workgroups is that that kind of data then synthesizes back to the larger committee and honestly becomes common language. As you hear of things or see things in provider land, please let us know.

**Brett Oliver – Baptist Health – Annual Report WG Member**

Great. Thanks. Just an example is when someone tells me they have interoperability and what they are talking about is a simple ADT feed. To a provider, that doesn't move the clinical needle, but we can say we have interoperability between these two organizations, and I think it would be really helpful moving forward and then interpreting the report for the average person.

**Aaron Miri – Imprivata – Co-Chair**

Great thought.

Yes, that would be interesting and as an idea I am throwing out there, ad hoc, Carolyn, is that we have the full report and maybe there is a skinny report that we could attach to it that truly just synthesizes it down into plain English for folks. This can get very technical, especially as you look at the USCDI and other, phenomenal work that has been done, all of us are in our own way in health world sort of geeky in our own way. We can get very technical, but it would be helpful to have a light version to attach that kind of synthesizes this.

**Carolyn Petersen – Individual – Co-Chair**

Sometimes people try to use the executive summary in that way, to a degree. We could think about a light version or perhaps a very basic slide deck.

**Aaron Miri – Imprivata – Co-Chair**

Yeah, that's great.

**Carolyn Petersen – Individual – Co-Chair**

Publish it on the website along with the report, and then people who are having local meetings or state meetings or whatever, they can pull it down and say, "Yeah, this is where ONC went and this is where they're thinking about going" and use it as a jumping-off point for their discussions and advocacy.

**Aaron Miri – Imprivata – Co-Chair**

Great thought. I love that.

**Carolyn Petersen – Individual – Co-Chair**

Hopefully ONC isn't shooting dagger looks at me for thinking about more things to do. That is something that we can pull together in February, after the bulk of the report itself is done and we could do that among ourselves, really.

**Aaron Miri – Imprivata – Co-Chair**

Great. That is exactly what I am thinking. Maybe we sit down with Brett and a few others and ask what really makes sense and what we can take to the clinician community and say, "Hey, does this make sense to you or is there something here that we've missed?" and that sort of thing.

**Carolyn Petersen – Individual – Co-Chair**

Or just setting aside a half an hour or an hour at the January in-person meeting, when we will all be there. That would be another opportunity.

**Aaron Miri – Imprivata – Co-Chair**

Yep, agreed.

**Carolyn Petersen – Individual – Co-Chair**

So, do we have anything else to say about interoperability, do you think?

**Aaron Miri – Imprivata – Co-Chair**

Let me ask this question. Interoperability means – and I am going to key on what Brett said a minute ago – it means a lot of things to a lot of people. Is there value in our also looking at these various topics and say how they affect a specific constituency. Case in point, what does interoperability mean to patients? I know that we have stakeholder groups listed here, but perhaps we look at not just what it means to them but what barriers they have had in the marketplace thus far.

Case in point, we listed on a privacy/security slide varying state laws that require different types of breach notification in case there is an oops, those types of things. Is there a way to tie these subject areas together to each other to say, "Look, this isn't a standalone item. There are various facets and issues here that tie together." Do you think there is a way to do that, so at the end of this we have a crosswalk of how many of these things intersect?

**Carolyn Petersen – Individual – Co-Chair**

I think it is good to cross-reference things. I would rather not commit to a specific writing structure without having given that some thought.

**Aaron Miri – Imprivata – Co-Chair**

Sure. I am just throwing ideas out there to think about and something to marinate on.

**Christina Caraballo – Get Real Health – Annual Report WG Member**

When I am looking at this light, I think of this in landscapes. So, what we are doing right now and what you are referencing would be more under the gap analysis right?

**Aaron Miri – Imprivata – Co-Chair**

I would agree. But I would also think that even under the landscape, they all sort of tie because if someone says the landscape analysis content idea of the TEF – Well, the TEF has multiple components to it, obviously, that have been proposed, so how does that all tie together? For example, the USCDI plays into the TEF. I wonder if there is value in showing folks, and I am throwing it out on the wall to see if it sticks, is there value in somehow how these things tie together or not?

**Christina Caraballo – Get Real Health – Annual Report WG Member**

That is actually a good idea and maybe we – and Carolyn, you mentioned this in your overview, looking at and kind of deciding on how we put the different stakeholders in. Maybe under each of the areas we could have a grid – or as an exercise as we go through this for our own reference – where we have the stakeholders listed, and then we put some notes on the landscape for each individual stakeholder, and there might even be a sliding scale of super-interoperability, things are working for stakeholder A, but it might be less for another stakeholder, and maybe that would be a clear way for us to identify the stakeholders that are not achieving interoperability as well. I think we are going to see some really positive use cases where interoperability is happening very well and then we are going to find there are other stakeholders that it is just not.

**Carolyn Petersen – Individual – Co-Chair**

Yeah. Maybe it is bullet lists or maybe it is some kind of basic diagram that has dashed and full lines. Something that sort of shows the relationship. I would think that kind of format of such a thing would probably become more apparent as we get into the writing.

**Aaron Miri – Imprivata – Co-Chair**

I agree. And I love that idea of going into it that way and ranking them because call it two years from now, we can look backwards and say we advanced our respective stakeholder

group from a medium to a high interoperability or whatever we want to call that measurement, and he gives us ways to go back and sample and test the water of "Did we achieve progress here or are there other barriers that need to be addressed?"

**Carolyn Petersen – Individual – Co-Chair**

That would definitely facilitate looking back at the benchmark and baselines in future years and we can set something up that way.

**Brett Oliver – Baptist Health – Annual Report WG Member**

Yes, I really like the small, medium, and large – however we want to term the measurement because ultimately this is to get Congress to advise them. We just don't want a landscape what's happened, but where the gaps continue to be.

**Aaron Miri – Imprivata – Co-Chair**

That is correct. That is exactly right. In addition, it also helps the community at large to understand where there are barriers. If I put my hospital CIO hat on, and say the community feels that a respected stakeholder group is not as interoperable as another, then I am able to look at solutions to work with various vendor partners and say, "Hey, help me address this aspect that I intersect with," and it starts gives me a way to plan without getting hit in the head or blindsided by saying, "Oh, man I didn't know this was an issue." So, there's a lot of value in that.

**Brett Oliver – Baptist Health – Annual Report WG Member**

Very well said.

**Aaron Miri – Imprivata – Co-Chair**

So, we have this section. Do you want to go to another section now?

**Carolyn Petersen – Individual – Co-Chair**

Yes, let's go to the next set of topics.

**Aaron Miri – Imprivata – Co-Chair**

Okay. Privacy and security. This is my favorite. **[Laughter]** These are some items here that we thought of in thinking about things. Are there other topics from privacy and security? I think the general answer is yes, but are there specifics that we know front and center to health IT that we really need to put on here?

I will share one of Carolyn's comments when we were planning around the security protections for patient-generated health data and how do we make sure that those are in place for the Fitbits, Apple Watches, or 23-and-Mes out there: How do we look at that and how do we work through what those are? I think it is a very relevant, in the news and in the forefront of consideration to think through. Are there other topics like that that we should be addressing?

**Brett Oliver – Baptist Health – Annual Report WG Member**
I think it would be helpful in that particular sense, excuse me – go ahead, sorry.

**Carolyn Petersen – Individual – Co-Chair**
No, go ahead, please.

**Brett Oliver – Baptist Health – Annual Report WG Member**
I was just going to dovetail on that particular line item on the privacy/security for patient-generated health data. Also, what is the patient's responsibility once the information leaves? This is all new territory and we just finished, with my organization, the Apple Health Record, and we had a little bit of – well, we didn't buy it – but buyers' remorse in saying, "Once it leaves, did we properly educate our patients on the fact that this isn't an app that we created and now that it's downloaded, it's out of our control?"

I guess, I am not really sure where I am going with this as much as to say, "What is the responsibility once the patient receives the information?" because that is going to explode, the smart on FHIR apps, at least for organizations like mine, where the patients are going to now have this. That is fabulous; that's what we're working towards, but making sure they understand we are no longer protecting them once it is on the phone or wherever that information resides…

**Carolyn Petersen – Individual – Co-Chair**
Right. That brings up the whole question of how we do patient education around what HIPAA covers and doesn't cover. I think it's probably not realistic or helpful to remind people to read the terms of service for their third-party app. We don't do that for anything else. **[Laughter]**

But I think there is value in some discussion around this notion of how do we help patients and consumers and users of this data, like caregivers and family members, understand and become more aware of the fact that not everything is covered and there is value and understanding where data can go and what is the potential implications if it goes places that you didn't think it was going or want it to go. And we talked about that in the full HITAC too, and how we can incorporate that piece.

**Brett Oliver – Baptist Health – Annual Report WG Member**
Absolutely. When an app or organization says your data is protected by this mechanism, does the average person understand what level of protection that provides them? Or should that be something that is mandated that you have a certain level of protection on some of these apps? There are just a lot of moving parts that make me nervous with patient data.

**Aaron Miri – Imprivata – Co-Chair**
Yes. I will go back to something that was said in the first meeting, which is that there is some really great work that ONC and OCR did in previous FACAs to try and synthesize this out, and I think it is worthwhile, setting some of this out. Carolina sent you the final task force recommendations on May 12 of 2016, and on Pages 43 and 44 – and I can send this to everybody on this call – they did a great job of putting this crosswalk together of the actors,

the system, and the roles of the operation and what are the rights and responsibilities that are HIPAA-regulated and not regulated.

I think if we take this and continue iterating on it or asking for more clarification, Brett, to your question there, and some of those real-world examples that you have, this is where this becomes helpful. I took this, a couple of years ago, to our compliance chief and said, "Hey, as we are working with our vendors, we need to make sure that we put this as part of our risk-assessment process to understand the risks that we are accepting in dealing with prospective **DAs**." This is where the good stuff comes out, and this is just a consideration point, not to discount the work that's been done before.

**Brett Oliver – Baptist Health – Annual Report WG Member**
Absolutely. It is wonderful to hear that it's already been done to some extent.

**Carolyn Petersen – Individual – Co-Chair**
That points up a potential recommendation in the report that HITAC look at some way of bringing all of that good work to the forefront and help to make it more visible for both providers and for patients and consumers as we go down the path to getting the exchange framework and some of these other things in place and we move from conceptual to starting to happen in the field.

Certainly, the good work that is there, but it is a question I think of helping both to understand that if we are not ready to use it and "Oh by the way, here it is."

One other thought that I had around the PGHD, we don't want to forget the remote-sensing data and applications, things like in-home sensors and other stuff that is starting to mature. Maybe there is some telemedicine aspect there that we should be thinking about or be considered by HITAC in the future.

**Brett Oliver – Baptist Health – Annual Report WG Member**
Absolutely. That is a great point.

**Carolyn Petersen – Individual – Co-Chair**
Not just on health.

**Christina Caraballo – Get Real Health – Annual Report WG Member**
I agree with all the comments that been said so far. I think we should add patient-generated health data topic under privacy and security and I think that is one of those areas that, as you said, Brett, there is a lot of opportunity, but it is scary for providers right now, so we can start looking at kind of mapping that out, and I think that would be really helpful, especially as we progress into looking at more remote monitoring and telehealth. We should add – Go ahead.

**Brett Oliver – Baptist Health – Annual Report WG Member**
Right. One of the basic concerns is if I don't understand, as a provider, some privacy issues,

and my patient says I have this app, and by law, I am required to get the data come but what is my requirement to educate them on what happens to their data with this particular app?

What I have been trying to think about for organization is do we have some kind of vetting process to where you say, "If you need a hypertensive app or a diabetic tracking app or whatever it might be, we have reviewed these from security to accuracy and effectiveness and sort of approved them," but I am not sure that's even practical given the scope of what we are talking about happening in that space right now. Any thoughts on that? Is this even pertinent to what we are talking about right now in the privacy and security topics?

**Aaron Miri – Imprivata – Co-Chair**

This is my perspective on that. I think those questions that you just brought up our spot on. I think there is a lot of industry head-scratching as to where the buck stops, per se. I think this is exactly the point of our landscape content section is to say there are these types of questions are sitting out there that are somewhat ambiguous that we need clarity on. That is where the powers that be or HITAC can ask to look further into or research those sorts of things. I don't have an answer, but I think that is exactly the point of this is to look at this and say, there is an issue here that we at some point need to address.

**Christina Caraballo – Get Real Health – Annual Report WG Member**

I did a lot of work on this with my connected health committee within the last fiscal year, and we put together a market landscape on what patient-generated health data would look like in a provider organization from really easy to implement, just getting a survey out to patients without a whole bunch of technology to support it, all the way to… kind of a scale of – we did five different buckets, kind of a progression for organizations look at, all the way to complex, and that complex went to complete use of patient generated health data for analytical purposes and the whole gamut of where we aren't yet, but it allowed organizations to see a step-by-step process.

One of the areas that we did have under there was questions around privacy and security. I don't remember them all offhand, and that is not necessarily my area, but I can pull that up and get it and send it out to this group. It could be a good starting point because we did talk to a lot of different stakeholders just to ask a lot of questions on what their concerns were, so that could be a good starting point for us.

**Brett Oliver – Baptist Health – Annual Report WG Member**

Yeah, I would love to see that. Thank you.

**Carolyn Petersen – Individual – Co-Chair**

That would be great.

**Aaron Miri – Imprivata – Co-Chair**

In the interest of time, let's go to the next section. So, patient access to information topics; the Blue Button data collection using mobile/wearable, exactly what we were speaking about just a minute ago; use and sharing of patient generated health data and emerging health

platforms; and what else? What are some of the other patient access information topics in progress?

**Carolyn Petersen – Individual – Co-Chair**

I suppose there is general usability and disability-accessibility issues around patient portals. That feels like a topic that has been around for a long time, but given that people are still indicating problems with them, or performance issues are still being identified, it probably shouldn't be ignored.

**Aaron Miri – Imprivata – Co-Chair**

I would agree. Brett, let me ask you a question I'm thinking about on this topic. Are you seeing more of a use for social determinant data, looking at the social media for emerging symptoms of the flu in a respective area and being able to staff up appropriately, seeing that that may be coming before there is a public health bulletin put out there. Are you seeing any of that in the clinical realm?

**Brett Oliver – Baptist Health – Annual Report WG Member**

I am seeing a lot of interest in it right now. I think there are some organizations out there that are further along that continuum than we are, that are actually doing it right now. I think it's sort of in a nascent state…

Yes, we want to do that. At least the major vendors, we are an Epic shop, but I know Cerner has similar things, and Allscripts, where social determinants of health – We're building not just the patient's health record, but it's broader than just a medical record by bringing in those social determinants and trying to use those data and predictive analytics for just like what you said, whether it is for staffing… or even with patient-generated data.

As a provider, I don't want to see your data. Maybe it's neat to saw that you can actually transfer it, but what am I going to do with it? However, if I could bring that into a data warehouse and run some analytics on it and then present it when someone's activity level drops below a certain point, and we know that maybe they are at risk for depression and the case manager may call and check on them. That is where we're right on the cusp of those things exploding and social determinants of health and those factors that are coming in from community resources, that data, I think, becomes even more valuable. Right now, I think we are in the theoretical phase moving toward that. But we should address it, for sure.

**Aaron Miri – Imprivata – Co-Chair**

Fascinating, and I see that as hitting multiple areas here with these four bullets that we have here, but that's even a potential fifth one, which is social determinant data or whatever we want to call it, which is beyond patient-generated health data because now it's sort of an aggregate, community-based and what a lot of folks are saying about a specific topic, so it may be something for us to consider. In particular, I am hearing about this from the industry that I am in, and I'm hearing that's where the industry is going, so I would love to hear from the rest of HITAC, what they think.

**Carolyn Petersen – Individual – Co-Chair**
I agree.

**Christina Caraballo – Get Real Health – Annual Report WG Member**
I think we need simple access in here as well. Just where we are even with electronic health records. Just where we are even with electronic health records. My mom called me furious the other day, because she had lab work done, and she went into HealthVault, and said, "I hate Microsoft HealthVault; my labs aren't there," and my response to her was that it was not the technology's issue; the provider did not push it to Health Vault. That's still happening, and in the personal example, she was still complaining about it yesterday, and I won't go into the whole story, but my point is we're still not accessing – patients don't have access to their health information in a way that we think that they do, within our tech bubble. It's still not being shared.

**Aaron Miri – Imprivata – Co-Chair**
You are exactly right, and you know what? There was actually another topic on here for this slide, but just came in mind with your story, and so, thank you for sharing that.

Health systems don't have a great way of identifying accurately who that patient is. I mean, sure, you can send them an access code in their mail, via snail-mail or whatever, to get into a portal, but really, identification of the patient and understanding that this is really patient Aaron Miri that is trying to access this data, so therefore I can translate it to him or her: That's really an issue.

I don't know if that is something that we want to put on here are back on the privacy/security consideration, but accurate identification of the patient is key. I would think – and Brett, correct me if I am wrong here – from a clinical perspective, making sure it that the right data is getting to the right person as you give them a clinical diagnosis, it has to be important.

**Brett Oliver – Baptist Health – Annual Report WG Member**
Absolutely. It is critical. You're exactly right.

**Aaron Miri – Imprivata – Co-Chair**
All right. I know that we are getting closer and closer to time there. Unless there are any other comments, let's go to the next area.

Gap analysis, interoperability topics here… and Lauren, how much time do we need to give to the public? I want to be respectful of that, as well.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**
We are scheduled for just open discussion until about 12:50 or so.

**Aaron Miri – Imprivata – Co-Chair**

Okay. We have time. So, we have plenty of time. Alright, perfect. Alright, good. Thank you for that.

Interoperability topics. We have expansion of the use cases to meet additional care settings; technology maturity – again, this is gaps, so we're looking at gaps, here, for interoperability – data quality and provenance; metrics for HIE exchange; and then, incentives for change across stakeholder groups. What are some other topics here and what are the concerns?

Alright, I will start. An interoperability gap I can think of off of the top of my head, that maybe we should consider, is one around – we say incentives for change, but I would also go one step further and say financial metrics and financial reimbursements of interoperability. There was some consideration of looking at federal funding or CMS looking at a way to measure to make or make a part of a multiplier or whatever else. Perhaps expanding of that and continuing that work and really making it a meaningful exchange of data, I think, would be helpful, because the healthcare community moves quickly when there is a reimbursement tied to something.

**Brett Oliver – Baptist Health – Annual Report WG Member**

Yeah, Aaron, that is a great point, in particular for the smaller offices that have smaller vendors. They don't have anything – Their margin is so thin, and they have used up all of their dollars to install this thing, and maybe they were sold a bill of goods or not, but then when you are trying to integrate with a CIN and their practice, you realize the data they bring to the front door is not always usable. If you could get incentivize them to make those changes, to become more interoperable, that could be very useful.

**Aaron Miri – Imprivata – Co-Chair**

Yep. Another one that I can speak for – No, go ahead. Your turn. I'll go next.

**Christina Caraballo – Get Real Health – Annual Report WG Member**

No, it's fine. I was thinking that this would be a good area for us to look for some of the kind of comments that were brought up with the TEF. I know that goes along with what other people were already saying, but there was a lot of really positive feedback, but then really negative feedback, and it is kind of because what we have uncovered is that there are a lot of issues around some of the comments we've gotten on business cases crossing state borders with information and there is a whole slew of them. I think diving into the negative comments that we received on TEF would be really helpful here.

And I'm kind of silent right now because I have a lot of thoughts on this, and I'm thinking of where to start. But I will volunteer to help on this section in our report and come back with better thoughts.

**Carolyn Petersen – Individual – Co-Chair**

Yeah, I am trying to think of the specifics related to telemedicine, because that is certainly advancing, and I think it's fair to say that we are going to be seeing more of that going

forward.

I mean, you would think the data is just the data, and if we're using these accepted standards, then it shouldn't be an issue, but I'm trying to recall if I've heard something about telemedicine, something inherent in telemedicine systems that can make that more complex or potentially not feasible – interoperability, I mean.

**Aaron Miri – Imprivata – Co-Chair**

So, I can speak to the direct knowledge of implementing telemedicine from my perspective, previous lives in health systems, one of which is making sure that dosage and weight and scale was appropriate for the patient.

I've been in both pediatric and adult care, and it's amazing how many times a prospective med is entered in for the wrong weight or the wrong kind of dosage or the wrong strength, which impacts clinical care, and it goes back to identification of the patient accurately. There are a lot of things, when it comes back to data and data quality, that really impacts interoperability because it is that appropriate clinical prerogative to make sure before you commit an order or create a med or order a med to make sure that it is appropriate for Aaron, and that it's the right density and weight.

Once you get into the world of pediatric medicine, it gets even more complicated. There are a lot of things here that standardization will help with, which we address here in data quality and data provenance. To your question, that is been my experience that really hung us up and we had to work through.

What other topics? Alright, we'll go to the next one, **[laughter]** privacy and security –

**Carolyn Petersen – Individual – Co-Chair**

On the interoperability, should we also add infrastructure?

**Aaron Miri – Imprivata – Co-Chair**

When you say infrastructure, what you mean?

**Carolyn Petersen – Individual – Co-Chair**

Infrastructure is referenced on the patient access information slide, two slides forward, and do we need to broaden that or to make it to cover that third bullet point there?

I'm sorry. Is it on the previous slide? I saw infrastructure a second ago, but anyway, it is on one of these slides.

I am wondering if that has to do also with net neutrality, but I am wondering if that needs to be broadened to include more groups? It's framed as a patient issue, but maybe it's broader than that?

**Aaron Miri – Imprivata – Co-Chair**

That is a thought, a really good thought. It could include that.

**Carolyn Petersen – Individual – Co-Chair**

If patients in rural area don't have the bandwidth to be doing some things, can we say that that's an issue that is only patients and not the providers and the health system entities as well? Probably not.

**Brett Oliver – Baptist Health – Annual Report WG Member**

You're going to have providers **[inaudible] [00:58:22]** self-service.

**Aaron Miri – Imprivata – Co-Chair**

I literally was just speaking with a very large provider in the upper Midwest that serves multiple states, and some of the providers they are trying to connect to in a very rural part of the country, literally have nothing. It's almost impossible for them to even access a medical record remotely, much less provide telemedicine. To your point, if we are talking about infrastructure as in broadband, fiber optic, or whatever capability, I would totally agree. I think a lot of systems that are doing heroic work for rural parts of our country are just sort of stuck; they don't have options.

**Carolyn Petersen – Individual – Co-Chair**

Yes. Okay. There is the infrastructure. It's the fourth bullet point there. I knew I saw that somewhere.

**Aaron Miri – Imprivata – Co-Chair**

Yes. It is not just patients, right? I think you're right. It's everything. We can leave it on here, but I think that infrastructure probably needs to go on multiple slides. That was my point earlier about these things tying together. A lot of the issues are affecting multiple categories.

**Carolyn Petersen – Individual – Co-Chair**

Yeah. I mean, interoperability is an obvious one also. It doesn't matter if you can read the data on both sides if you don't have the bridge to move it.

**Aaron Miri – Imprivata – Co-Chair**

That is exactly right. It actually may help us as we put this together, to say, "If you have a topic on infrastructure that affects multiple dimensions, this is obviously a topic that we should prioritize as critical, and maybe we look at it in detail first as a committee." It starts giving us a priority listing. If we all agree that infrastructure is a major issue inhibiting health IT across multiple dimensions, that should be a topic that we really focus heavily on. You know what I mean?

**Carolyn Petersen – Individual – Co-Chair**

Yes.

**Brett Oliver – Baptist Health – Annual Report WG Member**
Agreed.

**Carolyn Petersen – Individual – Co-Chair**
That may be something to call out in the executive summary also.

**Aaron Miri – Imprivata – Co-Chair**
Exactly.

Let's talk about patient access. What else about patient access beyond infrastructure are issues today that you can think of?

**Carolyn Petersen – Individual – Co-Chair**
Health literacy, visual literacy, numeracy… but I am struggling to think about how we frame those within something that is within ONC's responsibility to address. Obviously, we recognize that there are problems, and it is good for providers to offer clear communication, to be clear about what the provider responsibilities versus patient responsibilities etc., but ONC is not really a patient-education organization.

**Aaron Miri – Imprivata – Co-Chair**
Let me challenge you a little bit on that, Carolyn, because I agree with you: there is a lot of responsibility on the patient, but ONC really put together a fabulous patient-education website, and I want to say it was last year because I remember talking about it at the policy committee. They rolled it out, and I know it has to still be up. They actually go into talking about different dimensions of "as a patient, you should know this, and this is what this means." Maybe this is an opportunity to highlight some of that work or to highlight areas they can continue to work on. They did start that process.

**Carolyn Petersen – Individual – Co-Chair**
Oh, absolutely. I agree. I just mean that it is not one of ONC's specific charges, to go out and educate patients. It works and has other charges that have the consumer-patient focus.

**Christina Caraballo – Get Real Health – Annual Report WG Member**
I do think that education and awareness is a major gap, though and there is this whole culture shift of patients having a right to be part of the healthcare system and even if it is not something that ONC can do, I think highlighting it in the report as a gap could be really helpful.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**
Just for reference, that's the ONC Patient Engagement Playbook **[inaudible] [01:03:27]** reference.

**Carolyn Petersen – Individual – Co-Chair**

So maybe another appendix section is a section on existing ONC resources and how they support the work that's done to date and the recommendations for future work.

I mean, we would certainly intersperse some of these things throughout the writing of the report, but having a collection of them in one place as sort of a reminder, like, "Here is your go-to stuff…" I know that the website has gotten fairly large and complex and there have been some changes, and not everything is where I used to see it, so it probably would not hurt.

**Aaron Miri – Imprivata – Co-Chair**
I think that is a great idea, and it would be good to have it in the appendix so if there are curious members to get the final report, and they can say, "Oh, let's just see what's been going on," and they know right where to go, and to the point that I have been saying, there is been some fabulous work that has been done.

**Carolyn Petersen – Individual – Co-Chair**
I agree.

**Aaron Miri – Imprivata – Co-Chair**
What other topics on this one? Alright. Next section then.

**Michelle**
Aaron, this is Michelle. Did you want to talk about the privacy and security gaps as well? I think we skipped over that by accident.

**Aaron Miri – Imprivata – Co-Chair**
Yes. Thank you.

There you go. Perfect. Privacy and security gaps: variability of information sharing – and we kind of spoke on that a little bit earlier – HIPAA and 42 CFR Part 2, which is substance disorder; granular levels of consent; we talked about GDPR; the Consumer Privacy Act; and widespread adoption of cybersecurity frameworks.

The sixth one there really speaks to the continuing focus privacy/security task force and other health IT – the standards committee and the policy committee point toward NIST as a very excellent framework to focus on, so continuing that emphasis on NIST and/or other frameworks that the committee finds appropriate, those sorts of things. I just want to kind of clarify in granular detail what that bullet means and the importance of that. Health systems must have good cyber-hygiene in following the framework of something. Are there other privacy and security topics that we think of that should go on this list for further discussion and ideation?

**Carolyn Petersen – Individual – Co-Chair**
We don't mention social media here, and maybe we don't need to call it out in particular, but

I think it certainly wouldn't hurt for consumers and patients to have some better awareness of settings and how to go about changing the settings in the mHealth app and other things they might use, typically, to manage their health. I wouldn't say in general, like Instagram or some other general platforms that are not health specific, necessarily, although you might have some uses of those platforms that are health specific.

**Aaron Miri – Imprivata – Co-Chair**

Maybe we could term that as patient education on privacy and security, in general, and we could talk about all kinds of social hygiene and other dimensions?

**Carolyn Petersen – Individual – Co-Chair**

Yes. The notion that you just don't download an app, and it's a two-part function, where you download the app and then you go into the preferences or whatever they are calling it and look at what it wants to do with data, and be sure that you have things checked off that align with what you want to do with data and where you wanted to go: Is it made public? Sometimes you can't control where the transmission is, but you can often control whether or not it is publicly visible or only private or only to users that you are connected to, and that kind of thing.

**Aaron Miri – Imprivata – Co-Chair**

Yeah, that's a good thought. Other topics?

Okay. Let's go on then. Have we gone through all of the sections now?

Ah, stakeholder groups. There we go. Are there other stakeholder groups here that should be organizing principles, and we talked about this earlier, but looking at the stakeholder groups, have we capture that accurately or are there others that are missing, and/or should they be termed something else?

**Christina Caraballo – Get Real Health – Annual Report WG Member**

We don't have behavior health providers on here. We don't have the LGPAC.

I think one of the things that we kind of identified and we are working on, the USCDI, is that there are a lot of stakeholders. We started coming up with a list of stakeholders and it got to be over 20. I think what we need to have in here is something like "emerging stakeholders," where we bundle them all together, so it's kind of like anybody outside of the normal players.

How are we looking at how we are going to expand? I don't know. I hesitate on this because I think there are a growing number of stakeholders. But then, do we want to stick with the main players? I don't know.

**Carolyn Petersen – Individual – Co-Chair**

Would it be possible to include a category of emerging stakeholders and then have a sentence or two that lists that broader list that you came up with in the other environment? You know, stakeholders who potentially may play a more significant role in the future or

something along those lines?

**Christina Caraballo – Get Real Health – Annual Report WG Member**

It can also be about how we define providers. So, there are traditional providers, like when we think of the EHR program who are more like the ones who are eligible for meaningful use incentives, but then there is a growing group of providers outside of that spectrum that ONC has identified as really important parts of the ecosystem, as well. I just don't want to miss that.

**Aaron Miri – Imprivata – Co-Chair**

That is a great point. I think it is worth at least addressing because as time goes on, there could be a minor stakeholder that suddenly becomes a major stakeholder in the future and we just don't see it yet. So, if there are these groups that we feel should be lumped together to at least be put on here, that is not a bad idea. An emerging stakeholder group is not a bad idea.

**Christina Caraballo – Get Real Health – Annual Report WG Member**

As an example, nonprofits, and especially nonprofits that are disease-specific – and this goes beyond just research purposes – but groups that are… I will give an example that I have worked with, the Immune Deficiency Foundation, and they reached out to all of their patients across the country and asked, "Well, what do you want?"

And the patients wanted a place to access all of their health information, and (full disclosure) they used my old company, Get Real Health Portal, but they couldn't really achieve what they set out to achieve because they did not have access to health information and data from the multiple providers from across the country. They have actually been stifled by the lack of interoperability, but they are a smaller nonprofit with only so much voice and lobbying power.

When I think of those groups that are trying to be more progressive and do things, I think that we need to also think about them because there are a lot of them, if you add them up. They are one, and if you take all of the patient groups out there, if we can actually make it so that they have access to health information, I think we are going to see some really cool things happen.

**Brett Oliver – Baptist Health – Annual Report WG Member**

I think the other thing that an emerging in the stakeholder category is that it holds to the spirit that HITAC had, and we have had an in all of our discussions, in that we want everybody's voice to be heard. We may forget somebody, but if we had that emerging category, it goes a long way toward the spirit and what we are trying to accomplish.

**Carolyn Petersen – Individual – Co-Chair**

I agree.

**Aaron Miri – Imprivata – Co-Chair**

Yes. Good point. Very good point. I agree. That is the goal of this is to make sure that this is totally inclusive. I totally agree with the spirit of that. Okay. Any other topics on this?

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**

I think this is the last slide before we go into public comment.

**Aaron Miri – Imprivata – Co-Chair**

Okay.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**

If there are no – We can circle back and maybe spend the last few minutes just talking about the workplan and the schedule and if there are any other questions there.

At this time, operator, can you please open the line for public comments?

**Operator**

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

Again, that is *1 to make a public comment at this time.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**

Thanks. And operator, do we have any comments in the queue at this time?

**Operator**

We have none at this time.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**

Okay. So, why don't we… So, Aaron, I will turn it back over to you. I don't know if there was anything that you wanted to wrap up in the topic areas, or Carolyn, if you want to spend a few minutes reviewing the workplan again, since this will be our last opportunity to meet before we have the HITAC meeting in September…?

**Aaron Miri – Imprivata – Co-Chair**

Yeah, I think it is worthwhile for Carolyn to go one more time through the workplan. I don't have any comments.

**Carolyn Petersen – Individual – Co-Chair**

What we will be doing in September at our in-person meeting in a couple of weeks is just updating the full committee and kind of running through a lot of what we talked about today, but probably not every bit of it in every detail, just to let them know what's ahead and what they can expect. We should be thinking about and expecting to see and be ready to work on a draft, around September 20, of our landscape analysis. We have identified a number of interesting and potentially very helpful ideas today.

I am thinking that probably ONC staff will compile that into some sort of list for Aaron and me, and maybe we will be sending it out as an email to others on the committee to start thinking about who wants to take on what or to work with the ONC resource person to start developing some of those sections. It will be a month there, but time moves quickly, and when school starts and we get back into medical meeting season, that time can go pretty quickly.

In terms of the HITAC, in the virtual meeting in October, we will want to have our landscape analysis finalized. Again, there is some work time there, but we don't want to let that go too long. We will have that gap analysis for us to be working on, a draft of that in early October. Then that also gets presented to the full HITAC in October at the virtual meeting.

In the meantime, we will be working on outlining the progress report for ourselves and need to try to get through a draft of that for us to review and approve by about 1 November. The AMIA meeting is typically like November 2 or 3 through the 7th or 8th. We are losing a great chunk of time there in terms of our own personal commitment because we have to bring the final draft of that progress report to the HITAC committee at the virtual meeting on the 14th of November. So that may be another time when we're a little tight.

So, in terms of the full report, we'll continue to work on that ourselves through November and bring in a draft in December. Then, the full HITAC reviews the final iteration of the annual report at a meeting in January.

So, we have time and we don't need to be panicked, but I think it's good to keep these deadlines in mind, and when we see the opportunity to try to push forward with something so that as these other events and meetings and travel come up, we don't find ourselves working at 2:00 in the morning. That is not usually the best time to edit or come up with innovative ideas. Did you have any additional thoughts, Aaron?

**Aaron Miri – Imprivata – Co-Chair**

No, I think you are spot on, and there will be a lot of work done and I think there will be an email as well as we come up with different drafts and steps, and as you said earlier, Carolyn, if we need to consider calling another meeting at some point in between these dates for whatever reason, we will talk to the team and figure out what works.

**Carolyn Petersen – Individual – Co-Chair**

Yeah. I mean, one of the nice things is that if we push to try to go forward with our draft, we can do it all or largely all asynchronously by email, which tends to work a lot better in terms of people's personal schedule and having a chance to read something or draft something for

a day or two before you go back to it and make any additional adjustments.

We do have that option also.

**Aaron Miri – Imprivata – Co-Chair**
Yes.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**
We are just a few minutes early. Anything else either Aaron or Carolyn, or **[inaudible] [01:20:57]**, did we go over everything that we wanted to today?

**Aaron Miri – Imprivata – Co-Chair**
I'm good. Carolyn?

**Carolyn Petersen – Individual – Co-Chair**
No, I think we had a really good discussion and lots of good ideas and things that we hadn't conceived of earlier, and I am looking forward to this. We have done some really good planning work and are in a good place to go forward.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**
Okay, sounds good. So, with that, I think we can adjourn and we will see each other relatively soon in the next couple of weeks. We are also looking forward to our first draft later in September.

**Aaron Miri – Imprivata – Co-Chair**
Fantastic. Thanks everybody. Thank you.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**
Thank you. Goodbye.

**[End of Audio]**

**[Duration: 81 minutes]**