



## Health Information Technology Advisory Committee

Transcript  
December 13, 2018  
Virtual Meeting

---

### SPEAKERS

- Carolyn Petersen, Co-Chair, Individual
- Robert Wah, Co-Chair, DXC Technology
- Michael Adcock, Member, University of Mississippi Medical Center
- Christina Caraballo, Member, Kizmet Health
- Tina Esposito, Member, Advocate Health Care
- Cynthia A. Fisher, Member, WaterRev, LLC
- Brad Gescheider, Member, PatientsLikeMe
- Valerie Grey, Member, New York eHealth Collaborative
- Anil K. Jain, Member, IBM Watson Health
- John Kansky, Member, Indiana Health Information Exchange
- Kensaku Kawamoto, Member, University of Utah Health
- Steven Lane, Member, Sutter Health
- Leslie Lenert, Member, Medical University of South Carolina
- Arien Malec, Member, Change Healthcare
- Denni McColm, Member, Citizens Memorial Healthcare
- Clem McDonald, Member, National Library of Medicine
- Aaron Miri, Member, Imprivata
- Brett Oliver, Member, Baptist Health
- Terrence O'Malley, Member, Massachusetts General Hospital
- Raj Ratwani, Member, MedStar Health
- Steve L. Ready, Member, Norton Healthcare
- Patrick Soon-Shiong, Member, NantHealth
- Sasha TerMaat, Member, Epic
- Andrew Truscott, Member, Accenture
- Sheryl Turney, Member, Anthem Blue Cross Blue Shield
- Denise Webb, Member, Marshfield Clinic Health System
- Kate Goodrich, Federal Representative, Centers for Medicare and Medicaid Services (CMS)
- Chesley Richards, Federal Representative, Centers for Disease Control and Prevention
- Ram Sriram, Federal Representative, National Institute of Standards and Technology
- Lauren Thompson, Federal Representative, DoD/VA Interagency Program Office

**Operator**

All lines are now bridged.

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

Good morning, everyone. Welcome to the December edition of the Health Information Technology Advisory Committee. I'd like to, first, wish everyone a happy holiday season, just in case this is our last meeting of the year. And thank you all for your time and being with us today. It's a busy season for all of us, I'm sure, especially busy here at ONC. So, I appreciate you being with us today. We will have remarks from our national coordinator and our deputy national coordinator shortly. But I will, officially, call the meeting to order starting with roll call first. Carolyn Peterson?

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

I'm here.

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

Robert Wah?

**Robert Wah – DXC Technology – Co-Chair**

Present.

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

Michael Adcock? Not yet. Okay. Christina Caraballo?

**Christina Caraballo – Kizmet Health - Member**

Present.

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

Tina Esposito?

**Tina Esposito – Advocate Health Center - Member**

Present.

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

Cynthia Fisher?

**Cynthia Fisher – WaterRev, LLC - Member**

Present.

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

Brad Gescheider did indicate he would be absent today. Valerie Grey?

**Valerie Grey – New York eHealth Collaborative - Member**

Here.

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

Anil Jain?

**Anil Jain – IBM Watson Health - Member**

Here.

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

John Kansky?

**John Kansky – Indiana Health Information Exchange - Member**

Here.

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

Ken Kawamoto.

**Ken Kawamoto – University of Utah Health - Member**

Good morning.

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

Steven Lane?

**Steven Lane – Sutter Health - Member**

Here.

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

Leslie Lenert?

**Leslie Lenert – Medical University of South Carolina - Member**

Here.

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

Arien Malec also indicated he would be absent today. Denni McColm?

**Denni McColm – Citizens Memorial Healthcare - Member**

Present.

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

Clem McDonald?

**Clem McDonald – National Library of Medicine - Member**

Here.

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

Good morning. Aaron Miri?

**Aaron Miri – Imprivata - Member**

Good morning.

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

Brett Oliver?

**Brett Oliver – Baptist Health - Member**

Here.

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

Terry O'Malley?

**Terry O'Malley – Massachusetts General Hospital - Member**

Here.

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

Raj Ratwani?

**Raj Ratwani – MedStar Health - Member**

Here.

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

Steve Ready?

**Steve Ready – Norton Healthcare - Member**

Present.

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

Patrick Soon-Shiong?

**Patrick Soon-Shiong – NantHealth - Member**

Here.

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

Sasha TerMaat?

**Sasha TerMaat – Epic - Member**

Here.

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

Andy Truscott? Not yet. Okay. Sheryl Turney?

**Sheryl Turney – Anthem Blue Cross Blue Shield - Member**

Here.

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

Thank you. Denise Webb?

**Denise Webb – Marshfield Clinic Health System - Member**

Present.

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

Thank you. Kate Goodrich? Chesley Richards? Ram indicated he would be absent. And Lauren Thompson?

**Lauren Thompson – DOD/VA Interagency Program Office – Federal Representative**

I'm here.

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

Great. And for anybody here at ONC, Elise Anthony, John Flemming, John White, Don Rutger, and Steve Pattison. And with that, I will turn it over to our national coordinator, Dr. Rutger.

**Dr. Don Rutger**

Thanks, Lauren. First of all, thanks, everybody, for attending. I know it's a busy time. And your work is much appreciated. We've been busy as well. I think as folks know, the Cures Rule, the 21<sup>st</sup> Century Cures Rule is in the OMB clearance process. So, we hope to get that out relatively soon. I don't have a specific day. We're also moving along quite rapidly on the work around the trusted exchange framework and the common agreement. And once those are released, the trusted exchange framework we're putting out for another round of comment. And, obviously, that actually is, technically, not a rule but something called a framework. There are very specific definitions of all of these things. But we're putting it out for public comment as if it were a rule. And the open API specialty information block in the Cures Rule will, of course, in the regular order, go out for notice of public rule making comment.

We anticipate all kinds of comments there just because it really does change, I think, the landscape of how consumers can get their clinical information and interact with their clinical information and really

have new forms of giving care. In that, there are also some things to sync up the certification program to the concepts around open APIs. Some of you may want to go on mute. I don't know.

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

If we could have assistance muting some of the lines for background noise.

**Dr. Don Rutger**

Yeah. We have a bunch of noise. Thanks. Two recent events that you may have seen in the news, we recently, in the fourth, I believe, had an interoperability event at the White House. A number of people were convened by the White House to talk about things missing in interoperability. I think the takeaway there is that this is an area of national focus and of White House interest. FEMA spoke, Jared Kushner spoke, folks from the VA spoke. And I got to comment as well. Congress remains very interested in the 21<sup>st</sup> Century Cures Act. We've had a number of times, and for various reasons, mostly on the congressional side, it hadn't happened. But we had an oversight hearing of ONC's work on 21<sup>st</sup> Century Cures with the Health Subcommittee of Energy and Commerce. That was on Tuesday. I think they, basically, asked me questions for an hour and 45 minutes. So, if anybody wants to see that, it's online under energy and commerce.

So, you can Google that. It's a little bit dry. I don't think we met the total excitement standard for congressional hearings, thank goodness. But I think it does give you – I think the way to take that is there's a deep interest in this. And the members of congress, I think, had some very specific questions. We've had a number of discussions and questions from the staffers on this. They're very interested in HITAC. Giving advice will be in the report and just, in general, on interoperability. The privacy and security question that is Item No. 2 on the HITAC charge came up in probably half the questions, I would say. Security also, obviously, to the access part also, the third item, big concerns. So, those things are out there. The last few things I want to talk about, briefly, are under Cures, we're required, joint with CMS, to put out a report on the provider, mostly, to be truthful, physician burden. And we extended that actually to provider burden related to electronic health records.

That is out for public comment until January 28. And there is a lot of material in that report. So, if folks or the organizations that HITAC members represent, if there is anything, in general, you want to comment on in American healthcare, there's probably a hook in that report to do it. So, for example, it would be great, one of the things we're starting to look at, and we'll have more interaction with HITAC on this as well and the Interoperability Committee, I believe, is prior authorization. This is a big area. This is a very interesting area, in terms of what can be computed here. Things like CDS folks do that and up, there's a massive amount of stakeholder interest in this. So, folks have some thoughts there that they would like to put into public comment. And, again, just as an FYI, the public comments are visible to everybody. So, it is a way to do some messaging. The final thing, there is a provision in the Cures for an electronic health record reporting program.

Think of this as a consumer report. It was, originally, supposed to be – it was authorized to be budgeted at \$15 million. It turns out that didn't happen. But we are starting on that. We've engaged a contractor to start putting some comments. We had 77 responses on an RFI about how that should be done forward. And I think that is an area that's not the immediate top priority list of HITAC. But that may be something for you to think about. So, thanking everybody for their work here, I'd like to turn it over to John White, our Deputy National Coordinator.

**Dr. John White**

Thank you, Don. Hello, everybody. Good morning. Thank you for taking the time to be with us. I just want to offer a tip of the collective ONC hat to Dr. Rutger for his testimony to the house subcommittee. He did a very masterful job, rich and thorough discussion, with very good engagement from our legislative counterparts. So, cheers, boss. I want to be able to recap for you a little bit about the ONC annual meeting. ONC hosted its eighth, unbelievably, annual meeting last month. It was very well attended. This year's theme was highlighting progress and driving success. Our agenda was chock full of distinguished speakers, including Senators Alexander Baldwin and a number of other folks. There were some very good, enriched panel discussions and deep breakout sessions on a variety of topics, including interoperability, healthcare standards, such as fire, health information exchange, addressing the opioid crisis, application and proper interfaces, value based care, and a whole host of other topics. I know some of you were in attendance.

Thank you for those who participated in person. We had a cast of thousands online as well. So, great attendance all around. Our sessions, I believe, will be posted, if you want to be able to stream sessions, at a later date. We're vetting them to make sure that they're all cleaned up and tidy for you. But you should be able to come back and take a look at those sessions online later. We would love to hear any feedback, from those of you who attended, if you want. So, thanks to everybody at ONC for making the annual meeting such a success, particularly John Kaplan, our Director of Communications. I want to expand a little bit on Dr. Rutger's comments on the burden reduction report. On November 28, ONC and CMS released, for public comment, our draft strategy on reducing regulatory and administrative burden relating to the use of health IT and EHRs, as required by the 21<sup>st</sup> Century Cures Act.

Our effort was led by Dr. Andy Gettinger with strong efforts by Peter Karis and a team of ONC all-stars on our side, as well as our colleagues at CMS. Under the Cures Act, we were charged to establish a goal for burden reduction, to develop strategies to support that goal, and make recommendations to drive those strategies, with the specific call for recommendations that improve the clinical documentation experience, that improve patient care, that can be taken by the secretary and other entities, and can reduce the reporting burden required of healthcare providers. In the development of this draft strategy, ONC and CMS held a number of listening sessions, townhall meetings, and webinars to inform the report with a really rich tapestry of input from a wide variety of stakeholders. I know several of you were involved with those. So, thank you, again, for those of you who give us your input. The report is broken down into several key burden topics, including clinical documentation, quality reporting using EHRs, health IT usability and user experience, and public health reporting.

As Don said, the report is now out for public comment through January 28. If you don't want to comment on it yourselves, please consider your colleagues that you know who might have some useful feedback for us to send them the draft report, so they can give us their feedback as well. You all are wonderful experts in and of your own right. But you've got really rich networks that would give us really valuable input for attacking really what's one of our two top priorities in this administration. So, we encourage each of you to comment individually, if you wish, of course. You can find the report on [www.healthit.gov](http://www.healthit.gov). But we'll also send you the URL directly. And we do expect the final strategy report to be released in the spring of 2019, coming up soon. And we will, certainly, share the final report with you then. And that is all from me. Thank you for your attention. Back over to our co-chairs, Carolyn and Robert.

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

And before we transition to Carolyn and Robert, I think Elise had some remarks as well. Elise?

**Elise Anthony**

Yes. I just want to take a minute and thank everyone, again, as John said, for the work on the annual meeting, particularly the presenters and the staff for the breakout sessions. I think they were just a wonderful opportunity to hear perspectives, not only from ONC's side but also from those who attended. Lessons learned, opportunities for collaboration and coordination. So, thanks, again, to everybody who helped pull those together. I also wanted to provide a quick congratulations to several members who have been reappointed to the Federal Advisory Committee. As you know, the initial appointments were made on a staggered basis, which allows for there to be continuity, in terms of turnover of members over time. And several members were on one year appointments. Those members have now been reappointed by their respective appointing bodies for another three years. So, congratulations to Robert Wah who was reappointed by HHS, to Carolyn Peterson, Michael Adcock, Terry O'Malley, Sasha TerMaat, and Andy Truscott as well who were reappointed by GAL.

So, thank you, again. We look forward to all of the work that you will continue to do, as part of your participation in the FACA. And just a note that the reappointments are for three year terms. So, we'll be able to bug and bother you for a little while longer. Thank you so much.

**Dr. Don Rutger**

Yeah, thanks.

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

Thank you, Elise. And we will now turn it over to our co-chairs, Carolyn and Robert.

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

Good morning. Thanks, Lauren. I will review the agenda, and then, we will do approval of the October meeting minutes. This morning, we have three presentations. We have, first, Data Brief 42, electronic health record adaption, and interoperability among US skilled nursing facilities and home health agencies in 2017. That will be presented by Talicia Searsy, Data Analysis Bureau Chief at the Office of Technology at ONC. And Aaron Miri and I will present an update on the annual report work group's work so far. And that will be followed by an interoperability standards priorities task force update focusing on referrals and care coordination draft recommendations from Ken Kawamoto and Steven Lane. We'll have a period for public comment, and then, we will adjourn. And I'll pass the baton to Robert for review and approval of the October meeting minutes.

**Robert Wah – DXC Technology – Co-Chair**

Thank you, Carolyn. Good morning, everyone and happy holidays to everyone as well. You've had the meeting minutes from our October meeting distributed to you. And, at this point, I wasn't to ask if anybody has any additions, corrections, or comments on those minutes that were distributed. Hearing none, we'll now take a vote to approve the October meeting minutes. All those in favor, please say aye.

**All**

Aye.

**Robert Wah – DXC Technology – Co-Chair**

All those opposed? Any abstentions? With that, the meeting minutes are approved for our previous



meeting. Again, thanks to all who put together those minutes. They're high detail minutes, so I appreciate the level of work it takes to compile those. With that, I think we'll turn it back over to the presentation of Data Brief 42, is that correct?

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

That is correct. And so, we do have Talicia on the line, correct?

**Talicia Searsy – Office of Technology at ONC – Data Analysis Bureau Chief**

Correct.

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

Okay. It's all yours.

**Talicia Searsy – Office of Technology at ONC – Data Analysis Bureau Chief**

Wonderful. Good morning, everyone and happy holidays. So, again, my name is Talicia Searsy, and I am the branch chief for the data analysis branch in the Office of Technology at ONC. And today, I'm going to present new data on the use of EHRs, as well as interoperability, among skilled nursing facilities, as well as home health agencies. And so, do I have control of the slides?

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

Just ask us to advance. We'll control for you.

**Talicia Searsy – Office of Technology at ONC – Data Analysis Bureau Chief**

Okay. Great. So, if we could go to the first slide, excellent. So, one of the reasons why my team has been really focused on trying to understand how long term care and post-acute care providers are engaging in health IT adoption, as well as interoperability, is that they're a critical piece of the care continuum. In 2015, 49 percent of hospitals reported that they electronically sent summary of care records to long term care providers. However, in most recent data, we found that hospitals reported that there is still a major barrier in electronic exchange and the fact that their exchange partners lack the capability to receive data. So, they could send summary of care records out, but depending on who their partner is, they may not be able to receive that information either because they don't have an EHR or because their technology doesn't possess the capability to receive.

Also, there's recent legislation of the improving Medicare Post-Acute Care Transformation Act, say that 10 times fast or the Impact Act, that calls for reporting on measures related to transferring health information for skilled nursing facilities, inpatient rehab facilities, as well as long term care hospitals and home health agencies. Please keep in mind that LTPAC, or long term post-acute care providers, were not eligible to participate in the meaningful use program, nor are they going to be able to participate in the promoting interoperability program. Next slide. So, we partnered with IQ Via to develop a 10 question telephone survey. We filled it between September and November of 2017. And the survey was completed by 1,000 self-identified skilled nursing facilities, as well as 1,004 home health agencies. And these facilities were verified as skilled nursing as well as home health agencies using CMS data as well. Next slide.

So, what we found was that EHR adoption rates were higher among home health agencies compared to SNFs. In 2017, about 78 percent of home health agencies reported that they had an EHR compared to 66 percent of skilled nursing facilities. And so, there is a statistically significant difference between home health agencies and SNFs in that home health agencies have a higher rate of EHR adoption. Next slide.

So, what we asked ourselves was, okay, we see that there is adoption happening. How are these facilities actually using their electronic health records? And what we found was that a majority of home health agencies and SNFs use their EHRs for medication management purposes. Specifically, 98 percent of home health agencies reported that they use their EHRs to reconcile patient medications. And almost all reported that they use their EHR to record patient meds. Similarly, SNFs about 87 percent reported that they use their EHRs to record patient medications. And 83 percent reported that they use their EHR to reconcile patient meds. Next slide.

So, the main question that we asked ourselves was how are home health agencies and SNFs engaging in interoperable health information exchange. And the way that we define this is we have four domains. One is can you send electronically patient health information through an organization that is outside of your own. Can you receive information that is sent to you from an organization that is outside of your own electronically? Can you query, or can you find or search for information outside of your organization? And can you integrate external information received into your EHR? We also care about the extent to which facilities report that they have information electronically available from outside sources. And what we found was that home health agencies were more likely than SNFs to engage in each domain of interoperability. And, again, those domains are sending, receiving, finding, and integrating.

And about 50 percent of home health agencies reported that they can send information to sources outside of their own as well as receive information. About 36 percent reported that they can receive or integrate information received. And 41 percent reported that they can find information when searching for information outside of their organization. And about 55 percent of home health agencies reported that they have information electronically available from outside sources of the point of care compared to 48 percent of SNFs. Now, one thing that is important to note is that integration has, typically, lagged behind, not just for long term care providers but also for nonfederal acute care hospitals as well as office based physicians. So, that integration and query is something that we've been monitoring sometimes, in other settings, to see how those aspects of interoperability advance. Next slide. So, then, we wanted to know, okay, so we know that they have EHRs.

And we know that they're engaging in the four domains of interoperability. But what exactly are the other technologies that they may possess that might help to further their exchange of patient health information? So, we examined the extent to which they reported that they not only had an EHR but participated in health information exchange organization. Or if they have read only access, so they could read or view another facility's electronic health record to get information about their patients, but they can't modify that record. And so, what we found was about 32 percent of home health agencies reported that they use an EHR alone compared to 37 percent of SNFs. But when we looked at the number of facilities that use an EHR, a health information exchange organization, as well as have read only access, what we found was that about 20 percent of home health agencies reported that they have access to all three methods compared to 8 percent of SNFs.

Additionally, when we looked at who could have access to their EHR or provide read only access, we saw that about 19 percent of home health agencies reported that they have EHR and read only access compared to 17 percent of SNFs. Next slide, please. So, then, we wanted to know are those facilities that report that they have these different methods of exchange, are they more likely to be able to engage in the various domains of interoperability? And what we found is that SNFs that use an EHRs, HIOs, and had read only access were twice as likely to have clinical information from outside organizations electronically available than SNFs that only use an EHR. And so, I just ask for folks to focus on that last

row where it is EHR and HIO and read only access. And you can see home health agencies that can do all three; about 94 percent report that they have the ability to query or to search for information outside of their organization. Similarly, 74 percent of SNFs report that they can query.

And about 82 percent report that they can send. One thing that is interesting to see is that about 68 percent of SNFs that report that they can do all three reports that they have information available electronically from outside sources at the point of care. Next slide. Another thing that we were really interested in understanding is how home health agencies may leverage mobile technology to provide care. Keep in mind, home health agencies, their workers or providers are often on the move to see patients. And so, when we asked home health agencies, what we found was about 72 percent reported that they use mobile technology during patient visits. And by mobile technology, we mean smart phones, tablets and that kind of thing. And of those that reported yes, 85 percent reported that they can use that mobile technology to directly enter data into their EHR. Next slide. We also asked about telehealth capability. Again, keeping in mind that, in the home health realm, a number of folks are moving around, and they may be remotely engaging with their patients.

And what we found was about four out of ten home health agencies use telehealth technology to keep track of patients' health between in person visits. It's also important to keep in mind that there were no differences between home health agencies that perhaps were in rural or urban or were private or government or nonprofit entities. So, the use of telehealth did not vary, based on those characteristics. Next slide. So, in summary, EHR use is common among home health agencies and SNFs, with a majority in both categories reporting that they have an EHR. Home health agencies and SNFs most commonly use their EHR to exchange health information. Those facilities that use health information exchange organizations and had read only access in addition to their EHRs were more likely to have information electronically available at the point of care than those that use an EHR alone. One-quarter of home health agencies and one-third of SNFs did not use EHRs or other tools to enable electronic health information exchange.

And nearly 40 percent of home health agencies use telehealth technology to keep track of patients' health between in person visits. And three out of four home health agencies use mobile technology to collect patient data during visits. Last slide. I'm happy to take any questions that you may have. Also, our team is finalizing lots of analysis related to nonfederal acute care hospitals. And we would like to come back and share those results with you as well. So, I'm happy to answer any questions that you may have about this presentation.

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

All right. Thanks so much, Talicia. For the committee members, we do have a few minutes for questions.

**Leslie Lenert – Medical University of South Carolina - Member**

I have a question. This is Leslie Lenert. Were these results surprising to you? And what do you think that the implications of the results are?

**Talicia Searsy – Office of Technology at ONC – Data Analysis Bureau Chief**

So, we were a little surprised. Last year, we completed a similar survey just for the skilled nursing facilities and had somewhat similar results, in terms of EHR adoption rates. However, for the home health agencies, this was our first time collecting data on them. And to see how much more they leverage health IT was a little surprising. I wasn't exactly sure. I thought that it would be a little bit more comparable to the SNFs and not necessarily exceed them. One of the key takeaways, at least that I have,

is the importance of having a business case for the use of health IT and interoperability. For home health agencies, it's clear. The providers are on the move. They are going from patient to patient. So, having mobile technology, being able to electronically exchange, would make sense because there's a clear use case for it.

But I do think that it would behoove us to do a little bit more of a deeper dive to really try to understand a little bit more about how long term post-acute care providers are leveraging technology and what are some of the barriers that they're experiencing to exchange.

**John Kansky – Indiana Health Information Exchange - Member**

This is John Kansky. In the broader healthcare market, not specific to LTPAC, I'll admit that I hold the opinion that we talk about using multiple ways to access data from outside of an organization, kind of an and not or approach, meaning that the EHR vendors offer certain capabilities. HIEs or HIOs offer certain capabilities, etc. And it's interesting. This data seems to support the idea that whether we like it or not because it is a little messier, and it's not particularly elegant. But when an organization is using multiple ways to access the data, they're, ultimately, successful I accessing more data or more organizations have access to that data. Is that your observation as well?

**Talicia Searsy – Office of Technology at ONC – Data Analysis Bureau Chief**

Yes. And we're seeing something similar. We are really seeing a data brief very soon looking at nonfederal acute care hospitals and the methods that they're using to exchange, including participating in national health information exchange networks. And we're seeing something similar. Those that participate in POs as well as have an EHR, or maybe they're participating in multiple networks are in a better position to be able to be interoperable or have the information that they need. So, we are seeing that, in some other settings as well.

**John Kansky – Indiana Health Information Exchange - Member**

Thank you.

**Denise Webb – Marshfield Clinic Health System - Member**

Hi, this is Denise Webb. I have a quick question. On the 1,000 SNFs and 1,004 home health agencies that responded, do you have an idea about what percentage of the total number of skilled nursing facilities and home health agencies that represented? Maybe you said, and I missed it.

**Talicia Searsy – Office of Technology at ONC – Data Analysis Bureau Chief**

Hold on one second. I had it. I'm so sorry. I had it pulled up. Give me one second.

**Denise Webb – Marshfield Clinic Health System - Member**

That kind of gives perspective.

**Talicia Searsy – Office of Technology at ONC – Data Analysis Bureau Chief**

Yes. It's about, and I'll triple check my numbers, it's about one percent in each category. There's about, I think, the last data I see is that there's about 12,000 home health and I would say about 15,000 or so skilled nursing facilities. I would need to triple check that. But I can say that, based on the calculations that we've done, and looking at the CMS data as well, our results are generalizable to the population. I can double check on the denominator for you.

**Christina Caraballo – Kizmet Health - Member**

Hi, this is Christina. Thank you for the presentation, first. And then, looking at the data, there is a significantly higher interoperability percentage for those that are actually using the HIOs. Do we understand why the HIOs aren't being used for SNFs and home health agencies? Is it a business case? Is it a lack of availability?

**Talicia Searsy – Office of Technology at ONC – Data Analysis Bureau Chief**

Unfortunately, in this survey, we were limited to 10 questions. So, we weren't able to do a deeper dive into some of these questions that definitely make sense for us to better understand. One of the things that we are doing, in trying to understand how health information exchange organizations are operating and who is their client base, we are in partnership with Julia Atler-Middlestein in developing a survey of health information exchange organizations. And we are also, funding available, interested in the future and building on these surveys to try to ask a few more questions that could kind of help us to better understand various aspects of use and what some of the limitations of use might be.

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

This is Lauren. I just want to acknowledge we do have a couple of members in the cue with their hands up. Steven and Michael. So, why don't we go to Steven and Michael perhaps maybe for our last couple of questions?

**Steven Lane – Sutter Health - Member**

This is Steven Lane. Again, thank you so much for the presentation. I know that your focus is really on evaluating the sector and presenting the data. So, maybe this is a question for some of the other folks who are on from the ONC. But what plans do we have to try to close this gap that we can now see in the skilled nursing area where we've always known that there's been a gap there compared to providers and hospitals. But now, we even see this gap compared to home health agencies that, presumably, work really pretty much in the same spheres. What are our plans for trying to help them along?

**Talicia Searsy – Office of Technology at ONC – Data Analysis Bureau Chief**

I defer to my colleagues that are on the line. But I do know that the Impact Act is really going to – although there may not be resources devoted to it, there may be definitely a driver there to help increase interoperable exchange amongst LTPACs. The act requires CMS to make an interoperable standardized patient assessment and quality measure data and data on resource use and other measures. So, there's definitely some movement that CMS is leading to try to at least, through implementing the Impact Act, I think, there may be some implications, in terms of advancing interoperability amongst LTPACs as a result. But, again, I defer to others on the call from ONC or CMS who might shed some additional light on that.

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

Talicia, maybe we can circle back for any additional information from the ONC side on that question. And, Michael, did you have a question? Are you on mute or did we lose connection with Michael? Okay. We'll see if we can get Michael back on the line. With that, any other comments or questions before we conclude this portion of the agenda? Okay. With that, Talicia, we want to thank you for your time today and look forward to hearing from you again in the future.

**Talicia Searsy – Office of Technology at ONC – Data Analysis Bureau Chief**

Thank you all so much.

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

Thank you. And with that, we will now turn to a report from Carolyn and Aaron on the HITAC annual report that is quickly approaching us. Aaron and Carolyn, you have the floor.

**Aaron Miri – Imprivata - Member**

Thank you and good morning. Once again, I want to wish everybody a happy holiday season. And I really appreciate the opportunity to present this morning to the HITAC to walk through some of the items that we have identified for us to talk through as a larger group and to really consider and work through, in our thought processes. As we've been saying, in our previous presentations to the HITAC, this is a work in progress. So, this is definitely a lot of draft items that we want to talk through with you all and really get feedback on. I also want to take a second and really acknowledge the phenomenal work by the ONC team that, behind the scenes, have just done a Herculean job and an amazing quality effort, which I'm sure you all will appreciate. Carolyn, any comments that you want to add?

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

No. I appreciate the opportunity to update the full HITAC on our work and look forward to answering your questions.

**Aaron Miri – Imprivata - Member**

Fantastic. Okay. Let's go on to our next slide, please. So, I'm going to, again, introduce this topic and the item that we have to present to you. And Carolyn and I will fill in the details here. So, our annual report work group update, we're obviously going to go through what is going on now. So, where are we with the development cycle? Sort of the outline of the section on our HITAC progress. And then, as the insights from a deeper dive on the privacy and security target area. And then, work through what our next items are. Next slide. These are the folks that are participatory on this work group. And, again, I give a lot of credit to the individuals from the federal side. The ONC team have just done an amazing job. Next slide. So, our scope. This work group was to inform, contribute, and review the draft and final versions of the HITAC annual report to be submitted to the secretary and congress each year.

As part of that report, the work group will track the ongoing HITAC progress in detail. We're supposed to be providing specific feedback on the content of the report as required by 21<sup>st</sup> Century Cures Act, including an analysis of our HITAC progress related to the priority target areas, the assessment of health IT infrastructure and advancements in the priority target areas, analysis of the existing gaps and policies and resources for the priority target areas. And last but not least, ideas for potential HITAC activities to address any of the identified gaps. All right. That's sort of the update of where we are with things. Next slide. So, from an outline perspective, we're going to go through and just do sort of the summary here, overview. This is sort of the HITAC progress in FY '18, what did we accomplish, which is pretty numerous. What does their health IT infrastructure landscape analysis look like? Where we are with things from the gap analysis, which was presented to you before.

And they were initially presented as recommendations on addressing some of those health IT infrastructure gaps. But also, really what we want to focus on today with you all is looking at that and taking the feedback we learned in October and really synthesizing that out for additional comment to you all. And then, for additional HITAC activity, we really haven't identified anything for FY '18, obviously, since it's really coming close now to the end. But there are items there that we really want to

talk through going forward. Next slide. All right. So, sort of the outline of the section on the HITAC progress. Next slide. So, from a trusted exchange framework task force, the overarching charge was for the trusted exchange framework to develop an advanced recommendation on Part A and Part B of the draft TEF to form the development of the final TEF framework and common agreement to TECCA.

Our specific charge was to make specific recommendations of language included in the minimum required terms and conditions in Part B, including recognized coordinating entity, the definitions, and requirements of a qualified QHIN, permitted use and disclosures, and, of course, privacy and security. And some accomplishments in FY '18, we held nine public meetings of the task force and transmitted 26 recommendations to the National Coordinator for Health IT. Next slide. From the USCDI task force, the overarching charge was to review and provide feedback on the USCDI structure and progress. A specific charge was to provide recommendations on the following. Mechanisms and approach to receive stakeholder feedback regarding data class priorities, proposed categories to which data classes would be promoted and objective characteristics for promotion, how the USCDI would be expanded and by how much, and any factors associated with the frequency with which it would be published. From an accomplishments perspective, we held nine public meetings of the task force, and we transmitted nine recommendations to the National Coordinator for Health IT. Next slide.

From the interoperability status priorities task force, our overarching charge was to make recommendations on priority uses of health IT and the associated standards and implementation specifications as supports such uses. Our specific charge was the ISP task force will make recommendations on the following. Priority uses of health IT consistent with the Cures Act, the standards and implementations specifications that best support and may need to be developed for each identified priority, and subsequent steps for industry and government action, and thus, publish a report summarizing its findings. Our accomplishments in FY '18. We held six public meetings of the task force. We produced an initial list of priority uses for further discussion. Next slide. On the policy framework, the 21<sup>st</sup> Century Cures Act states that, in general, the health IT advisory committee shall recommend to the national coordinator a policy framework for adoption by the secretary consistent with a strategic plan, under Section 3001 for advancing the target area described in the subsection.

Each policy framework shall seek to prioritize achieving advancements in the target areas specified in Sub Paragraph B of Paragraph 2, and may, to the extent of this section, incorporate policy recommendations made by the health IT policy committee as the existence before the date of the enactment of the 21<sup>st</sup> Century Cures Act. So, what did we do in FY '18? The HITAC transmitted a recommend policy framework to the ONC for activities to national coordinator for health IT. Next slide. So, the HITAC annual work group. This presentation, what we've been working on, the HITAC formed a work group to inform, contribute, and review the draft and final versions of the HITAC annual report to be submitted to the HHS secretary in congress each fiscal year. As part of that, we will help track the ongoing HITAC progress, which consists of five HITAC members, two of whom serve as work group co-chairs. Our accomplishments this year, we established the scope of the work group's activities in support of the development of the FY '18 annual report. We held three public meetings of the work group.

And we're updating the HITAC full committee on the progress that was started on 9/5 and continues even to today. Next slide. So, our discussion question for HITAC members for this section. Are there any questions and comments about the draft section and the HITAC progress and what we've accomplished year? And did we incidentally or accidentally leave out any important areas that you feel that we definitely need to highlight on? So, I'll pause there and ask for that feedback. All right. Barring no

feedback, Lauren, I'm going to move on to the next section then. Next slide. And this is where I'll turn to Carolyn to pick it up.

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

Thanks, Aaron, for that very succinct and clear review of where we've been. So, one of the things that the work group was interested in doing was getting kind of a deeper dive into the privacy and security priority target area. I think we've all been hearing in the news about a lot of breaches and issues with social media platforms sharing information in ways that people didn't expect and so forth. We thought it would be relevant to get a closer look at some of the potential issues specific to healthcare. And to do that, we convened some experts to come and share with us their insight. Next slide, please. So, we had these experts at our meeting last month on the ninth. Specifically, we had experts from the National Committee on Vital and Health Statistics presenting on health information privacy beyond HIPAA. We had someone from the National Institute of Standards and Technology presenting on their cyber security framework.

And we had a presentation from the HHS Office for Civil Rights on cyber security tools. And then, we convened and discussed these presentations within the work group at a meeting last week on December 4. Next slide, please. We've identified several opportunities for future action next year and perhaps beyond within the work group. I'll be sharing those with you today. And we'll be looking for some feedback on things that we would like to see in the annual report and perhaps other actions and opportunities for future activity. We solved a couple of really important opportunities. First, to consider what to regulate about the internet of things. From the NCVHS report, we have a problem that the internet of things turns data that was previously mostly static. And today, it is in motion most of the time. There are no governance structures or policies or frameworks or agreements or legal boundaries or anything that's around this data in motion.

From that, we take, as a suggested HITAC activity, to identify areas of the internet of things use that would benefit from guidance and examples of success in the healthcare industry. We also note support for the education of technology users regarding privacy and security protection, including for health and other information shared on social media. Here, the problem is that, while social media platforms can enable collaboration, users also are vulnerable to privacy breaches and misuse of health information. So, our suggested HITAC activity is to identify educational approaches, technological mitigators, and potential regulatory solutions that offer improved privacy and security protections. Next slide, please. We've also identified a number of other opportunities. Increased uniformity of information sharing policies across states. For example, we can look at the implications of the California Consumer Privacy Act of 2018. In that area, we might consider looking at the federal rule and setting guidelines for the exchange of data across states.

Another opportunity would be support for widespread adaption of cyber security frameworks. Here, there are a couple of suggested activities to consider the impact of the nationwide adoption of cyber security frameworks. And also, to delineate some cyber security accountability for data by rule. Next slide, please. Another opportunity would be granular levels of consent to share and disclose information. The current situation is that consent form collection and storage practices are static and not aligned with this data in motion, in the sense that the consent doesn't flow with the data. The design and use of consent forms need to become more user centered. A suggested HITAC activity here would be to undertake a review of emerging consent approaches and the technologies that underpin them and make recommendations for the improvement of current consent approaches. Next slide, please.



Some other opportunities that the work group has identified would be to address the implications of the European Union's general data protection regulation and privacy shield, education about HIPAA and confidentiality of substance use disorder patient records, that's 42CFR Part 2, the implications of these regulations, and to continue to improve patient matching when data is being shared. Next slide, please. So, our discussion question here is what other suggested HITAC activities that you would like to bring forward or have us to include in the annual report for this privacy and security target area. And Robert, I'll ask you to acknowledge the question.

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

We may have lost Robert on the audio. But I do see that Sasha has her hand up.

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

Please go ahead.

**Sasha TerMaat – Epic - Member**

Hi, this is Sasha. So, I noticed that, just this week, there's actually a request for information out about potential revisions to HIPAA, which seems to align nicely with some of the privacy target areas that you mentioned, Carolyn, including confusion about what HIPAA currently permits or areas where there might be restrictions that haven't evolved with the capabilities over time that healthcare providers and patients would like to take advantage of. Would that be an opportunity for the committee or a sub group of the committee to review and consider offering recommendations?

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

Yes. I saw that announcement come out yesterday because of some guidelines around federal reporting and making information available ahead of meetings. We were not able to go in and update the slides because of the time situation there. But absolutely that is something that the group could undertake. We would need to make that an activity taking place at the January meeting, I believe, because I'm thinking the deadline for submitting comments is sometime in February.

**Sasha TerMaat – Epic - Member**

February 11.

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

Yeah. I was going to say, I don't have that announcement right in front of me. But it's something we would need to do quite quickly. But, certainly, if that's something that HITAC is interested in, Robert and I can work with Lauren and the ONC team to ensure that that's on the January agenda.

**Aaron Miri – Imprivata - Member**

Yeah, this is Aaron. I think that's a phenomenal idea. And I appreciate that. And something as a thematic item in this report you'll see is that we always try to encourage us to weigh in and work in with our other federal agency partners. So, I think it's a great tip of the hat to that, as well as an activity that is important. So, good idea.

**Robert Wah – DXC Technology – Co-Chair**

Thanks. Next, I think we have Valerie's hand up.

**Valerie Grey – New York eHealth Collaborative - Member**

Good morning. Thank you. This is not exactly a question. Really more just I want to commend the work group for identifying privacy and security as a priority target area. I strongly support doing some more work on increasing uniformity across states for sharing. I think that's one of the biggest challenges in TEFCAs. And I would love to see us try and do more to promote cross state exchange. And I strongly believe, too, that it would behoove us to do more work on Park 2. I know that's been a debate that's raged for many years. But I think it's extremely important. So, I just wanted to weigh in. And I think Sasha's idea on the RFI that just came out relating to HIPAA is another area to weigh in on. So, I strongly support expending some energy here. So, thank you so much.

**Robert Wah – DXC Technology – Co-Chair**

Thanks. Denise Webb, you have your hand up.

**Denise Webb – Marshfield Clinic Health System - Member**

Yes, thank you. I was just going to suggest, and this relates to the area of identifying areas of the internet of things used that would benefit from guidance. And, actually, I think that kind of dovetails into the changes for HIPAA as well. But I think it's going to be really important for us to identify groups that are working on these topics to present and to partner with to formulate our recommendations. And one group I was thinking of was the Caring Alliance, which has the involvement of the former national coordinators and quite a few people across the stakeholder groups and the health IT industry. And I know they've been doing a lot of work on a trust framework, particularly, around the use of apps by consumers and consumer directed exchange.

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

Thanks, Denise. I recall seeing something released about their work quite recently, maybe in the last three to four weeks. It's certainly something that we can take into account as we prepare the annual report and also keep on the list of things to look at for 2019.

**Denise Webb – Marshfield Clinic Health System - Member**

Yeah. And they also did a project, I can't remember the group they did it with, around consent, automated consent.

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

Great. I'm making a note of that for the report. Thank you.

**Robert Wah – DXC Technology – Co-Chair**

Next, we have Terry O'Malley.

**Terry O'Malley – Massachusetts General Hospital - Member**

Hi. I would, too, like to commend the group for targeting privacy and security. And I think you've selected some excellent targets. And I was just wondering if you would focus more in on unique patient identification because I think the interdependencies with that and consent and authorized use and how that all sits under TEFCAs becomes sort of the keystone, in my mind, of those relationships. And so, is there any way to find out some more thinking about how we could end up with an effect on the national registry or patient identification, even though it's not a national registry, whether it's a combination of local registries somehow governed? But I think we need to get to some sort of unique patient identifier that's available across all settings. And I just wonder about more work in that corner of the world. Thanks.

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

I'm adding that to the list of topics to explore and try to at least mention, in the annual report, if not have a broader presentation. Thank you for that. It's certainly relevant to some of the other issues that we've brought up as possible areas for activity.

**Robert Wah – DXC Technology – Co-Chair**

Good. Thanks. I think the last question is from Ken Kawamoto.

**Ken Kawamoto – University of Utah Health - Member**

Great. Thank you. So, one area that I'd suggest is around the new technologies around FHIR and things like Smart on FHIR CDS Hooks. And the way those technologies work, right now, access is very broad based. So, the way it's set up is, if you want any information about the patient's demographics, say the patient's gender or how old they are, it's all or nothing where just to share that, you need to share things like their name, all of the email addresses you have on file, all of their phone numbers you have on file, where they live, what their marital status is, that kind of thing. And I think that's a place to look at. I think it's along the lines of there was a recommendation around more granular consents. It's the notion of only sharing what's reasonable to share, in a given context. And then, it's related to things like if you have something that needs to track someone's weight, the current standards are such that, in order to give a third party app vendor access to the patient's weight, you also need to give it access to the patient's sexually transmitted disease results, things like that.

So, I think there are ways to potentially resolve this. And I think the recommendation would be to add a few things. One is in the area where there was the notion of saying hey, let's have better education of consumers. So, it was in the context of social media kind of use. But especially with the apps that patients are going to be getting, I think it would be useful to look at how to improve the education patients get on the current state of the technology so that, instead of saying, for example, do you consent to give me access to demographics with perhaps limited information to say, well, what you're actually consenting to is that where you live and your email address and your work phone number, if you listed it with your provider, and whether you're married or single or divorced, etc., that will be shared. And observations is a similar kind of thing to see. Any kind of lab that your systems may have will be shared with this provider and that kind of thing.

And then, one is education with folks. Another is seeing if there are ways that we can tighten this up technology wise. For example, by using FHIR profiles, we can say, if you actually don't need to know all of that, all you need is usually the date of birth and gender. We can use the profile to say that is all that will be shared. And I think, thirdly, getting in touch with NCVHS and getting some guidance on what we can do to make sure that we're compliant with current HIPAA or updated HIPAA. I think it's a solvable problem, but it's something that's probably not going to just happen on its own.

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

Those are great suggestions, Ken. Thanks for bringing those forward. I made some notes. And I may follow up with you offline just to be sure I'm clear about specifically what you're referring to, so we can ensure we get that into the report correctly.

**Ken Kawamoto – University of Utah Health - Member**

Thanks.

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

Thank you.

**Robert Wah – DXC Technology – Co-Chair**

Great. Any other comments, questions, suggestions for the committee? All right. Aaron and Carolyn, thank you very much for this great work and to all of your committee for all of the efforts put forward on this issue. As we've noted before, the work groups and the committees are where most of the work of this committee gets done. So, thank you all for your time and efforts, in that regard.

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

Great. Thanks, Robert. We do have a couple of slides to follow that just quickly summarize the remaining meetings and activities around the report. Obviously, we can transition. So, next up, the work group is already working on the draft report, which we will be continuing to review and edit over the holidays. We will be sharing that draft report with a full HITAC in January. We will have a full committee review report and suggest edits of that. And then, the full HITAC will approve the revised report. HITAC will then move that final report to the national coordinator who will bring that to the HHS secretary in congress. Next slide, please. So, for the work group, we are working on the report right now. And then, we'll meet to discuss it on January 10. That is a public meeting. So, there will be an opportunity for any of you who want to listen in to participate. We encourage that.

Then, through the winter and into the spring, we'll do whatever other work is needed requested by ONC. And then, later in the spring, we will start on the fiscal year '19 report. Next slide, please. So, the review schedule for the full committee will be that in January and our in person meeting in Washington DC. We will have that review of the annual report. And then, in February, we'll review and approve the revised draft of that report, the revisions being what came out of the January meeting. And then, later, we will submit that to HHS secretary and to congress. Next slide, please. So, I know we're a little bit behind on time. But if there are any other procedural questions about what we're doing or HITAC's role, I'm happy to address those now.

**Robert Wah – DXC Technology – Co-Chair**

Carolyn, I think Clem has his hand up as well.

**Clem McDonald – National Library of Medicine - Member**

Yes. Well, I didn't ask a question in the last round because I thought it was constrained to privacy and security. But if this is a big report, we still haven't gotten back to what additional observations or variables are we going to encourage to be part of what's required to be delivered. And one of my pet ones is x-ray reports. And is that going to ever happen that we will – we started all of the meetings with that, and we didn't really come to conclusions, I don't think.

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

We will, certainly, review the draft with an eye toward where we can be sure that that's included. I'm not sure that it fits in specifically with the privacy and security today.

**Clem McDonald – National Library of Medicine - Member**

No, no, it doesn't. That's why I didn't –

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

But yes, as we've gone along, we've been taking notes as has the ONC annual report team that's helping

us pull this together. And we do want to be sure that we include feedback.

**Clem McDonald – National Library of Medicine - Member**

Okay. Thank you.

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

Yeah.

**Robert Wah – DXC Technology – Co-Chair**

Other questions and comments for Carolyn and Aaron? Again, thank you for your work. I think, at this point, we'll switch over to the next topic, which is the interoperability standards and priorities task force. And we'll turn it over to the two co-chairs, Ken and Steven.

**Ken Kawamoto – University of Utah Health - Member**

Great. Thank you very much. So, I'll get us started. This task force has been pretty active and busy. Since our last update, we've been focusing on closed loop referrals and care coordination and have been discussing the draft recommendations. So, what we'd like to do today is to update folks on our draft recommendations, in this area, and spend most of the time on that and getting feedback. And then, we'd like to give a recap of orders and results, in terms of our previous recommendations. And we've had a few additional recommendations come forward from task force members. So, we'd like to review those as well. Next slide, please. Okay. Since October, we've had five meetings on this topic. And we've gotten a lot of presentations from a number of experts, including Brett Andriesen from ONC, Louis Moss from the Direct Project, Matt Menning from the American Medical Association, and Brett McHart from the Wave One Associations.

And what we were really trying to do is to get a better understanding of what are the current and being worked on and potential future standards associated with this topic on closed loop referral and care coordination. And as I noted in subsequent discussions, we also identified two additional priorities for the orders and results topic, which we presented to this group in October and which we'd like to go over. Next slide, please. So, similar to what we did with the orders and results, we tiered the recommendations. And this is just a draft. So, we'd like folks' input from the full HITAC. And these are the top level descriptions of what we, as a task force, came up with, in terms of Priority 1 and Priority 2 recommendations. I won't go into these, as Steven will be going into each of these in detail. But we, basically, have both specific to closed loop referrals, and we also came across some cross cutting recommendations as well. Next slide, please.

And these are some of the additional general observations. We'll go into this in further detail as well a little bit later. But, essentially, as we came into the second topic of focus, moving from orders and results to referral and care coordination, we found a number of issues that seemed that they were cross cutting across use cases and clinical priorities. These included the similarity of requirements often between these areas, the need to consider a wide variety of use cases, including transitions of care, not just referrals, such as across outpatient ED and LTPAC transfers. The cost and complexity associated with having what we call custom interoperability solutions or solutions that are use case specific. And where there might be potentially some benefits to be gained from using a common approach across use cases.

And the notion that, when there's no clear, single best approach to interoperability in an area, there is a desire to do some harmonization to avoid having support from multiple approaches. Next slide. Steven, back to you.

### **Steven Lane – Sutter Health - Member**

Yeah. Thank you so much, Ken. And thank you to the entire HITAC for the opportunity to come and present this work. We did not include, at the beginning of our deck, a listing of all of our members. But I really want to take a moment just to acknowledge all of the work that people have been doing. We've had great participation. Our task force has 22 members, 16 of whom hail from the HITAC itself. But we have six additional members that really round out the representation and, I think, bring additional voices to the table. We have representation from large IT companies like Google and Apple. We have Cerner, which is, obviously, an important, large EHR vendor represented. And then, also, we have a clinical practice with a home grown EHR, one medical group, which I think really brings a unique perspective to our discussions, as well as a healthcare data quality solutions provider, clinical architecture represented.

So, it's a group with a lot of voices. And there's been great engagement that's contributed to these recommendations. So, I just wanted to acknowledge that. And thank you, Ken, for setting this up. What I'm going to do is go through, in a bit more detail, the observations that we've made and the recommendations that have come out of them. And then, some acknowledgement of where we see that there may be policy levers that could be pulled to try to implement some of these recommendations. So, the first major area was really what we started on, which was that closed loop referrals and the communications that support them are really challenging, in our current interoperability landscape. And we are aware of the good work that's been done on the 360X project. We have all seen demonstrations, or at least there have been great demonstrations, of this at ONC meetings.

We were able to learn from the key architects of that project where they are, which is really ready to start piloting that, as well as some of their observations about where they think this needs to go. So, we do feel that it's important for the ONC to encourage and support pilots of that project, to look at that across a number of different settings, and using different technology solutions. And then, there were also, clearly, opportunities to evolve and enhance that approach. And we looked at some specific areas. Expansion of the use cases. Initially, it's really designed to support fairly straight forward ambulatory referrals. But clearly, the same methodology can support referrals in and out of acute care, LTPAC, home care, etc. Also, there are opportunities to use the basic technology of solutions and architecture to support prior authorization, which is often a key part of the referral process.

And as part of that, the need to support the transmission of insurance information as that is important for prior auth and also for supporting real time scheduling. One of the key components of 360X is that it requires patient identity management. And this is an area that we feel that the ONC should continue to support, as this is important for the referrals to be tracked all the way through to completion and the closing of that loop. One of the challenges that we identified, as we went through this, is that there are, as Ken suggested, multiple solutions sometimes to some of the problems that need to be solved, as the technologies are rolled out. One of the key points that we identified, in looking at referrals and care coordination, was the need for message context. And there are a number of different groups that have worked on this. And there are multiple solutions out there. And we do feel that these need to be harmonized or that there needs to be an acknowledgement that there are multiple ways to do something.

And those need to be supported. We also, and you'll see this as a motif through all of this, we're all living in a time where we have established methodologies for exchange using documents, while FHIR is fast evolving into this work space. So, we do feel that there are FHIR based approaches that can provide

the functionality that is called for in the 360X and that is required for closed loop referrals. And we feel that those should be supported and that pilots should be done, including the FHIR based argonaut scheduling protocols. Next slide, please. So, some of the policy actions, as mentioned, that would be support for 360X pilots, support for the FHIR based efforts to address these closed loop referral and care coordination messaging needs and to include defined baseline closes loop referral capabilities as requirements for certification. Our group is very sensitive about requiring technologies for certification.

But we really feel that the functionality and the capabilities that are needed to support referrals and care coordination are critical, while, as Ken mentioned, sometimes, it's hard to know what is the exact right technology, at a given time. We also feel that CMS has an opportunity to align their programs to support these closed loop referral processes, as they become more doable within the technology solutions that are available. Next slide, please. So, the next item that we focused on, and we took a pretty deep dive into this, is the acknowledgement that there are no standards now for the clinical and administrative data that should be collected prior to referring a patient from one point of area to another, from a referring provider to a consulting provider. And we felt strongly that it would be valuable for work to be done in this area, a collaboration likely between multiple groups that could lead to evolving standards of what information is required or is recommended prior to referring a patient.

That this could streamline the process, lower costs, improve quality, and make it more satisfying for both the patients and their clinicians. And we see this as ideally being developed on a specialty by specialty basis and, within each specialty, looking at, first, the most common reasons for referral. So, we reached out to a number of folks, including the folks at the AMA in their integrated health model initiative looking to see what might be the appropriate home for this work. We identified a number of groups that might have a stake in this. And we would hope that the ONC would help to convene those groups and move this kind of work forward. Next slide. So, here again, there's a recommendation to convene stakeholders to look at this with exemplars in both the CCDA and FHIR, how to move this information that's necessary to support referrals, and to include best practice guidance for how this data is going to be displayed between systems.

Here again, we thought there was an opportunity to align the clinical referral processes with work that we all anticipate being done on the USCDI and how to get the relevant profiles of USCDI, that is to say, the content that's called for in USCDI, to be sent as part of the clinical referral workflows. Next slide. Going on, we had a number of additional recommendations that we felt were really a top priority. One was the support of clinician to clinician patient specific messaging. This is available today using the direct protocol. But it's really not well utilized in the community of clinicians. It hasn't been adopted consistently across IT systems or across organizations. And we felt this should be supported and incentivized. We also looked into how FHIR based approaches could be leveraged to support this functionality. Here again, separating out the functionality that we think is important from the specific technology standards that allow it. But that's an important area.

Provider directories are, obviously, critical to supporting this kind of messaging. And we acknowledge that a lot of work has already gone on in supporting provider directories. But this really needs to continue so that any clinician can find other clinicians, find their address, the direct address, etc. so that this communication of referrals and care coordination messaging can continue across organizations. We did speak of the requirement for governance in this area and the potential role of the TEFCA. We made reference back to the recommendations of the TEFCA task force, which did specifically call out that the trusted exchange framework should establish a floor capability for the on ramp provided by QHINs to be for all forms of EHI exchange, including but not limited to query based exchange and push based

exchange models. So, this notion of including push based exchange in the TEFCA has been discussed by prior task forces.

And our task force also felt that would be very helpful. Next slide. In terms of the second order priorities,

we did speak of the desirability and really the importance of automatically incorporating relevant information into patients' EHRs that, today, we know that so many referrals and so much care coordination messaging are occurring using the fax machine. We're all aware of the desirability of a part of CMS and now whole other countries who are doing away with the fax machine. But clearly, it's important that this messaging be implemented in a way that it allows discrete data to move between systems. We also dug in a bit to the area of patient clinician messaging, acknowledging the fact that today, this is mostly done inside of EHR tethered patient portals. But there is a lot of work being done by personal health record developers. And there is work being done looking at how patient/clinician secured messaging could be supported using the direct protocol and potentially even using FHIR.

And we've heard, from patients, that they want to have a flexibility in choosing the apps that they want to use to communicate with providers, as well as being able to manage all of those communications in a similar way, as opposed to having to jump between portals to communicate with different members of their healthcare team. But we also acknowledge that it is important that these solutions be integrated with established EHR workflows for clinicians, in order for them to really be scalable. We can't just ask clinicians to take on a whole new workflow for each method of communication. So, there's clearly work to be done here, but we felt that this was important to support care coordination generally. Next slide. All right. A couple more of what we saw as second level priorities. One is the notion of a patient centric multi stakeholder, multi institutional care plan.

Clearly, if you're talking about coordinating care, one of the real challenges is having a care plan that everyone can see, that folks can appropriately contribute to, and that can be iterated over time. Some work has been done, in this area, in both the FHIR and the CCDa realm. But we feel that these need to be supported and advanced and that there are key items that belong in that care plan, such as the patient, caregiver, and family goals that need to be included. And then, the last area that the less technology that we considered in the area of care coordination was real time text messaging where this is being done increasingly in hospitals but with the care teams there. But also, there are use cases for using this real time messaging in other settings, in the ambulatory setting. And so far, this has been largely untethered to EHR workflows. The information is not consistently documented. And we felt that, for care coordination to really move forward, this should be considered as well.

The next slide makes reference to a policy action that could support Priority 2C regarding the multi institutional care plan really feeling that there is a need for additional research and development, in this area, and that there need to be standards developed and tested so that this can be used again in a way that it could cross organizations, cross vendor technology solutions, and really be a patient centric tool. Next slide. I'm going to hand it back to Ken here to talk about some additional recommendations that came up as we went through this.

#### **Ken Kawamoto – University of Utah Health - Member**

Great. So, Steven talked through the primary and secondary recommendations. We also have some additional recommendations that, often times, are cost cutting. And it really did start surfacing, as we tackled multiple party care domains. So, the first was that at least when we looked at these two, we found that there are technology needs that are across both of these, both in ordering and resulting in



closed loop referrals and care coordination. It's, essentially, in various ways of doing closed loop exchanges where one party exchanges information with another and gets information back. So, this made us think it would be really good and sort of is beyond these use cases as well. But when there are underlying, similar approaches or similar patterns of health information exchange, we should try to work towards identifying options for harmonization just to reduce the burden associated with managing different standards.

And I think the focus on burden reduction among clinicians and physicians and caregivers is really important. But I think reducing burden, in terms of health IT implementers, is also a good thing. In terms of transitions of care, we recommend that we identify opportunities for harmonization of, again, standards and governance for the various instances of transitions of care so that, for example, referral to a specialist in an outpatient setting versus referring to a long term care facility, etc. They're all, basically, similar in that they're transitions of care. And the idea here is let's try to avoid, as much as possible, having very narrow technology use cases that have different standards across them and different ways they're governed because that, again, just adds cost and complexity. So, related to that, again, is this notion of custom interoperability solutions.

And the idea here is that this happens, in terms of different approaches being created for individual use cases because it's just sort of the natural thing to do in that, when you're working on trying to solve a problem, the problem is big enough that just to be able to make progress and to keep your scope manageable what you typically do is to say let's just solve this problem acknowledging that there's other work going on. But the idea here is we should actively seek out and identify opportunities to consolidate, simplify, and render cost effective the landscape of interoperability. Another topic that really came to the fore with this topic that we covered was that there's sometimes no clear single best approach. So, this is something that we discussed at quite some length. What do you do when there are potentially different ways of doing it? So, for example, direct versus FHIR or using CDA's Version 2, etc.

The recommendation here is to avoid picking winners prematurely and then, remaining open to potential alternative approaches, which may, in the long run, be ultimately superior whether for that problem or when you consider various use cases as we discussed. Next slide, please. So, based on this, we have some potential policy actions that could be taken that we recommend ONC consider. One is to commission efforts to identify functional overlap between standards and identify opportunities for consolidation or harmonization. This is a notion that, if you're working on a particular use case, you're typically not thinking so much about what's the best way to harmonize this with other approaches beyond just thinking about it. To make this more concrete, for individual ONC funded projects, we recommend ONC consider including required and/or optional tasks for exploring such cross use case harmonization and de-duplication in the project scope.

The notion here is that when this kind of work is done in a project, if it's not in a task, then, it would simply be considered out of scope. And you will, basically, be not having this opportunity baked into what folks do. Another recommendation is to convene HL7, Direct trust argonaut, TECA participants, EHR vendors, and other relevant stakeholders to establish the standards of evolution pack to allow applicable functionalities currently available in Direct to also function in FHIR. So, there seems to be a fairly good consensus that the Direct based referral approaches being currently worked on look very promising and have a shorter time to market, in terms of availability. But there's a lot of excitement around FHIR. And we really should have a plan for how we may transition to where we're moving infrastructure wise as an industry. And final recommendation was to consider developing certification criteria and associated CMS programmatic changes to allow the flexible transition to the appropriate use

of the FHIR standard. So, those are our recommendations. And I will then pass it on to Steven.

**Steven Lane – Sutter Health - Member**

Yeah. And I just want to, actually, close out this segment of the presentation a little bit by saying that our task force was really charged with looking at priority uses of health information technology and the standards that exist to support those uses, and then, making recommendations. So, that's really what we've been focusing on. As we've gone into this, what we realize is that it's important to tease this apart a little bit. And the framework that we've come up with is trying to differentiate the important functionality that is required, separate that from the content that needs to be exchanged, and here again, looking for those opportunities to align with work that will be done in USCDI, the technology standards that are needed to move that content to support those functionalities, and then, also, the governance, which will be required to assure that all of this moves forward.

So, those four components, functionality, content, technology, standards, and governance we really see as cross cutting to the work the work that we've been doing. So, I think what we wanted to do now was stop and have some discussion of our observations and recommendations and get the input of the HITAC. And then, afterwards, we'll go on and provide a recap of our prior recommendations on orders and results and some additions that we want to make to those.

**Robert Wah – DXC Technology – Co-Chair**

Ken, thanks to you and Steven for this great work again. And just as a note to the overall committee, everyone seems to catch on quickly, but please do use the raise your hand function in the Adobe Connect application. It's at the top of your screen about a couple of inches to the left. It's helpful for us to know who is raising their hand. And I appreciate everyone using that. And on that topic, the first person with their hand up is Terry O'Malley.

**Terry O'Malley – Massachusetts General Hospital - Member**

Really? I didn't even raise my hand. Thank you because I was going to make a comment. So, again, great presentation and a really complicated piece of work. So, kudos to Ken and Steven. Referring back to Slide 50, which, actually, talked about the standard clinical data that's needed to move between a primary care physician and a specialist in the particular use case we looked at, I think, it's important – what I would do is I would add an emphasis there that we ought to expand that same general process of identifying standard, clinical data that's required and apply it to the transitions of care. Given how critical transitions are, they're really the way our system holds itself together. We only really connect around the care of patients. And it's important that the information that one team needs to get from the other, the sender and the receiver, gets really standardized and complete.

And you could look at transitions from anywhere to the Emergency Department. What does the Emergency Department want to get in a referral from who knows where? And similarly, what does who knows where, the PCP, the home health, the SNF, want to get back from the Emergency Department unless they send the patient? And wash, rinse, and repeat for all of the other transitions. Discharges to and from facilities discharges from LTPAC to anywhere. So, I would just put a plea that we expand the standard clinical data that should be collected and add a line there for high value transitions of care as well. Thanks.

**Steven Lane – Sutter Health - Member**

Terry, I want to just comment. I think you make a really good point. It really speaks to what we continue to identify, which is that there are these cross cutting issues that each of these domains we go into

really relates to other domains. And while we have called this out as being needed based on clinical specialty, I think you could also, as you say, expand that to care setting in a certain sense that a skilled nursing facility could be seen as similar to a specialty. What do they need when a patient is transitioning to them? Or what is needed from them when that patient is transitioning to either a physician subspecialist or to a hospital or to another level of care? So, I think your point is really well taken.

The other thing I'll say about this is that our task force did make a formal submission to the AMA's integrated health model initiative to see if they might be an appropriate organization to take on this collaboration to look at developing and maintaining some of these standards. Clearly, the AMA's focus is going to be more on physicians and physician medical specialties as opposed to what's needed for, as you say, other transitions of care. But we're waiting to hear back from them as to whether they have an interest in that. But, clearly, we think that ONC should help to figure out where the appropriate home is for this work.

**Robert Wah – DXC Technology – Co-Chair**

This is Robert. If you need help with AMA, I'm happy to push on that regard as well.

**Clem McDonald – National Library of Medicine - Member**

I don't know if my hand raising is not working, but I've had it up –

**Robert Wah – DXC Technology – Co-Chair**

No, no, Clem, I see you.

**Clem McDonald – National Library of Medicine - Member**

Okay. All right.

**Robert Wah – DXC Technology – Co-Chair**

Go ahead, Clem.

**Clem McDonald – National Library of Medicine - Member**

Well, there are a couple of things. 1) I would be cautious about the harmonization word. It's sweet and pretty and everybody agrees to do it. But it's been 20 years, and no one does it. I think we should talk about unification if we want to make it easy not harmonization. And just to be honest, it hasn't happened. Secondly, the issue that Ken raised, I think his issues were all good, but the one about not being too fast to adopt something, that's not been our problem in the last 20 years. It's been too slow. So, it's true, you don't want to early lock down this, and you shouldn't. But if we wait forever to make it right, we're not going to get anywhere either. And in the computer industry, there's been a lot of commitments made to given standards, and they evolve. It's not like you're done forever. And then, the third thing regarding the transition of care, clearly, everything that's been said is right.

But in the environment I worked for a while, you can just look at the records from all of the hospitals at once in an HIE, and that worked pretty darn well. The problem with pre-specifying the things to send, I know it's an advantage because you don't overload the guy. But the downside is that the thing they come in for, there may have been a miscommunication or misunderstanding. They come in with Problem X, and all of a sudden, Problem Y emerges. And you'd like to look at data related to that problem, too. So, I think we ought to be highlighting or at least emphasizing, health information exchanges, too, as a way for receivers of patients to explore other issues that may not have been sent in the specified package.

**Steven Lane – Sutter Health - Member**

That's a really good point, Clem. And I think that really the idea is not so much to limit the data that would be sent but more to focus on assuring that the necessary data has been collected. I think we all, certainly 360X, assumes that a CCD patient summary record would be sent that we would hope that there will be the ability to query and ask for additional data. But it was really just on the content side saying, if you're sending someone to an endocrinologist for out of control diabetes, you should have collected an A1C, etc., before sending them.

**Clem McDonald – National Library of Medicine - Member**

I agree with that. I just was trying to point out another opportunity to get some kinds of information.

**Ken Kawamoto – University of Utah Health - Member**

Thanks, Clem. Other comments?

**Robert Wah – DXC Technology – Co-Chair**

Other comments or questions for the task force?

**Steven Lane – Sutter Health - Member**

We expected more.

**Robert Wah – DXC Technology – Co-Chair**

I'm just making sure people aren't hesitant out there. This is great work, you guys. As you said at the beginning, kudos also to all of the members of your work group. You guys led a nice presentation here, and we appreciate that. But all of the work that you and your group are doing is really important and very much appreciate.

**Steven Lane – Sutter Health - Member**

Well, let's go ahead then. So, a reminder of the path that we are on. We are working our way through a set of prioritized uses of health information technology. The first area that we looked at was orders and results. And we developed a set of draft recommendations, which we presented here two months ago. We have continued to receive input on those and have a couple of additional draft recommendations that we wanted to bring to the attention of the HITAC today. We will also continue to consider and revise our recommendations around referrals and care coordination, as we move on to additional domains with the task force. And then, we are scheduled to prepare a formal report next year and bring it back to the HITAC.

So, as HITAC members have a chance to think about what we've said and what we have drafted, we welcome your input because we really want to make sure that the final product is a thorough reflection of all of our thinking. So, I think Ken was going to just go through quickly and review what we presented a couple of months ago to remind you where we've been. And then, we will present a couple of additional recommendations for orders and results. Ken?

**Ken Kawamoto – University of Utah Health - Member**

Okay. So, this part will be quick. It's just a recap of what we've already presented. And then, we'll move on to the updates. Next slide, please. Here's the overview of the priorities around ordering and then, also around further standardization. Next slide, please. Okay. So, again, we've already presented this material before, so I'll be very quick. The first priority was the consistent encoding of the lab and other

test results using LOINC and SNOMED CT and having it provided by resulting agencies as a CLIA requirement. Another recommendation was to identify and prioritize the most common informed results of each order type. Another was to require and enforce the use of information models and terminology standards for all test orders and results. Also, the map codes must be included with results, as they're maintained and exchanged between HIT systems.

Also, the resulting systems, such as EHRs and LISs should provide a mechanism that allows clinics to map internal result codes to standard vocabularies when such mapping hasn't already been done. And also, to implement mechanisms to support and ensure proper LOINC encoding, such as auditing or certification by CLIA. Next slide, please. Another high priority recommendation was around results needing to be sent to clinicians in codified formats. So, our draft recommendations included utilizing USCDI to show that prioritized results are interoperable via V2, CCD, FHIR, and future transport standards. Another recommendation was to prioritize complete and accurate coding at the data source rather than trying to code or correct externally sourced data further down the line where there's less information available to know what the right code is or right semantics are. Another recommendation was to require the resulting agencies to provide standardized metadata, such as normal ranges to ordering and copy to providers as well as to patients.

And the final recommendation here was that standard metadata must be maintained as result data is transmitted between systems. Next slide, please. Another priority here was results need to be available for patients and proxies to be, receive, and utilize. So, our draft recommendations included requiring that ordering providers make results available to patients and proxies within a reasonable timeframe, to make all results in the EHR available to patients via APIs, whether or not they've already been standardized and coded. Another recommendation was to develop a highly sub standardized patient friendly result display names for patients, to consider requiring resulting agencies to make results available directly to patients. And also, to align state and federal policies to assure consistent and predictable patient data accessibility and interoperability. Next slide, please.

Further priorities, these were around orderable tests needing to be standardized between systems and with mapping the standard terminologies. So, draft recommendations included developing and eventually requiring the use of standard space catalogs of orderable tests with consistent mapping associated code sets for all order types, utilizing consensus development processes to develop standard orderables for the most common and important tests of each order type, and to standardized commonly used order panels, including for the about 2,000 order panels currently cataloged by LOINC. Next slide, please. And secondary priorities included, one was around the need for standard methodologies to integrate external additional support. And draft recommendations included leveraging and advancing the CDS Hook standard and also developing and supporting the use of standards to determine and expose net pricing information to relevant stakeholders, including providers, payers, and patients. Next slide, please.

Another priority was the need for standards to support priori authorization workflows. So, this fits in very nicely with what Dr. Rutger mentioned. So, there's a number of prior authorization standards. Standardization efforts are underway. And these should be harmonized into a consistent approach. And, again, a very high values case, for example, could be potentially to tackle these using CDS Hooks, once the ordering based hooks are defined and validated. There's active work ongoing on that in the CDS work group right now in HL7. Next slide, please. Back to you.

**Steven Lane – Sutter Health - Member**

Thank you, Ken, for the rapid fire review. And I think it is just helpful for the full HITAC to recall where our task force has been. But, again, we did receive some additional input for additions, suggested additions, to our recommendations around orders and results. And one of them has to do with the provenance data and the real importance of assuring that this metadata is maintained with results as they move between systems. And this includes not only what was the source system but also what we've found in practice, and this is true in my organization as well, is that you really need to maintain internal system identifier data. You need to know that a given result came from a specific system, what that order was that was made and resulted because the receiving system needs to know if there is new data coming in on that same order.

You need to be able to identify when a new data transmission maps back to previously received data if there is a need to addend the earlier version of the data. And this is getting down into the weeds, but it really is important. And it's important that that provenance and internal identifier data moves independently of the transport mechanism. Again, we keep talking about the fact that this data might move via HL7 V2, V3, FHIR. But this is one of those areas where we need to separate out the functionality, the content, and the underlying standard that supports it. The other item that was raised, and, again, I want to include a caveat here that our task force has not had a chance to really drill down on these yet, but we're bringing them here for the HITAC's consideration. The idea that as data begins increasingly to transmit between healthcare systems, payer systems, patient controlled systems, which we all believe is a good thing that there are concerns being raised about the fact that that data might be tampered with along the way.

So, the idea of exploring the value of acquiring digital signatures on orders and/or the results information to assure that that data has not been modified along the way. These signatures or whatever term we end up using should allow the originating system to be confirmed, values to be verified, and any tampering or changes to the data that might have occurred along the way to be identified. So, we wanted to bring these additional recommendations back to the HITAC and see if you have any input. As I said, we will be discussing these in more detail with our task force and incorporating them into our final report.

**Robert Wah – DXC Technology – Co-Chair**

Thanks. Clem, you have a comment?

**Clem McDonald – National Library of Medicine - Member**

Yeah. A couple of comments. So, regarding the last thing, the additional, real deep importance of having that identifier is what happens is you get results passed on from a second clinic or a third clinic, and you don't know which one is what. So, I think you get clutter if you don't have a way of what's the original. And in terms of Ken's presentation, which I loved because he was back to getting the actual data being shipped around, two additional things for metadata to add maybe would be a normal flag, which makes it easy to sort of filter things to look at hard and adjust for different normal ranges. And then, units of measure, which I'm sure he means to be included but didn't mention. And then, the last thing is, on the initial slide, it talked about SNOMED CT and LOINC for being lab reporting. But some people mix that up thinking it's either/or.

And what I think you really meant is that LOINC for the test identifier and SNOMED for the results or the values when they aren't numeric or text. And if that's what you meant, I think it would be helpful to clarify it. It will get confused by later readers otherwise.

**Ken Kawamoto – University of Utah Health - Member**

Absolutely. And I think that was in our details, but yes, that was absolutely the intent.

**Steven Lane – Sutter Health - Member**

Yeah, Clem, you've driven that differentiation home quite well. And it is definitely included in our task force recommendations.

**Clem McDonald – National Library of Medicine - Member**

Okay, thank you.

**Robert Wah – DXC Technology – Co-Chair**

Any other comments or questions for the task force? All right.

**Steven Lane – Sutter Health - Member**

Again, we appreciate the vote of confidence, but we remain open to people's input after the fact if you'd like. If you go on to the next slide, the other domain areas that we have balloted and prioritized include evidence based disease management, the incorporation of clinical evidence into the care process, and medication and pharmacy data. There are other areas that we've looked into, including social determinants of health. I think, realistically, we probably have time to go through at least two more domain areas. So, these will likely be the ones that we focus on. But depending on the pace at which we go through them, we will continue in the new year with a twice a month meeting cadence. But we're also well aware that, as the ONC rule comes out, there may be a need for us to take a pause to focus the participants' or the members' energy on other work that perhaps might be a higher priority.

We're looking to our ONC team to help us determine what that's going to be. But, at this point, we've completed these two rounds of initial work and really appreciate the chance to be able to come and review them with the HITAC.

**Robert Wah – DXC Technology – Co-Chair**

Great. Other comments, questions, as we wrap this up? Okay. Again, thank you both for your hard work and to your entire task force and the committee on this. At this point, I think we are at the public comment period, is that right, Lauren?

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

Yeah, that's correct. I realize we are a little bit ahead of schedule, but we will go ahead and open the line. So, operator, if you could open for public comment, please.

**Operator**

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

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

Thank you. And we just want to acknowledge that we were joined by traditional committee members,

Michael Adcock, and Andy Truscott. Any other committee members who were not on at the top of the call when we did roll? Okay. Operator, do we have any commenters in the cue at this time?

**Operator**

Thank you. Our first comment is from Lori Greg from Duke University.

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

Thank you. Go ahead.

**Lori Greg – Duke University**

Yes. I just wanted to clarify, by changing the name from physician to provider, are you trying to finally, finally, finally acknowledge the role of us nurses? I was a nurse when Regan was shot. I took care of James Brady. There was no automation at GW. And within a year, I went to Georgetown as a nurse. And that was my last year as a bedside nurse. And now, I have all of my degrees in IT and health policy. I worked for Regan on health policy. So, I have to say I've been begging and begging you all to acknowledge that nurses are as frustrated as Dr. Rutger in his testimony on the Hill two days ago. The questioners, some physicians themselves, acknowledged physician frustration. And I think we nurses get lost in the sauce of our frustrations. So, is there going to be any – I noticed you're hiring two nursing informaticists. Is that to dig deeper into this issue?

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

This is Lauren from ONC. We can certainly follow up with you offline in regards to any open positions available on usajobs.gov. I'm happy to do that, but I do want to thank you for your comments and for your service.

**Lori Greg – Duke University**

But can I have an answer to the question about the name change from physician to the provider? Is that on purpose to expand the scope from just physicians' meaningful use and ease of use to now nurses? We are the ones using as a concern at the bedside all over this nation.

**Clem McDonald – National Library of Medicine - Member**

Could I offer a comment? This is Clem.

**Lori Greg – Duke University**

Thank you, Dr. Resnick, please.

**Clem McDonald – National Library of Medicine - Member**

I think the nurses have the same frustration. And I think it's good that it be expanded. They're sitting in a terminal all day sometimes. So, I appreciate the caller's comment.

**Lori Greg – Duke University**

Thank you, Dr. McDonald.

**Aaron Miri – Imprivata - Member**

And this is Aaron Miri if I could make a quick comment as a provider CIO of an academic medical center.



To the degree that I hear from the nurses all of the time, the importance and urgency there. And so, I think, on behalf of all of the hospital CIOs that are out there, we hear loud and clear the nursing community and stand with our partners in that.

**Steven Lane – Sutter Health - Member**

And this is Steven Lane. I'll offer a comment as well. I think we have seen, on the part of ONC, an expansion. Clearly, the physicians' voices are quite loud in the health IT space. And there are a number of us represented here on the HITAC. But we also have nursing representation. And I think, in many of our efforts, we make a point of referring not just to physicians but to providers more generally, to clinicians more generally, and really to call out the needs of all members of a patient's care team, which often includes family members and community services, etc. So, I think that the point that you're making, certainly, I embrace it. I think most of the members of the HITAC see it similarly. And, again, thank you for your comment.

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

Operator, any additional comments in the cue?

**Operator**

There are no further comments at this time.

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

Thank you. That will conclude our public comment period. Before we adjourn, I will just have a few general reminders before I turn it over to Carolyn and Robert. The first of which, as always, for the members of the public, you can find today's meeting materials on [www.healthit.gov](http://www.healthit.gov). And the meeting summary will be available in a few weeks. Also, our next in person meeting will be January 23. That will be at the Omni Showroom in Washington DC. So, you can also find additional details closer to the time of that meeting on [www.healthit.gov](http://www.healthit.gov). Also, as a reminder at the top of the call, you should have all received an email with a link to the Strategy to Reduce Burdens. You should have received that link in an email. Please submit your comments and share that link with your colleagues.

And last but not least, in anticipation of new task forces that we expect to send up in response to the proposed rules, we would like to remind everyone that, if you are interested in joining one of our task forces, you may do so on [www.healthit.gov](http://www.healthit.gov), on our HITAC page under membership applications. You will be able to submit your application if you have not done so already. So, that concludes all of my reminders. I will now turn it over to Carolyn and Robert for any last minute closing remarks.

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

Thanks, Lauren. I appreciate all of the excellent discussion that we've had today and the courteous attention to our presentations. Just as a recap, the interoperability standards priority task force will be meeting on January 8. And the annual report work group will be meeting on January 10. If you're interested, please dial in and listen or provide us with feedback offline. We are here to serve the full HITAC. I appreciate everyone's service this year and wish you all fine holidays. I'm looking forward to seeing you in January.

**Robert Wah – DXC Technology – Co-Chair**

Carolyn, thanks. This is Robert. And just also to say to the committee Carolyn and I are always seeking input and suggestions for how to make this process better. So, please do send us email or comments about what you'd like to see, in the future. We're looking forward to our next face to face meeting in January. And again, if you have suggestions about things we can do to improve that, please let us know. Clem, I see – no, you're just putting your microphone on. So, again, as has been mentioned multiple times, we appreciate everyone's hard work on the committee. It's been a great year and a privilege to serve as your co-chair along with Carolyn. We look forward to the holiday season for our families. We wish everybody a great holiday season as well. And with that, I think we'll turn it back over to Lauren to close us out. But have a great holiday season and travel safe, and we'll see you in January.

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

Thank you. And I also just want to thank Talicia for her presentation today as well as our task force co-chairs and our work group co-chairs. Unless there are any additional comments from the committee members, we can adjourn. Thank you, everyone.