The Office of the National Coordinator for
Health Information Technology

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) MEETING

March 26, 2020, 10:30 a.m. – 1:30 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Carolyn Petersen	**Individual**	**Chair**
Robert Wah	**Individual**	**Chair**
Michael Adcock	Magnolia Health	Member
Christina Caraballo	Audacious Inquiry	Member
Tina Esposito	Advocate Aurora Health	Member
Cynthia Fisher	PatientRightsAdvocate.org	Member
Valerie Grey	New York eHealth Collaborative	Member
Anil Jain	IBM Watson Health	Member
Jim Jirjis	Clinical Services Group of Hospital Corporation of America (HCA)	Member
John Kansky	Indiana Health Information Exchange	Member
Ken Kawamoto	University of Utah Health	Member
Steven Lane	Sutter Health	Member
Leslie Lenert	Medical University of South Carolina	Member
Arien Malec	Change Healthcare	Member
Clem McDonald	National Library of Medicine	Member
Aaron Miri	The University of Texas at Austin Dell Medical School and UT Health Austin	Member
Brett Oliver	Baptist Health	Member
Terrence O'Malley	Massachusetts General Hospital	Member
James Pantelas	Individual	Member
Raj Ratwani	MedStar Health	Member
Steve Ready	Norton Healthcare	Member
Abby Sears	OCHIN	Member
Alexis Snyder	Individual	Member
Sasha TerMaat	Epic	Member
Andrew Truscott	Accenture	Member
Sheryl Turney	Anthem, Inc.	Member
Denise Webb	Individual	Member
Amy Abernethy	Food and Drug Administration	Federal Representative

James Ellzy	Defense Health Agency, Department of Defense	Federal Representative
Adi V. Gundlapalli	Centers for Disease Control and Prevention	Federal Representative
Jonathan Nebeker	Department of Veterans Health Affairs	Federal Representative
Michelle Schreiber	Centers for Medicare and Medicaid Services	Federal Representative
Ram Sriram	National Institute of Standards and Technology	Federal Representative
Donald Rucker	Office of the National Coordinator for Health Information Technology	National Coordinator
Steve Posnack	Office of the National Coordinator for Health Information Technology	Deputy National Coordinator
Elise Anthony	Office of the National Coordinator for Health Information Technology	Executive Director, Office of Policy
Avinash Shanbhag	Office of the National Coordinator for Health Information Technology	Acting Executive Director, Office of Technology
Seth Pazinski	Office of the National Coordinator for Health Information Technology	Director, Strategic Planning & Coordination Division
Thomas Mason	Office of the National Coordinator for Health Information Technology	Chief Medical Officer
Lauren Richie	Office of the National Coordinator for Health Information Technology	Designated Federal Officer

Operator
All lines are now bridged.

Lauren Richie
Thank you. Okay, good morning, everyone! Welcome. We certainly appreciate you accommodating the quick turnaround for another much needed meeting here today. I've just got a couple of quick administrative reminders. We may have a few members who are not on Adobe who are on audio only, so we'll just ask you to pipe in during the conversation if you have any questions or comments. And then for the members that are on Adobe, we'll try to stick to our usual routine of using the hand feature and announcing your name before speaking.

For members of the public, just as a reminder, the phone number for the public comment period can be found in the lower left-hand of your screen. We'll display that again a little bit later, but just wanted to queue that up for the public comment period towards the end of the call. And with that, I will go ahead and get us started. Starting with roll call. Carolyn Petersen.

Carolyn Petersen
Good morning.

Lauren Richie
Robert Wah.

Robert Wah
Present.

Lauren Richie
Michael Adcock. Present. Okay. Christina Caraballo.

Christina Caraballo
Present.

Lauren Richie
Tina Esposito. Cynthia Fisher. Valerie Grey.

Valerie Grey
Good morning.

Lauren Richie
Anil Jain.

Anil Jain
Good morning.

Lauren Richie
Jim Jirjis.

Jim Jirjis
Good morning.

Lauren Richie
John Kansky.

John Kansky
Yeah, I'm here.

Lauren Richie
Great. Ken Kawamoto.

Ken Kawamoto
Here.

Lauren Richie
Steven Lane.

Steven Lane
Here.

Lauren Richie
Les Lenert. Not yet, maybe. Arien Malec.

Arien Malec
Good morning.

Lauren Richie
Clem McDonald. Aaron Miri.

Aaron Miri
Good morning.

Lauren Richie
Brett Oliver.

Brett Oliver
Good morning.

Lauren Richie
Terry O'Malley.

Terrence O'Malley
Good morning.

Lauren Richie
James Pantelas. Not yet? Okay. Raj Ratwani.

Raj Ratwani
Good morning.

Lauren Richie
Steve Ready. And Abby Sears?

Abby Sears
Here.

Lauren Richie
Alexis Snyder. And Sasha TerMaat.

Sasha TerMaat
Good morning.

Lauren Richie
Good morning. Andy Truscott indicated he would be absent today. Sheryl Turney.

Sheryl Turney
Good morning.

Lauren Richie
Denise Webb.

Denise Webb
Good morning.

Lauren Richie
Michelle Schreiber?

Michelle Schreiber
Good morning.

Lauren Richie
James Ellzy? Ram Sriram?

Ram Sriram
Good morning.

Lauren Richie
Good morning. Adi Gundlapalli?

Adi V. Gundlapalli
Present. Thank you.

Lauren Richie
Jonathan Nebeker? Okay. Amy Abernethy will be absent. Do we have Nina Hunter on the line from the FDA? Or another representative from the FDA? We'll circle back to concern that. And so, on the ONC leadership side, we have Dr. Rucker, Steve Posnack, Elise Anthony, Avinash Shanbhag, Seth Pazinski, and Dr. Tom Mason. At this point, I will turn it over to Dr. Rucker for opening remarks.

Donald Rucker
Yes. Thank you, Lauren. Appreciate it. First of all, we would like to thank everybody for joining in on short notice to trade ideas and get thoughts on the COVID outbreak and see what we can do there. Before we get into the discussions, I just wanted to highlight that we've reviewed the FY'19 HITAC Annual Report and it has now been turned in to the Secretary and Congress. I would like to thank everybody for their work on that and in particular Carolyn and Aaron for leading that work. So, obviously, with the virus, I think both the clinical responses and then, you know, the subset of things that have a big IT component to it, I think it's interesting, because we don't really fully know the biology and what the exact patterns of transmission are of folks who are asymptomatic. I think it's pretty clear, certainly in some parts of the country, that there was probably a lot of transmission before the travel bans went into place and before people really understood the existence of this. That seems to have been the case certainly in Northern Italy as well.

For our conversation today, as you might imagine, all of HHS, the senior leadership is absolutely consumed with a vast array of activities around fighting the virus. And so, the things that we have to think about is just I think because of the vast amount of work you're doing, we have to make some decision making, I think, on what things might be plausible to suggest. We cannot just suggest everything that might be an idea and rely on people who are super busy to do all of the filtering of that. So, I think as we have our discussions here today, I think they should also include some filtering of is this really likely to make a difference, and if so, what is the time frame of making that difference? There are lots of things that we could talk about that eventually would be great to have in future pandemics, but I think we also need to figure out what is doable in the very near future.

And I think then the other thing we have to sort out is what are things that sit in ONC's bailiwick and purview that we have – I think they say in academia face validity to give opinions on and where our opinions collectively matter versus things that would be, quote, "advice" to other parts of HHS that then would need to get filtered through all of their processes. So, again, I would just ask folks to think about the immediacy of things and to think about things that are in the better sort of natural topics for ONC. I will say, as probably won't surprise folks, there's a vast amount of inbound suggestions coming in daily on product things. Some of these are in various ways seem to be a bit of a sales pitch and the marketing activity, as much as they are something that is a high priority for fighting the infection. So I think we need to just keep all of those things in mind. And with that, let me just turn it over to Steve.

Steve Posnack
Thanks, Don. Good morning, everyone. I appreciate your time as always in joining with us today. I want to make sure that you're aware of a couple resources that our intrepid staff has put together in the past few days and week. We do have a main Coronavirus page on HealthIT.gov, so HealthIT.gov/Coronavirus. We have taken an approach to organize a lot of the health IT relevant information and guidance that our sister

agencies and others have had made available. So there's a range of general guidance, EMS-specific guidance, HHS guidance, and OCR-related components and guidance on data standards and some other supporting information. We also have made available a new section in the interoperability standards advisory, so HealthIT.gov/ISA, specific pages, COVID-19. That includes all of the relevant terminologies, so, LOINC, SNOMED, ICD-10, CPT, HCPCS, all of those are now listed. We have the appropriate value sets of which we're aware.

If anyone listening or anyone on the committee has additional information they would like us to include relevant to the different either value sets or terminology that we've missed, please get in touch with our staff at ONC and we'll be happy to update that. So, I just wanted to let folks know those two resource that we helped organized on behalf of the Health IT community and we just look forward –

Arien Malec

Can you repeat those two URLs?

Steve Posnack

Sure. I'm happy to tweet them as well. But the first one is HealthIT.gov/Coronavirus. And then the second one is HealthIT.gov/ISA, which will take you to the main interoperability standards advisory page and there's a link center straight on the page about our COVID-19 ISA page.

Arien Malec

Thank you.

Steve Posnack

Yep. I will turn it back over to Lauren. Or Robert or Carolyn.

Robert Wah

Thank you, Steve. And thank you to both you and Don for joining this call. But I think the committee remembers that we just had our monthly HITAC call and there was a strong interest on behalf of the members to create an opportunity for us to speak about and talk about what are the health information technology opportunities that we can surface and discuss that can help in this fight against the Coronavirus. I think we all recognize, as Don noted, these are extraordinary times. And everybody is anxious to do whatever they can to join in this fight and this is one way that we thought would be helpful in accommodating that. But we recognize that putting a meeting on just a few days after our monthly meeting was no small task and I think I want to make sure we recognize all the work that the ONC team did to help us get this together. Carolyn and I have been working hard to accommodate this real strong interest on behalf of the committee. And I hope you will find this useful today. And I think we all have a lot to contribute to that.

Just as sort of a housekeeping order, our plan was to collect the information that you all provided. Many of you provided feedback and suggestions, and I think Carolyn will go through how that was collated. But as you remember at the end of the call last week, Carolyn asked you all to submit your ideas before this call and we have gotten a lot of input on that. And I hope that you will be able to see that. We sent out a Word document to the membership detailing all of that feedback, and I would commend that to your reading. I know that came in very close to this call. The cookie batches we were not able to do way in advance on this particular call, and so we recognize that you got it very close to the call. So there is more to digest right

before the call. But I would commend you to that document. The slides have been distributed as well. We'll be going through those. And our plan is to -- and we lay it out in the slides, a series of steps.

We wanted to first surface all of the information that had been suggested by the committee, and we have that organized in the slides, so we can go through that. And we thought what we would do is present all the information that we have received, the information that we have collated on the slides, so there will be a run-through of all of that as our first step. But we think that what we really want to do then is, as Don said, there's a refinement process here where we can't talk about everything, so we will surface everything but then we'll need to narrow that down into some areas that we want to take a little deeper dive into.

And so that will be the first step, but our goal in that is to really find and highlight and discuss initially those things that we think are health information technology opportunities in this fight against the Coronavirus, and then I think the other part will be, as Don said, it will be important to think about who is the natural owner – this is the face validity comment that Don made – about these various things. And we're looking for those things that the Office of the National Coordinator and the HITAC would be the natural owner for as opposed to other parts of the ecosystem that is out there, the environment. So there are things that maybe natural owner may belong to another agency, another operating division within HHS, or another part of the government or the private sector. So we'll have a discussion about making that distinction as well. Who would be the natural owner for these? And make sure that we're talking about those things where the Office of the National Coordinator and the HITAC would be the natural owner.

And then there will be a determination about timing. Some of the things we will discuss may be things that need to be dealt with and can be dealt with in the very short-term, and there may be things that we'll discuss that will have a longer time horizon, and we'll need to make that distinction as well. So, that is our plan for the day. Again, I hope you recognize how quickly we had to put this together, and we appreciate your accommodation and understanding as we did that, and hope that the materials that we've provided you will be very helpful. We recognize that you got a lot in a very short period of time. And so, with that, I'll turn it over to Carolyn to lead us through a review of the information that has been submitted.

Carolyn Petersen

Great. Thanks, Robert. And thank you to everyone at ONC for working so hard so quickly to get this meeting set up for us. And also to all my fellow HITAC members who made time today on short notice to come in and be involved in this discussion with us. As Robert mentioned, we have sent back all the feedback that you sent to us, back to you. I believe the file with all the general comments came back as a PDF rather than as a Word doc for easy handling. And in that batch that you got last night, there were several other documents that were submitted by members that we just sent back as their own separate document for easy reading. And to manage the discussion, we have put the ideas in broad categories so we can kind of see how things shake out. For those of you who are on the phone, I'm going to read through the slides. For those who are on Adobe, please bear with me as we get through this. So, let's dive into the slides. If we could please have the first one. Thanks. And let's go to the next slide.

Okay. So, the input that we received from HITAC, first category is technology: COVID-19 clinical decision support, testing and tracking systems, identification of risk indicators, and ADT feed or system. The next category, telemedicine and telehealth. In that one we have support increasing telehealth activity, SDOH data to incorporate into remote monitoring and telehealth, and concerns about cost sharing and

reimbursement for telehealth services. The third category is standards and data. In that group, we have normalize data of suspected cases, leverage ongoing efforts, like health IT developers, review current standards, including FHIR, accessibility to researchers, review COVID-19 related data elements and code sets, such as SNOMED, coding test orders and results to support interoperability, and standardized reporting data elements and feeds to report capacity across all levels of care. If we could have the next slide, please.

The fourth category is privacy matters, and we have here HIPAA enforcement and data sharing rules and concerns, research needs, including standard IRBs, consideration of location data in EHI for pandemic situations, and addressing existing authority for data privacy and data liquidity. The fifth category is patient matching, and here we have national patient identifier and national database for reported symptoms, testing, outcomes, treatments and risk factors. The sixth category is policy. Here we have impact on interoperability rules, reevaluate timelines for information exchange critical to public health crises, review timelines for new mandatory PIP reporting and other PIP measures, suspension of quality measure reporting requirements and timelines, like MIPS and PIP, delay education and operations testing period before implementation of PAMA, evaluate public health use case under TEFCA, evaluate whether EHRs and EHI should encompass travel history as part of USCDI, and congressional proposals and activity. And if we could have the next slide, please.

The seventh category would be public health. And there we have review prior standards committee discussion of Zika related efforts, identify a clearly defined value set for exposure status, optimal electronic case reporting mechanisms that can be deployed rapidly, and disease surveillance via labs and EHRs. The eighth category would be information exchange, and there we have HIEs temporarily designated as public/local health authorities, allow for access to HINs in cases of extreme emergencies, advance ability to share test results, consider how testing and results data will be incorporated into HINs, and allow access to data by epidemiologists. The ninth category is "other," and there we have review and collate various COVID-19 online resources, standard methods for communicating testing status and results, workforce concerns and staffing requirements, and PPE and ventilator supply/demand availability and data feed.

So now, we're going to move into the discussion. And we have now seen the complete list in the slides, and we want to see where your interests lie. The meeting support staff are going to note the topics of interest that come up on the whiteboard tool that you see in Adobe. That is the one that has the notes designator. And we will read them back for everyone on the phone after this part of the discussion is concluded. So, if you're not able to see, we will read that back. Don't be concerned. And with that, Robert, do you want to start the discussion?

Robert Wah

Sure. So we're planning to use the hand raising process that we usually use, and I see some people have already done that. And again, for those that are on the phone and you can't use the app, please just announce yourself and we'll get you in the queue for the discussion as well. What we thought we do is we'd go through that long list – and recognize that it is a long list, but we couldn't think of another way to do it. But also, it coincides with the information that you were sent last evening as well, but this is really our attempt to summarize and organize all the feedback that we got from all the committee members. So, what we would now like to do is pick out some of the items that you all have submitted for further discussion. So, let's start with the folks that are on the list with their hands up. Clem, why don't we start with you?

Clem McDonald

So, I think the list is a great list. I think it's spectacular list. But it's a two to three-year list, and we've got weeks and months to get this changed. And so, I think the focus should be strictly on doing things like Korea did, you taking advantage of contact information the way they did and moving fast, which will require changes to a lot of things. I think most of the others are very worthy, very important, but it's not going to change the outcome in the next couple months.

Robert Wah

Yeah. Thanks for that, Clem. Clearly, we're all very aware of the time urgency here, and I think that is what we need to think about. We were trying to be complete in showing everything that was submitted because of the great work that people did in submitting suggestions to the committee. But by no means are we suggesting that we would take on this entire list. That's hopefully what we're going to accomplish here, is we need to focus our work on those things that again, are doable in the short term and that the ONC and the HITAC are natural owners of. And, Clem, if you had another suggestion about what things you would want to put on that list, I'll let you go ahead and give it.

Clem McDonald

Well, I think really, a lot of it has to do with some of the issues on the list about relaxing access to data, specifically location data. I mean, what our problem is, we don't really know who to track and follow very well. And we could, with using Internet – I mean, email data and all the stuff you've got on iPhones to figure out who has been near who. I mean, it's going to be rejected by some parts of the population, but there's a lot of people dying. We have to do something important.

Robert Wah

All right. So, just so you can all see, we're also trying to real-time collect the comments as they are coming up, and if you want to refer back to the slides that we just showed, we can do that as well. But we're trying to accommodate a very fluid dynamic in this meeting here. So, Aaron?

Clem McDonald

I just would like to hear what other people have to say now.

Robert Wah

Yeah. Thanks, Clem. So I'm going to recognize Aaron with his hand up.

Aaron Miri

Yeah, good morning. I wanted to also stress what Clem said. And so, I appreciate everybody on this call and in the discussion here and I also want to go into a couple specific examples of some things we're facing here in Austin, boots on the ground, as we battle this thing real-time. I also want to take a second, though, and acknowledge some of the excellent work that HHS has done across all of the divisions in relaxing licensure and other rules that were preventing telemedicine being deployed en masse here at UT Austin. We have embraced it whole hog. The city has embraced it and it's been tremendously beneficial. So, it does show that rapid action which was done by HHS across multiple divisions can work. And we're seeing thousands and thousands of patients benefit from that, including social services and my psych department, which are trying to keep people calm, but being able to visit now with them via telemedicine.

Okay. Let's talk about a few issues. No. 1, there's a new ICD-10 code for COVID-19 that was published by the World Health Organization. There are a number of electronic medical vendors out there that are reluctant to add this code in anytime soon. A lot of the EMR vendors have put a pause on any new updates, therefore we cannot code using this new ICD-10 code. I would stress that we take a look at that and say, "Is there anything we can do to support the vendor community?" And get that out there so that we the providers can utilize that.

No. 2, I would say that there is a tremendous need for information sharing as related to what are we learning on the front lines. I'll give an example. Data elements that we're seeing, and I give a lot of credit to the academic medical centers out there around smell, around loss of smell, loss of senses, that are early indicators of Coronavirus infection. Those kinds of things are coming up anecdotally and via the great information sharing platform that's called Twitter. I think everybody is following each other and learning, but we need to do a better job of highlighting those real-time aspects that we're learning in the field.

No. 3, things we're doing here at UT, particularly trying to get in front of the PPE shortage and others, around 3D printing, around all of these disinfection kind of items, I think there could be tremendous amounts of information that we can share with each other in saying what are we doing to either use N95 masks safely and securely and/or 3D print, which we're doing both here to try to get in front of the tide. So, to Clem's point earlier, I do think a lot of these items on this list are fantastic. I tremendously believe in that TEFCA and other items will be beneficial in the long fight, because this is going to be a long fight. But in the short fight, there are some things we can do immediately to really get a leg up and help empower our clinicians to be successful. Thank you.

Robert Wah
Thanks, Aaron. Arien.

Arien Malec
Well, it's good to come after that incredible list, and I want to endorse one of the key things that Aaron said, which is the role of rolling out terminology to support biosurveillance, disease surveillance, and other critical activities. It concerns me that we don't have ubiquitous adoption rollout, for example, of updated lung terminology for testing of updated SNOMED CT and ICD-10 terminology, and making sure, for example, that the already deployed CDC BioSense 2.0 network is being informed by the appropriate data with the appropriate terminology. It seems to me to be a role for ONC and its coordination function. CDC in the most recent MWR re-released information on age, for example, as a risk factor. We have a huge amount of data that's sitting in the EHRs right now that could be used for looking at both disease surveillance and additional risk factors, and that data is not being as accessible as it could be due to some of the foundational activities that Aaron represents.

In addition, I think there is a need for urgent coordinated standards development in high priority areas. So, to give a random example, there's a team right now that's looking at making access to ICU status available via FHIR-based APIs in order to provide additional information for intake and response to direct people to available beds. That may or may not be the highest priority standards development activity. I think ONC has a role to play in terms of prioritizing standards development in terms of the needs of communities most affected. But in the areas where there's an identified need, I think ONC can play a role in coordinating

funding and helping to stand up local information systems in order to share more information in real time. And then, again, I think there's a critical role in the health IT and privacy policy intersection to make sure that ONC coordinates with sister agencies, including OCR on guidance for information sharing.

You know, the biggest role that ONC can play is as a convener and a coordinator as opposed to a regulator, and the information Steve already published in terms of making access to ISA information is fantastic. I do think we need a coordinated response for, as I said, terminology upgrades and would encourage ONC to put on its coordination role and then make sure that we have a clear set of prioritization framework where we can turn that coordination role to the greatest effect. I completely agree with the prior two commenters on the need to prioritize early rather than – we're going to have plenty of time after this is over to think about how we upgrade our disease surveillance and response systems. That will be an urgent activity in hopefully a month or two. But right now, let's make sure that we have a prioritization framework where we can pretty quickly chunk through some of higher priority needs and make sure ONC is putting its convening forces to the best effect. Thank you.

Robert Wah

Thanks, Arien. Michelle Schreiber from the CMS.

Michelle Schreiber

Hi, thank you. Hopefully many of you can see that CMS is really rolling out as fast as it can release to providers that they can be functioning as best as they can to focus on patient care, so we have waived a lot of regulations. We have waived a lot of the quality reporting rules, and I would actually encourage ONC to think of this towards the top of their list, what relief can they provide to providers around some of the policies in reporting regulations that we have, including some of the new ones that just came out in policy. Now might not be the time to implement them. And putting delays in them, which is pretty much what CMS has, I think would be valuable. And make organizations feel like it's one less thing they have to do.

No. 2, telehealth, which is again something that CMS has really just kind of unleashed here across the country, has been incredibly important, as was pointed out by others. And if there's any way that we can focus telehealth in telehealth capability or know-how, especially in areas that haven't used it before, like skilled nursing facilities or some of the other more remote areas that haven't had this kind of access, I think that would be very useful. I certainly agree with standardizing whatever terminology that we can. I would hope that ONC is at least sitting on some of these committees that FEMA is putting up, because if they are looking at offsite locations and standing up some of those locations, questions have come up about well, should we have electronic medical record reporting, should we just be doing this on paper? And I'm afraid it's all going to be disjoint unless there's a voice there for, "Let's try to keep as much information flowing digitally as we possibly can."

And then, I certainly agree with if we can make more data available. I know that there are some mechanisms for even standing up large datasets for sort of clinical trials and information if providers even are putting patients on clinical trials medications or on off-label drugs to report them in so we can see what is effective and what is not effective. But as much information sharing, and even to the big vendors who have a lot of clinical information, if they can be doing analytics and sharing that too. So, thank you.

Robert Wah
Thank you, Michelle. All right. I'd use that also to cite that at the end of the slide deck there are two pages talking about across HHS, a number of activities, and there's links there in the slides for that. You have to put it on presentation mode to make the links active. And then there's also a page about those current activities that were also submitted as part of the call for information from the HITAC. So, that last page has a number of activities that are already ongoing that we thought the committee would have use for, and they're not necessarily in the long list that Carolyn went through at the beginning of the call. Let's move to Christina.

Michelle Schreiber
Thanks. Can I just add, because I'm looking at the comments you guys typed in, that I don't think it was captured – it's not release information to providers. We have to relieve providers of the burden of some of our regulations so that they can focus on patient care. So, thanks.

Ken Kawamoto
Amen.

Robert Wah
Yeah. Thank you for that, Michelle. Yeah, as you can see, we're trying to capture real-time what some of the comments are. And so, if you see something that is not accurate in capturing what you said, let us know. So thank you for that, Michelle. Christina.

Christina Caraballo
Great. Thank you. I just wanted to echo what the others said that we need to move quickly. Arien brought up one of the projects that we're working on right now with some industry leaders on looking at how to kind of fast track some of the data that we need. If we think about the work we did with USCDI, one of the things that was brought up repetitively in our task force was a need to get really vital data through the process really quickly and deploy it on a national level, and I see this as a real opportunity to look at what was done in the prior FACA work under the Zika task force and build upon it. Right now, I think that as we look at FHIR standards for bed availability, as Arien mentioned, we convened – really quickly stood up within the industry a group of thought leaders that are looking at not necessarily a standards product but getting software ready to deploy rapidly in the midst of this crisis.

Currently, we pulled in vendors that include Cerner, Epic, Meditech representatives from HIE infrastructure vendors, Audacious Inquiry – my company – is working on it as well with keeping and driving a lot of this, NextGen, Microsoft, and others. And being on the calls, some of the consensus is what can we do now to not get in the way of ourselves and get things out to the industry really quickly. And it's really an all-hands on deck mentality. I think what could really be instrumental is for ONC as Arien mentioned, to coordinate some of this and get this information that's happening within the vendor community and having a dotted line to the standards development organizations to get it out into the industry, help us get it where it's needed and get pilots deployed so people can start using it now.

I also think that this is a really good opportunity to bring in some of the personal health vendors. I've been talking to a couple that have been working on deploying telehealth solutions. I think we have got a critical time right now where engaging patients and getting data from people is extremely important. I think there's

a lot of opportunities around that. The other thing that I think we should look at is what – I think Steve mentioned this earlier – but resources on ONC's site. I think that's great. I had not had a chance to look at HealthIT.gov right before this call, but a COVID response and how organizations can kind of look at how IT can be deployed quickly and what is working now and what is available I think would be extremely valuable, because people on the front lines right now don't have time to do all the research that we have been thinking about for years. So, making it easily accessible to people I think is extremely critical right now. Thank you.

Robert Wah
Thank you. Denise?

Denise Webb
Yes, thank you. This is Denise. I just wanted to add to some of the comments I heard from Aaron and Michelle related to telehealth. With a number of the states having orders from their governors to shelter in place, I think we realize there's an increased demand on the network and broadband infrastructure. And just to share some of what is going on the front line, yesterday on a call, a CIO expressed that they're very appreciative of the relaxation for telehealth that CMS has provided. But something that is occurring, and maybe this hasn't gotten back to CMS yet, and they certainly don't want it to be perceived as all about money and reimbursement, but some of the codes for telehealth reimburse at a lower rate for telephone versus having telephone audio and video. And this is putting a tremendous strain on the infrastructure, because a number of providers are demanding from the CIO to have the video capability.

And then, on the patient side of this, a number of the patients that they're having these telehealth visits with are the senior citizens, the elderly, who are isolated and sheltered in their homes, and typically rely on their children or their grandchildren to get connected up on technology. So they're facing the struggle of, "How do I even connect to do a video visit?" So, one of the things we might have ONC help with in terms of coordinating with CMS is to help bring to light some of the burden that is being put on the infrastructure that could be lessened, and we could prioritize what is happening on our infrastructure and our broadband. I mean, because everybody is teleworking too. So, we need to have priority for our healthcare communities and make sure that they're able to get access and be able to provide the services through telehealth. So, I guess the bottom line is what the CIO was suggesting, is that maybe for some of these types of visits that don't require video, that there's parity in the reimbursement rates for the particular code.

Michelle Schreiber
While you're typing, this is Michelle from CMS and I wanted to answer your question, and that's that CMS has heard about that. So, I just wanted to let you know that CMS has heard that loud and clear, and we will probably be proposing legislation so that we can work to answer some of your concerns, but we are very aware of it. Thank you.

Robert Wah
Thank you, Michelle. So, a couple items about the list, I'm going to try and recognize people who have not spoken before I go back and pick up people who have already spoken, to be fair. And also, as a reminder to the public, this is a time for the committee's discussion. There will be a comment period for the public at the end of the session and posted on the agenda. So, we appreciate your accommodation there as well. So next, let's go to Steven.

Steven Lane

Hi, thank you. I want to really support everything that has been said by others. I wanted to focus in on an area which was mentioned earlier, which is the importance of getting data quickly and accurately to public health departments. Today we have electronic lab reporting pretty well stood up across the country, but electronic case reporting, which goes to a deeper level of data, is really largely a manual process at this point. And as we have heard, public health agencies are having a real challenge getting additional clinical data because of HIPAA concerns.

So I think we have a real opportunity to leverage available technology that we already have working, including the eHealth exchange, direct transport, the PULSE system that the ONC has really invested in, as well as the care quality framework. All of these groups are really ready with a now-established process for electronic case reporting, which is now live in a number of place. Some of the early pilots went live even this week and has been tailored now to support case reporting for COVID. And I think that this is really a great opportunity for ONC to support something that is ready to go today. There are some challenges in particular that could utilize some input. I think the questions around HIPAA and whether there is an opportunity for a HIPAA waiver to support the access of public health agencies to getting more complete clinical data would be very helpful, whether they were using the new PULSE system that is being stood up to support COVID-19 or using care quality more broadly.

This kind of data access by public health will help with tracking the outbreak, with understanding the epidemiology, with determining the value of interventions, all things that I think we would like to see move forward as quickly as possible. So I would just like to encourage us to consider that as a high-priority, shovel-ready project.

Robert Wah

Great. Thank you, Steven. I think Brett, why don't you go next.

Brett Oliver

Yeah, thanks. Just briefly, kudos to HHS and CMS with removing some of the regulations. It's allowed tremendous expansion for us to provide virtual care in our health system at a speed that we have never seen before. What I wanted to add to the discussion is really my one, two, and three right now is PPE. If we don't get a better, more reliable supply of PPE to our frontline workers, we're going to see an absolute tragedy to send these folks into these situations in ICUs and ERs without the proper equipment. It's just sad and it feels almost criminal. So, whatever we could do to provide materials tracking, available resources, a central repository, perhaps a national 3D printing resource area for those that are able to do that. My supply chain folks in our organization, what they are having to do to try to find available PPE for our folks is just ridiculous, the amount of time and resources.

We're getting hijacked by the government. We had a million-dollar shipment of masks coming in from a supplier in China only to be taken over by the government and redistributed. And I understand there are national priorities, but we have to have a way that we can successfully order these things and know where they are, track them. We literally have a car escorting a truck from a southern state where we put in an order and got some things because we're afraid someone is going to take it from us. It's extremely important. I just can't emphasize it enough right now for the health of our healthcare system. If you notice, once China adopted severe PPE requirements, when they started putting on gowns, bunny suits, hats, goggles, double

gloves, they had zero healthcare workers infected. We have got to start moving to that and we have to understand at a local level what is happening with our suppliers and it's just a black box right now. So, I'll get off my PPE soapbox right now. I mean, all these suggestions are great, but right now if I don't get masks, gowns, gloves, sterile wipes, I'm hosed.

Robert Wah

Thanks, Brett. Anil.

Anil Jain

Great. Thank you. And I definitely agree with my colleagues who have made some great comments. I'll just start by saying I think the list that's put in front of us is incredibly exhaustive and should be broken apart in short-term, intermediate, and long-term. We don't want to lose sight of some of the suggestions that we may want to do down the road. I do think, back to comments that were made – and certainly in IBM and having access to data, we see some of this early on – is that the quality of data that is going to inform our public health officials and our researchers is going to be based on the completeness of it, and the consistent use of some of the standards that exist and some of the data points that we may want to, whether we mandate it or not, but promote, such as contact data, location data, travel history and things of that sort that are going to be critical if we're going to get a better handle on this as well as the next thing that may happen.

The other aspect of having and ensuring that the quality of the data is there is to make sure that we do as best as we can with some of the patient matching aspects that folks are plagued by. So, if there's anything we can do as a committee, as ONC, to help those groups who are doing patient matching make sure we have the best matches. Otherwise, I think we will have some pretty spotty holes in our data.

The other aspect of this would be I heard this mentioned a few times about HIPAA, and I will tell you from my vantage point and the conversations I have been in, HIPAA is occasionally raised as the bogeyman that tells folks what they can't do with some myths around that. And I think our group can take some of those misconceptions about what you can and cannot do under HIPAA and the public health crisis, and help our different agencies get the right messaging across. I don't think I'm unique in that. I've had conversations across the industry where they're hearing very similar things, where HIPAA is raised inappropriately as a barrier. But I do think at the end of the day, if our goal is make sure we get out of the way of our frontline docs, that we also have to make sure that what they are doing, when they're seeing patients, when I'm seeing a patient, for example, that we are collecting the data that is going to make a difference downstream, and for that we do need some standards and consistency. Thank you.

Robert Wah

Thanks, Anil. Les. Les Lenert? Maybe I've lost him. So, Carolyn is putting her hand up. You might not be able to see her on the participant list, but I can see her. Carolyn?

Carolyn Petersen

Thanks, Robert. So I'm feeling like my comment is a little bit out of order because I think it kind of goes with what Les was going to share with us today. But let me start by reminding everyone that the views expressed are my personal views and they don't reflect the policy or position of Mayo Clinic, which is my employer in my day job. I see that privacy and some privacy-related concerns were mentioned on the list that we presented from the slides, and I know there has been some fairly broad discussions about doing things like

relaxing restrictions on patient consent or regulations about sharing. And I want to start by reiterating my view that taking action that moves us towards saving lives from the COVID-19 infection is really, really important, and absolutely needs to be a high priority. I would not argue otherwise, being a long-term survivor of a high mortality cancer, and I really want to be clear about that.

At the same time, there will be a day when these COVID-related events are no longer the all-consuming priorities that they are today. And at that time, individuals are going to have needs that are related to health information access and use. Specifically, some of the things we can do today to facilitate COVID care, like relaxing regulations on patient consent and notification when patient and personal information has been shared, can have some really long-term implications for patients as well as for our healthcare system. And this is really important in light of the fact that efforts to revoke the ACA are ongoing. If the ACA goes away, then patients can again be subject to preexisting condition exclusions in health insurance. And some people who today can be insured will find that they can no longer purchase insurance that provides coverage for the things that they need, COVID care among them, but also things like heart disease and cancer and other conditions that are quite common and require ongoing care.

If that happens in an environment in which personal health information has been widely shared – all sorts of information about individuals, not just the COVID-related things like test results and treatments and so forth – then we are setting patients up to be uninsurable down the line when they really need to get care for other things, perhaps surgeries and treatments that are now being canceled so that we can address the COVID situation. I know in our past discussions at HITAC and within ONC, as well as other places among the industry – for example, within the Drummond Group – there has been some discussion about DS4P, Data Segmentation for Privacy, and I strongly entreat us to be looking at those aspects of health IT as well as the things we need to do to get the COVID-related information moving so we can help people today to facilitate patient care today and in the future. Thanks.

Robert Wah

Thanks, Carolyn. I think Les is dialed in now. Les?

Leslie Lenert

Yeah. Hi, thanks. I really appreciate that. Carolyn, you've raised an incredibly important point in that. So, let's be clear as to what I think we can do best as a committee. I think we can debate the pluses and minuses of healthcare privacy and privacy of healthcare data and come up with some recommendations that the government can implement rapidly to intelligently relax health privacy regulations to benefit the health of the population without the problems that Carolyn has so appropriately pointed out.

So, some strategic relaxations of HIPAA may be important for this. For example, is the minimum size of a geographic area that is considered anonymized, does it need to be 20,000? Or could we move it down to something like a block level with 50 or 100 patients without undue compromise? Are there state laws that are inhibiting health information exchange because they have additional privacy protections that are above and beyond what is in the HIPAA Act that need to be overridden temporarily so that the data can flow across states through health information exchanges for clinical care? Is it really necessary for public health to only be given the minimum amount of information necessary for operations? Or should we define the minimum amount of information that public health needs for the response to an outbreak is whatever it thinks it needs?

We can't be fighting this outbreak with one hand behind our back. We do need to look at the long-term privacy implications, and that's why the debate among people like Carolyn and myself and all the other members of this committee on health privacy issues for healthcare data is absolutely critical. And if we can make some intelligent compromises and get those recommendations to decision makers to implement through the Stafford Act, we can really make a difference in this outbreak.

Robert Wah

Thank you, Les. Let's see, I think John Kansky.

John Kansky

Thanks. So I just wanted to comment on amplifying some of the things that Steven Lane brought up a little while ago in incorporating the comments related to HIPAA. So, the good news is that the health information exchange infrastructure that exists in this country, there's many health information exchanges that have the capability that are actively jumping in, communicating positive and negative laboratory tests, reporting hospitalizations for influenza-like illness, responding to the needs in their state. So, I wanted to express that in terms of the urgency there is an existing infrastructure that is responding. One of the things that we have encountered – and talking with other HIEs, it's not unique – is that there is a very real need for data use agreements to cover exchanges that are being requested. For example, our state Department of Health has asked us to kind of serve as a single course of data, and for new sources of data that don't already contribute to the exchange, there has to be legal coverage for them to send us data.

So this is why I don't know if this needs to happen at a federal level, or if it could happen at a federal level or must happen at a state level, but if health information exchanges could be designated temporarily as public health authorities as defined in HIPAA, that would enable them to be immediately more useful.

Robert Wah

All right. Thank you, John. I think the other person that has not spoken yet is Terry O'Malley.

Terrence O'Malley

Thanks, Robert. This is a great discussion, and it seems like there are sort of two big buckets we're falling into. One is sort of moving the data around and making sure it gets to where it has to go quickly and easily. So John's comment, Les's comment, Steven's comment, Carolyn's comment. The other, though, is the sort of the quality of the data itself, and are the data sufficient for the work that we're asking the different parts of the system to do? So, do patients have a data set that they can be responsible for providers, researchers, public health system managers, supply chain folks. So, who needs what information, where are the gaps in the information they need, and how can we as the committee focus on filling those gaps? So, this is the other half of the piece. If we don't have good data, it doesn't matter.

Robert Wah

At this point, I want to take the chairman's prerogative to step away for being Chairman for a minute and make a comment, and I'm going to call on myself, I guess is what I'm going to do. And I see a number of people on the list that have already spoken, so I thought this would be a good time to do that. It occurs to me that I submitted some information about COVIDcheck and the CommonHealth project, and it probably needs more explanation than just submitting the two slides that are in the materials that you all got. And by

full disclosure, I was asked to join the board of the Commons Project last fall, and two weeks ago I was asked to lead, as Executive Director of COVIDcheck. So, I have a piece in all this.

But the two slides that I presented, I wanted to talk about the COVIDcheck. That was an immediate thing that came up, we tried to figure out what we could do to help in the fight against Coronavirus, and in the center it's got people, and we have four functions that we think that the capability will provide. One is an assessment, so we do a risk assessment based on CDC and WHO guidelines, but then we create the Guide, Subscribe, and Report function. And the guide is to, based on the risk assessment questions, help the individual figure out what is best for them. And then, that goes to the right side of the chart where that might be helping them find services, help them connect with triage services, help them connect with telehealth, help them connect with other direct care. And then, on the subscribe and support function, that goes to public health organizations on the left where they subscribe to reliable streams of verified information from public health organizations.

But also, they can report back their health status and potentially, if this infection gets way out of control, their life status, because we're very worried that as services get overwhelmed, we're going to need the front lines reporting not just health status but life status. Is there water, is there shelter, is there public safety, and all that kind of stuff. And that intersects with the CommonHealth project, which is the bigger release from the Commons Project, which is where we recognize that in the current environment, there's an iOS platform to pull information from various sources and consolidate on an individual's mobile device, but there's no Android version for that. And so, the Commons Project is really trying to be a nonprofit that sits between the private sector and the public sector. And so, we felt that this is something that we could do that probably no private sector or public sector entity would do.

So, we're releasing the Android version of Apple Health in early April. And this is where the technology is simply going to serve as a proxy login for individuals, pull their information off the various portals, and put it on their mobile device for them in a secure fashion. And the intersection that I see between these two and where I think the HITAC could use this as an example of where we can apply our expertise along with ONC is all about the data liquidity issue that this brings up. Because if CommonHealth is to work appropriately, we're going to really need persistent API agents so that when we log in we can get the data. Individuals will then be able to hold their information, and in an emergency, take it wherever they need to take it. So, many telehealth organizations are not connected with our normal infrastructure of information. And so, we're sort of putting the information in the hands of the patient, and they can create that link between their results, their medication history and those kinds of things, and provide that to the telehealth provider that may not have seen them fully before.

And so, this idea that there's a more free flow of information, as already been cited, is part of what we're implying in both of these activities. And so, I just wanted to put that out there, that I felt like there needed to be a joiner between those two pieces of information I put out in COVIDcheck and Common Health. But I think this highlights where HITAC and ONC can be useful.

I also will talk just a minute about things that we see coming up is there's going to be a need for better reporting of citizen status. We touched on this in the privacy issues, but in China, for instance, they're giving people a QR code with their health status. And so, if you are clear, you're not infectious, and you're good to go, then you get a green QR code that allows you through certain restrictions because you're not

infectious and you're not ill. And so, you can envision that that's going to demand that we have probably better identity management technology, but also how do we connect identity management with our privacy rules, and this whole idea about status. Are you an essential healthcare worker, therefore you can travel? Are you not ill, therefore you can go through certain barriers where ill people are being filtered out? These various status things that we need to do, they're probably going to be linked to some sort of identity management system.

So, I just put that out there, that I think what the next level of sophistication we're going to have to come up with as we think about technology in responding to this current pandemic. So, with that I would like to go back to the list of people that have already spoken. And I see Clem, you wrote me a note. I'm not sure you still need to speak, but I'll give you the floor if you need it. He said he had to drop off, so I'm not sure he's still – okay. Aaron? We'll go to you.

Aaron Miri

Thank you, yes. No, I appreciate that. So, I'm going to give a couple of, again, real-time updates and things that I believe we should consider. Again, I'm not taking away from all the other ideas. I think those are important. But I'm going back to the immediacy of this. And if people think that this is as bad as it's going to get, they really need to think again. The data's showing completely a different story. So, let's talk about some real-time ideas.

No. 1, raising issues with cellular bandwidth across the city. And again, I'm in the capital city of Texas. I believe there could be a partnership with the FCC to reserve bandwidth for all first-line responders and healthcare providers to ensure that they can be notified with timely updates, be able to communicate in the field as we triage. We know that we're going to have to expand services outside of the inpatient hospital for anybody that's not truly needing a ventilator or whatnot. So, how do we make sure that they don't drop connections? We're already seeing issues with that, because it's all being sucked up by people working from home.

No. 2, look at the forms that are out, particularly for contact tracing. The CDC form? Fantastic. Numerous fields. Numerous, numerous fields. In fact, it took us about a day just to make that form that's available on the CDC website into something we can type into with PDF, much less then turn it into discrete forms. But if you take the CDC contact tracing form, look at the state-level contact tracing form, look at your local public health contact tracing form, they're all different. Can we normalize that and get down to a set of data elements that makes sense so that everybody can adopt them in various forms? We're in the process of rolling out an app on iOS and Android trying to get in front of this, and we just had to take a shot and say, "Let's go with the national form and then deal with it."

No. 3, Data sharing. Right now, if you look at total numbers of people infected, looking at a timely dashboard, there's an issue between federal and state data sources on who is infected and what numbers those look like. As we do our standups every single day, we're having to reference multiple dashboards and say, "Well, they think this is the total number of people infected in Texas, we believe this is what it is." And then, if it's not updated at 7:00 a.m. or 7:00 p.m., we just don't know. So, is there a way to get this down into a synergy and say, "This is the defined gold standard as to what you're looking at and dealing with at a state level and federal level?"

Next one, protection. Looking at it, we also run a medical school. We have a residency program. We have medical students. Everybody is throwing in help. As you saw, New York relaxed their Year 4 students, or MS-4 students, to allow them to jump into the mix and become MDs really quick and skip their final exams. So, is there a way to partner with the ACGME and AAMC to publish guidelines on what the right protections are for medical students and residents and maintain data integrity in the medical record as they chart and prescribe and whatnot? We need to be able to fast track that so we say, "This is how you do it if you're going to suddenly use your medical students and residents to be doing more than what they typically would do in the course of care dealing with COVID."

Next, research. Clinical trials. We are doing a number of clinical trials here at UT related to COVID. How do we get FAQs for the IRBs and whatnot to speed up any human trials or announcement of grants or whatnot? Is there an ability to partner with AAMC and AHA and others? If you look at what MITRE's doing by bringing Coalition there, HHS could do the exact same thing by helping to say, "This are the FAQs on, say, HIPAA." Right? So, IRBs know that anything related to COVID, you have HIPAA waivers in place to be able to accept certain types of risks and try out an animal experiment or human trial or whatever else, per guidelines.

Next, let's look at military data sharing. How can we encourage partnerships with the military health system, the DOD, the VA, and others to share information related to COVID? Again, it's going to be hard when not everybody is utilizing the latest ICD-10 codes for COVID. And some, again, EMR vendors are very reluctant to do it, so how can we accelerate all of that and get a national framework together? The DOD has an excellent information sharing platform. Let's leverage it. Let's tap into it. Let's partner together and make this happen.

Next, how do we look at being able to relax certification and accreditation rules to turn, say, somebody building an ambulatory surgery center and is suddenly becoming an oxygen therapy or ICU beds or whatever else? There's a lot of head scratching going on, saying, "Hey, we have this new ASC we were going to open up. Can we convert those ORs into something more useful for COVID?" Perhaps you could. But if people don't understand what the regs and regulations will allow for, maybe we can streamline and fast-track that. And then, another idea that I have. Right now, we're seeing a tremendous amount of need for information into the public about what is really happening. Is there a way to tap into the Amber alert system and others to say, "Hey, here's the facts of what you do for COVID – stay away from the hospital unless you are absolutely sick, go to your nearest urgent care clinic or nearest outpatient clinic if you have a cough, they can help you there."

We've got to be able to get the right information out there to dispel some of the fud that's infesting into our clinical staff and our patient population, and say, "This is what you need to do on a city-by-city basis. If we do all of these things, that will help the problem right now. Right now. Which ties into every single larger idea which we've been speaking about and opining on this call. Thank you.

Lauren Richie

Okay, this is Lauren. I think Robert may have lost audio for a minute. I see Les is next in the queue.

Leslie Lenert

No, no I don't actually have anything more to add, thank you.

Lauren Richie
Okay. Sure. Arien? Another comment?

Arien Malec
Thank you. And again, I just want to double underline a couple of things that Aaron said. No. 1 is that if we don't have universal rollout of terminology, I'm not sure that anything else we're talking about matters, because we can't get Job No. 1, which is disease surveillance and risk management data for trials available for the rest of the ideas that I'm going to talk about. No. 2 is I don't think we need to go, as a number of folks have alluded to, I don't think we need to go to relaxation of HIPAA. I think we can use existing authority, HIPAA waivers, and existing guidance. But I think this conversation indicates how confused the conversation is, and better guidance in partnership between ONC and OCR in terms of information sharing that's allowed under existing authority would be extraordinarily helpful.

No. 3, I think Steve Lane talked about the amount of data that's flowing through Carequality. There's a huge amount of data flowing through CommonWell, which also has a Carequality bridge. We've got a number of HIEs that are up and running as John Kansky talked about. There's a lot of information that's actually flowing through the nation, and we should be able to turn and deploy that information flow to improve disease surveillance and improve identification risk factors and improve remediation and return to normalcy. So, again, I don't think any of the rest of this matters if we don't have terminology that's universally deployed. And I'd also like to – again, I don't know that this is an ONC authority, but I do believe there's an ONC role in coordination and convening relative to both standardizing IRBs for clinical trial approval, but also standardizing real-world data that is sourced from EHRs. And again, I think there's a role for collaboration between ONC and FDA and ARQ, and other organizations relative to standardizing clinical trial information and real-world natural history trials sourced from EHR data.

But again, I just want to underscore No. 1, there is a lot of information that's already flowing that's flowing in an uncoordinated and disaggregated way. There's a role for intelligent, smart privacy policy that already follows existing authority under HIPAA, but we need better guidance, better information, and No. 3, none of that matters if the underlying source data doesn't 'have the associated standards that allow for case tracking. And I also want to underscore and endorse the notion that if we're asking for duplicative case tracking information through menial processes, let's stop that. And again, I think ONC can play a role in convening information flows, standardizing information flows in partnership with CDC and state public health agencies. And I just want to again underscore the use of ONC as a critical role in convening and in standardizing existing work that's going through other HHS agencies, DHS, and other organizations across the federal government in coordinating with states. That coordination role is critical in a time like this. Thank you.

Carolyn Petersen
And let's go to Abby Sears. Are you on mute, Abby? We can't hear you.

Abby Sears
Hello?

Carolyn Petersen

Hello, Abby? Go ahead.

Abby Sears

Hi. Can you hear me? Okay. What I wanted to say was just that there are a couple of points. And a lot of this has already been reiterated, but we have a little bit different one, so maybe adding it in will be helpful to the conversation. The first thing is that I know we want to focus on what the ONC has the purview over, but the role of the ONC as a convener has such a big possibility of impacting the rest of the system that I just really want to reiterate the convening role. We're really struggling in the rural areas. We're seeing degradation of the networks. We're having issues with patients being able and providers being able to use the broadband and the services. There's a degradation, and they're not being able to access.

The second issue is really around the restrictions around CFR 42 data and the alcohol and drug treatment data. A lot of our patients have two, three, four, five, six, seven, eight comorbidities. And when they are connecting with their providers, especially in a time like this, it's not reasonable or practicable to assume that they're going to call only about one issue. They need to call about all the issues that they are experiencing, and that means that if they have alcohol and drug treatment issues as well, that they've got to be able to access and work with their providers. They can't be calling four different providers, because they don't even know if they can get ahold of them. So, I just wanted to make that kind of point and continue to reinforce the point around clinicians have the right and need to be able to know what's going on with patients so they can give them the best treatment possible. Those are the two, I think, really big issues that we're seeing out in the rural areas and with some of our providers.

The last thing I'm going to say, and it's probably not going to be very popular, but I'm going to probably put it out there anyways, is that our part of the delivery system does not have a lot of adaptive capacity. They are very quick, and just like the rest of the system, switching to virtual care as fast as they humanly possibly can to protect their providers and their clinicians. They can't afford to lose one or two providers for any reason. I don't think any of us can. And they absolutely do not have the capacity to implement the interoperability rules. And what I'm worried about is that they're serving some of the most vulnerable patients in the country, and they have to be in service to that first and foremost, and they're not going to be able to implement as swiftly as we might wish that they would. So, any leniency or delay in the implementation of the rules would be greatly appreciated, because I think if we don't do that, they're just simply just not going to make the timelines. They're not going to be able to.

Robert Wah

Thank you. Ram?

Ram Sriram

Yeah, this is Ram from NIST. I think there's a lot of good ideas put forward, and I'd just like to add one to that, is the use of artificial intelligence for addressing many of the issues that we are facing right now. For example, I put a URL to a website, Kaggle.com, which I guess was bought out by Google. They have all these documents that people are analyzing, and you can see the contributions there once you go into that. So, from an ONC perspective, I think we should look into the role AI can play in this, and how AI can accelerate the development of new vaccines, maybe, or how we can help with the information, how we can

deal with misinformation that's going on the web. We can do a number of things that AI can do, so those are my comments.

Robert Wah

Great, thank you. All right. So, I don't see any additional hands up now. Thank you all for your participation and your input and accommodating of this rather unusual way of going through our processes here as a committee. We recognize that this is not our normal cadence or process, but these are unusual times. So, thank you for your indulgence in that.

So, what I would like to propose then is sort of a short list of things that we have heard and maybe solicit additional comments in these areas. Because ultimately what we're hoping to do out of all this discussion today is Carolyn and I along with the ONC will take your comments and try to distill it down to some charges that we can put forward with HITAC, and then we'll present that back to the committee and solicit your participation in a task force. So, what I would propose is what I've heard is several categories. Privacy, data standards, data interoperability, infrastructure, and how all of those things tie back into the public health mission in the pandemic. So, I guess I'd like to hear your comments and feedback on that list, or if you wanted to comment more specifically about any one of those items on that list.

Carolyn Petersen

And what would be really helpful is proposing specific actions, like things that the Health IT Advisory Committee could comment upon or further in some way rather than more broad discussions about areas that are important. We're really thinking what is a to-do list that we can try to tackle, both in the immediate term and then some things, of course, that would be coming later a few months down the road. Thanks.

Robert Wah

Yeah, along with that, there's actually another part of the question as well. Is this in the realm, is the natural owner the HITAC and ONC as well? So, thank you. Sorry, I cut somebody off.

Cynthia Fisher

Yeah, sorry, I can't raise my hand online. This is Cynthia Fisher from Patient Rights Advocate.

Robert Wah

Go ahead.

Cynthia Fisher

Hi, how are you? So, thank you all for what you are doing and the intensity to deal with this pandemic crisis and some great ideas that came up today. I'm wondering of the HITAC and ONC, is there a way from the patient standpoint where people are told to stay down to where they are within their homes but you have, say, an adult child managing an elder who may live in Florida, for instance, in another state, or a college student at the same time who is staying in another state from the same family. So, as this epidemic progresses to serious illness, the shared access among family members to try to remotely care for their loved ones is ever more important. So, I would challenge us to see if we could look at the interoperability infrastructure and what barriers we can put down in that data sharing that we can readily get to the shared standards of, and the barriers that exist today to not allow for that interfamily sharing of data.

So, I was encouraged by your discussion earlier about working with Apple and perhaps to have a mobile app to that effect. But if you think about this as we read today, that we may see three waves of this epidemic, it's more and more important that we don't look at the two-year horizon for interoperability, but how can we address the needs of patients to have this critical access to their own and their loved ones' information shared readily? So, I just put that out there to say, what standards can we get going in parallel that we can open up the APIs to deliver on these standards and share through a mobile app or through those types of interfaces? How can we move faster?

Robert Wah

Thank you, Cynthia. Please let us know if you want to get back in the conversation any time. Thanks. Also, any other HITAC member that is dialed in, if you can't raise your hand, please do just say something on the phone and we'll get you in. So, we tried to put up on the screen, again real-time. We have all the comments before, and you can see them rolling out as we were having our conversation. Again, these are the ones that I heard that I put up that are being typed up right now. I would like to hear from the committee if this represents what you all heard and also if you have further comments or input in detail about any of these, we'll take that now. I don't see hands coming up. Now, they're starting to come up.

Carolyn Petersen

Aaron Miri.

Robert Wah

Boy, we have a lot to do. Yeah. Aaron, why don't you go ahead?

Aaron Miri

Yeah. So, real quick, I think you're right, Robert, and that you're hearing the categorization appropriately. I do want to stress, and I ask the fellow committee members to please consider that we turn HITAC in the immediacy into a "get it done now" circumstance. And while these other issues, I'm not saying they're not important, I can't stress enough that time is of the essence. Every single day, more of my providers are becoming positive-infected, more of my clinicians are being exposed, and the public is getting sicker and getting more anxious. We have to act. This committee can act as a convener across the entire federal government, pulling together agencies' jurisdiction that perhaps would not have talked in a normal basis around healthcare matters. We can do that. All the ideas listed before, the ideas many of you have laid out, we can talk about those things. We can work through it. We can make it done now.

So, I just ask everybody on this call that I think you're right, Robert, in the way you're looking and categorizing it, but we should focus on the immediate. Thank you.

Robert Wah

So, Aaron, If we can get you – what specifically would you, if I gave you the forum, what would you specifically want to focus on?

Aaron Miri

Sure, I would focus on the idea that I laid out for you in my previous rant in terms of looking at how do we reserve bandwidth for providers? How do we convene the FTC and brainstorm? I know they're looking at things right now. They want to help. How do we convene with the CDC and look at the tracking forms and

those items I brought up? These are relevant items that can be solved in pretty rapid fashion. How do we encourage the vendor community to go adopt the new ICD-10 code? Who cares what your worries are, who cares what your costs are for being able to do some R&D and development? Push it out. Get these new standards into the hands of the providers. The clinicians need them now, and data is our friend. Not our enemy.

Robert Wah
Thank you. Terry.

Terrence O'Malley
Yeah, sort of related to that – and I'm sorry, I'm in a marginal cell zone – is really making sure as best we can to get this information in one place. So, another ONC convening role might be to expand the ISA. In a sense, turn it into the go-to location for standards related to COVID more broadly. So, take the work of the committee but put it in a central place so people don't have to go out and organize it and collect it all by themselves. So, just to do it once and get it in one place.

Robert Wah
Great. Thanks. I think there was somebody else who was trying to get in. I didn't see their hand, but when Aaron was speaking, I thought I heard a voice that came on. Did I miss that?

Donald Rucker
Hey, Robert. Yeah, Don Rucker. To Aaron's point, I think we do need to be careful. There is already an entire command structure, much of which is now in concert with FEMA on doing things. So, we're not really in a position to set up a separate command structure here. I think we really have to think about how we package suggestions to make them operational by the folks who have the operational charge in the field.

Robert Wah
Thanks, Don. Are there – oh, I see. I have Abby.

Abby Sears
Would we be able to prioritize bandwidth and networking for healthcare activities? That seems like something we could ask for to the command center, and that would be fairly easy to implement fairly quickly.

Robert Wah
All right. Aaron. You had another comment? Aaron, was your hand up?

Aaron Miri
Aaron or Arien? Arien, right? Arien. I think it's Arien.

Robert Wah
Oh, I'm sorry. I looked at a microphone, not a hand. Sorry, there's two images showing up here. Sorry about that. Well, Arien, did you have another comment?

Arien Malec
Nope. Thank you.

Robert Wah
Yep. Sorry.

Carolyn Petersen
Are there any HITAC members on the phone who have thoughts to share?

Cynthia Fisher
Hi, this is Cynthia. You know, just from a patient standpoint across our country, we heard about the Verily project or Google project to let us know where there would be drive-up testing sites, but listening to the department chairs of emergency departments, their frustration of people with no symptoms or mild symptoms taking up beds and their protection garb to do a COVID test. I think, is there a way to fund interoperability from a frontline standpoint? We could have a data interchange that breaks it into categories, like no symptoms, need of test, mild symptoms, need of test sites to go versus critical systems to then go to ER. But how can we free up our emergency departments for the critical care and triage through our nation's interchange of communications? So, I was just curious, because people do not have the information and heard earlier the Amber alert type of notification, but if there's a way that we could provide that simple data interchange, it could tremendously help our emergency personnel.

Robert Wah
So, Cynthia, I'll take that because I'm doing a lot of work in this area. The idea of behind what we're doing is a risk assessment tool where we ask somewhere between 12 and 19 question. And using CDC and WHO guidelines, we try to give a clinically relevant risk assessment to the individual and then categorize them in what their particular actions and guidance would be, again, based on CDC and WHO guidelines. So, there is a belief that that can lower the pressure on the triage systems that are out there and not have everybody flood into the system unnecessarily. But then, the question that comes up right after you do the risk assessment and the guidances, how do you connect the patient with the guidance that you give?

So, they need a telehealth session, how do you give them the right information to take to that telehealth session? Or if there's a phone triage system that they should call in. So, we're trying to create a mechanism where they can take their responses to the risk assessment tool and give them to the people that they are interfacing with, whether it's a phone triage or telehealth provider. But we want to have a richer source of information that they could bring to those sessions as well. Maybe their medication list, their medical history, their lab results. Once more people are tested, how do we verify people's test results are connected to them? And that's why I mentioned the identity management issue. As we get into the status of people, I think there's going to be a need for more robust identity management to be able to classify what people's status is, whether it's their test status, health status, their medication status, or location status. All those things are going to be hinging on some sort of identity management.

Cynthia Fisher
I guess you know, Robert, I think if we know that most Americans have a form of a smartphone, Android or Apple, right? Or a platform of a smartphone, the issue at hand is you can't count on television or whatever, news or whatever updates, but if we know that is one of the most deployed devices of communications, is there a way that we can, through national emergency, provide a nationwide update that provides action for resource to triage? Again, not to choke and utilize supplies unnecessarily or time of our ED staff.

Robert Wah
Yeah, and like I said, there's a lot of work being done on these risk assessments. Some are symptom checkers, very simply symptom checkers. And others are what I call a risk assessment tool. But, yeah, again, touting the thing I'm working on, but COVIDcheck is trying to be a two-way information platform where the public can get a reliable source of information that is verifiable, not the sort of social media stuff that flies out all over the place, but a more curated version of that information so it's reliable. But also can provide a two-way communication link back to the healthcare system and public health organizations about individuals' health status or, like I said, life status. I don't want to monopolize this conversation though. I'm looking to see if there are other hands up. Abby, you have your hand up, but maybe it's from the prior comment?

Abby Sears
No, there was just one additional comment, which would be the IRB, and simplifying the IRB process and streamlining it and making it easier for us to do some of the trials that we're being asked to participate in. I think that would be something that is quick and – I wouldn't say easy to implement, but it's something we could tackle pretty quickly.

Robert Wah
Okay. Great. Thank you. Other comments about the four categories that we put up? Happy to hear additions, deletions, alterations, or if there's something more specific you want to talk about in any one of those four categories. Les?

Leslie Lenert
Hi, I wanted to comment off Abby's remark and endorse that. I think one of the biggest issues is going to be allowing investigators to directly contact patients who have COVID-19 without a clinical relationship with them. We have so much care going on in remote facilities via drive-thru testing and telehealth that the usual relationships that we have had in clinical care that have governed contacting patients for involvement for research aren't relevant anymore and we need a new approach.

Robert Wah
Thanks. Arien.

Arien Malec
Thank you. You know, relative to Don's comments, I would be interested in hearing what is already going on in these areas that we suggested. What is ONC already coordinating? I think just hearing a perspective on what are the met needs or the needs that are already being met, and then where are the unmet needs and work in this committee most effectively help in providing advice to the Office of the National Coordinator. But I do think it would be useful to have a baseline for what is ONC already doing, what is CDC already doing. You know, what already is being covered in the response and where are the unmet needs that we can help in?

Robert Wah
Thanks for that. We have envisioned that we were going to have them comment on this and this as good a time as any. So, Don, Steve, and I think Elise and Seth are both on as well. I'll let you guys comment on it.

Donald Rucker

Okay, yeah. So, obviously a number of thorny issues have been raised here on getting information and moving information. I think the federal priorities, ultimately the federal agencies have been, I think, going to what people have seen in the news media, pretty much, which is some of the resource, freeing up testing, those types of things. There's been a bunch of discussions about ancillary things like getting data from testing. I've been told the CDC – and Adi may be able to comment on that – is already getting the LabCorp and Quest feeds on outpatient stuff. So, they're actually getting a fair amount of information on, I guess, spread of the disease. In terms of case finding, whether that is manual case finding or automated case finding, and then contact tracing, obviously the manual case finding stuff I think in many ways has overwhelmed certainly the areas where there's a lot of disease already. And the folks there, the governors of those states have responded, as folks know, with various shutdowns.

There have been some discussions about using cellphone technology and things like that to do what I would call automated case tracking. I don't think, at least to my knowledge, those things are really far along, and the illness is I think moving pretty rapidly, so that for example, one model that was technically quite clever on encrypting phone pads, certainly for the iOS, the Apple phone system, and then sort of letting people have an app to track the known paths of patients. We don't really have a mechanism to either get or force data from folks who are positive. Let's say their last three weeks of movement, whatever the dormancy period turns out to be. I think there have certainly been some discussions there, but we don’t have that information.

I liked Aaron's comment about the Amber alert, that may be something. FEMA is more and more involved, so a lot of the original stuff was really more high-level at the cabinet agency level, but as this is being rolled out into FEMA, I think for all of you, there are local opportunities as well that you may want to think about investigating. There are also a number of other things out there. Some of the vendors of ADTC are trying to use this as an opportunity to mandate use of their products. You know, with some statements that they will be able to – for bed capacity from ADTC. How much of that is actually true, whether that would add value, since with my experience in 30 years of being an ER doctor is that hospitals and towns pretty much know what people's bed capabilities are just from managing all the EMS traffic live to begin with, as well as just waiting room waits, that type of stuff. So again, this is another time where folks may also see a chance to advance whatever their favorite business models are in there.

So, those are some of the things that are out there. Again, I think it is hard, given the number of wonderful suggestions here. But I think at some point it may be that we need a second call after we look at things and maybe work with Robert and Carolyn and do some internal prioritization and filtering to sort of figure out what we can advance. I mean, one thing that's clear is only a handful of these things, the bandwidth of folks, the bandwidth of the IT community, the bandwidth of the clinical community, the bandwidth of the public health community, is limited. So, if Adi is on from CDC – I don't know, Adi, if you have thoughts here before turning it over to Steve, but I'd like to get Adi's thoughts if he's on, in terms of all of this.

Robert Wah

Adi, I know you were on originally. I'm know if you're still on now.

Donald Rucker
Okay, all right. Steve, do you want to add in your thoughts?

Steve Posnack
Sure. Thanks, Don. You know, I think to piggyback on what some of Don mentioned, there are a number of areas where we as ONC, with coordination as our middle name, are stressed in terms of the internal coordination that we're providing within HHS. This is an area where we shine. We normally operate and interact with a wide cross-section of the sister agencies that we have in HHS, and a lot of our work behind the scenes has been to put them in touch with the right stakeholders in various different issues, raise particular challenges or other things that have been expressed to us as a first point of contact. So, if it's matter of getting in touch with CMS or getting in touch with OCR, NIH, CDC, you know, the names can continue.

We are providing that glue between a lot of those agencies as you might expect, being the Office of the National Coordinator for Health IT. We are providing a lot of consultative support from a data standards and technical perspective to those other agencies, that they have conversations with different private sector groups and want to track back and better understand kind of fact and reality and what are capabilities on the ground. Certainly fielding information just like the two resources that I mentioned at the earlier portion of the call where we can help organize and identify synergies between different group efforts. I think we're seeing a lot of very well-intentioned activities that are going on that are now starting to have some scope creep across each other's swim lanes, and we're starting to try to point that out to stakeholders as we interact with the various different communities.

So, that there are a number of things I would say more on the soft skill side of our work that we are continuing to do, and I would say rapidly more so as different activities are ongoing. I think we are sensitive to, perhaps as Don was mentioning, about adding new efforts that would otherwise pull people away from the response activities that they're involved in right now. So, we're being very judicious about how we engage in a primary manner as opposed to supporting a lot of our other sister agencies that are leads for different response activities.

Robert Wah
Thanks, Steve. Elise or Seth, did you guys want to chime in?

Elise Anthony
Yeah. This is Elise, and I think Steve and Don captured it well. The other point that I would highlight is there are some things that are already underway. We want to make sure we continue to be a resource to the health IT community. So, you see some of that in what we updated our website to reflect. There's a page related to COVID-19, but there's also updates that we have made to the ISA to capture in one place some of this information. And I heard that came up as part of the conversation earlier, and I just want to highlight some of that is already in place. So, if there are specific things that you think should be added, or as some of these codes are updated over time, that is something we can add to the ISA as well.

In terms of thinking about potential charges, I think that the co-chairs highlighted it correctly. We want to make sure we focused on something that can be immediately implemented or addressed and that is very squarely in the health IT space. When we were looking at Zika response, that is something we did as well.

There was a very immediate question around pregnancy status and how that is captured, and we were able to coordinate with our federal partners and that was a charge brought to the federal advisory committee at the time. So, that's just an example of what coordination can look like, as well as what the charge focus could be. It may be different in this case. There may be different issues that arise from the COVID-19 response versus what we have done in the past, but just to provide an example of how this can occur and what the charge could look like and what an immediate charge versus something that is more long-term can look like.

And then, the last thing I would say is I do think it's important, and I love the fact that the HITAC is capturing items that are not just for the short term, but also things that can continue to be considered for the long term. Because eventually, we do want to make sure we are looking at those as a government overall, but also, HITAC could have an opportunity to include those and think about that in a longer reaching effort like the Annual Report. But as has already been stated, the immediate need, focusing on things that can really be addressed now, can be updated now to support the current COVID-19 response is critical.

Robert Wah
Thanks. Anyone else, ONC? Okay. So, I hope that helps the committee. That was a good suggestion. We appreciate the input from the National Coordinator's office. Let's continue our discussion about where we as a committee would like to go. Looks like Terry, you had your hand up. Terry, go ahead.

Terrence O'Malley
Sorry. It was up from before.

Robert Wah
Okay. No problem. Other comments from the committee? Okay. Steven?

Steven Lane
Well, Robert, you had asked a question regarding where we as a committee would like to go. And I guess I would just ask Don, Steve, and Elise, would there be value in standing up a HITAC task force that might be able to meet with ONC staff weekly or whatever is appropriate to provide input on ONC's evolving sense of their own priorities and where they should be focusing their energies? Again, I know ONC is getting lots of input from lots of corners and everyone is sending in suggestions, but since we are the HIT advisory committee, could we play a more active role in advising and providing diverse input to ONC's decision making at this time?

Donald Rucker
Steve, it's Don. Yeah, I think absolutely we would be game to set something like that up. I think one specific area – obviously today the conversation has been, I think, framed somewhat differently – but I think one area, especially for folks who are on the line in clinical care is to hear – and we've heard that obviously in some part – but to hear what is working and what is not working. And also, some of the very high value might be to serve as an early warning system on, "Hey, these things are coming up. These are where system resources are inadequate. This is what is needed." I think it would be helpful to hear that directly from folks on the front lines. We get a lot of that filtered here in D.C. and frankly typically filtered with commercial interests and commercial spins. But it would be helpful to hear it from the folks who are actually

providing care on what they need, that type of information. Having that on an ongoing basis I think would be very helpful.

Robert Wah

Yeah, Steven, this –

Cynthia Fisher

Don, this is Cynthia – I'm sorry. I'm just raising my hand.

Robert Wah

Cynthia, I have you on the list here. Just hold on just a second. I guess, Steven, that is in fact our plan. What Carolyn and I and the ONC were talking about is we wanted to have this rich conversation today, and that's why we've been trying to figure out the best way to get all of your input into this very rich and robust conversation. But what we would like to do is then take all of your input, synthesize it, and create a task force with the appropriate charges, and then we'll come back to the committee. Again, that is a little different than our normal cadence where we usually come to you with a proposal for a task force at the meeting, but given the way this is a very dynamic situation, we thought it would be best to create an environment where we can get this very rich robust input from the committee, we'll synthesize that, create a task force with the appropriate charges, and then solicit volunteers from the committee and potentially the public to then stand up that new task force. So that is, in fact, our plan. We appreciate you suggesting it.

So, now I have several people on the list. And Cynthia, you're on the list as well, but I think Christina was before you, so I'll call on Christina now.

Christina Caraballo

Great. Thanks, Robert. I think some of these things that I was about to say were just addressed. But I heard, Steve, when you said there could be scope creeping. We don't want to pull people away from what they're already doing, but I think HITAC is in a unique place to have the industry's attention and convene thought leaders really quickly in a place where people are going to pay attention to what is happening. In the past we have looked at HITAC members only on our task forces and I think it would be really instrumental for ONC to kind of look at all the groups that are putting in recommendations. As Elise and Steve just said, you've got a lot of people doing a lot of great things, but are we doing it in silos? And can we as a task force pull some of those thought leaders together? So, I know I get on a lot of different group meetings like HIMSS and HL7, and it's kind of like, "What can we do?" But we're all working to just move.

So, I think if we can pull in some leaders in all these different organizations that are all kind of working on similar things, to have a convening place, that would be really helpful. So, I would challenge us to really think outside of just our committee considering the dynamics of the current situation and really try to convene people that are doing things and pull them together instead of keeping them in silos.

Robert Wah

All right. Thank you, Christina. And as you all know, it's often my practice, I want to identify people who have not yet had a chance to speak before I recognize others. And I see Sheryl on the list, so Sheryl Turney?

Sheryl Turney

Thank you, Robert. I do agree with what has been set out here today, primarily focusing on what activities are saving lives first. So, I would highlight the item brought forward by Brett related to PPE equipment and what kind of monitoring systems do we need in place for a pandemic that don't currently exist today to ensure that all of the appropriate hospitals and providers have what they need in order to protect themselves? And then secondly, Aaron's comment about the inability to report the COVID-19 codes appropriately. I think those are the two things, quite honestly, that we should focus on.

Robert Wah

Great, thank you, Sheryl. I see somebody on the list that only listed their first name as Steve. So, I'm not sure who that last name is.

Steve Posnack

That's probably me. Steve Posnack, sorry.

Robert Wah

Oh, okay.

Steve Posnack

I usually put in the parenthetical ONC, but I'm incognito today apparently. Yeah, just to think about a few things and to carry forward some of what Don mentioned, as we consider a task force in this space, keeping in mind what could be focused on to make an impact now to kind of just add some additional context to my earlier comment, and it should be labeled as such. Because there were a ton of really important, really interesting, super things that I would love for us to work on in the future, but that have a longer term – as Clem pointed out at the beginning of the call – have a longer-term tail to them, and trajectory. So, we want to make sure that the things that we raise and discuss have the potential for impact now in the near term, that it's specific. And from an advisory committee perspective, I think just to give the overall context as much as we can convene, the speed at which that convening can occur may not be the speed at which we may need to move, and ONC as an executive branch agency can move faster than the convening advisory groups when we do a lot of the other coordination that I mentioned before as we get input.

But I think having a way to funnel important issues like the ICD-10 code and other things that could be reasonably addressed in a very short period of time, those are important things for us to hear about and I want to make sure that as we set something up, we're not positioning everyone with misaligned expectations that would yield an over-promise and under-deliver of the work that we identified that needs to be done. We have a lot of magic powers as an executive branch agency, but there are a number of other things that we are not best positioned to do. So, supply chain management and other types of topics in that area are just not things that are principally within our wheelhouse to address.

Robert Wah

So, thank you, Steve. And, again, thank you for highlighting what I would call the natural owner process that we have to make a determination on as we look through all the input that you are giving us. So, I'll go back to our list. I see Les has his hand up.

Leslie Lenert
Yes. I think there are certain activities by volunteer standards organizations and by health information exchanges that need immediate financial support. And perhaps we could discuss about opportunities to provide that support in this area through ONC.

Robert Wah
Okay. Christina, do you have your hand up still or is it a second time?

Christina Caraballo
Oh, sorry, no, I don't.

Robert Wah
Okay. All right. Well, one thing that we have been noting is there is a lot of activity on the public chat comment, so we want to make sure we have adequate time for our public comment period. And so, those of you that want to make a public comment, please note that there's a phone number to be dialed into on the lower left corner. And we'll start that queue up pretty soon. I just want to give you fair warning about that, because we want to make sure that we do, in fact, hear from the public. Looks like we have about 100-plus people dialed into this on the application, and I don't know how many people we actually have dialed in on the phone. So, we appreciate that there's a lot of interest in this and we want to make sure we have an opportunity to hear from you. So other comments from the committee?

Clem McDonald
I'm back on the line. I have one quick comment that I'd put in to add.

Robert Wah
Yeah, go ahead, Clem. I also remember that Cynthia was on the line on the phone as well. So, Clem, can you just hold for a second? Cynthia, I didn't recognize you, and I know you were on the line earlier.

Cynthia Fisher
Thank you, Robert. This goes back to Don's earlier comment from the front lines, and I think Don, Dr. Rucker, we are very fortunate that your specialty is emergency medicine in this time of crisis, and I think you wear a different lens. So, the question I would have for our committee is could we look at implementing a data-gathering input from the front lines as John had mentioned. And not just what is brought into Washington, but actually real-time from the front lines on what our emergency personnel need and suggest or barriers or dataflow that they need to have the walls come down or the blockage stopped so that they can deliver the best care in this crisis. And I can give you two examples that I would say, is there a place that we could deploy the pipeline of two-way communication or a place where we could gather what their needs are?

And one of the examples I could give you would be, for instance, the emergency personnel dropping off patients that might have been exposed and wanting to know if they themselves might freely get tested by the ED staff when that has been revealed. But when they get a positive result from the patient, it's how do the emergency personnel deploy to the emergency medical staff, the firefighters, or the emergency EMTs that bring these patients in that they should quarantine if they maybe possibly have been exposed. So, we are having that problem in Massachusetts with firehouses exposure, etc., from their departments and not

being able to know where and when and have that coordinated. I think the other one is the EMTALA issues where patients do come in, again, asymptomatic or needing to have a test or not have a fever, and yet that requires in today's standard that a physician or PA needs to give a full exam. And if people -- if they could be sent or diverted to not being in that ED – but, again, I think with EMTALA, that is not possible today.

So, if we could look at is there a place that exists now within HHS that these emergency personnel can tell you where the siloed or bureaucracy or the privacy issues are helping or harming care and that we could expeditiously look in our data interchange and our records interchange or however we do it, what role we play, but is there also that two-way channel today.

Robert Wah
Thanks, Cynthia.

Donald Rucker
I think OCR has released some information there, I believe. I don't know, maybe Steve or Elise can comment on that? The OCR, the Office of Civil Rights.

Clem McDonald
Could I add to that? This is Clem. There are two points. One of them, I heard many conversations saying there's no way to report, there's just no standard code. That's not correct. That's completely incorrect. So, WHO, LOINC, and SNOMED have all made codes and publicized them. There are over 30 codes already out, and ones for the CDC and WHO. And they had a meeting today with 700 people on the call promoting it, it's very high interest area. So, that should be repeated as a rumor. It's not true. The second thing is it's not just emergency personnel that have to be warned. We've got to really identify contact staff and we've got to use every mechanism possible. I think the privacy stuff is inhibiting that. I don't know that. Maybe there's exemptions that we should be using. Every mechanism we can. And the person – I almost think we should publicize where they were, so that others can identify where they were in conjunction with them.

We don't have time. And I know there's a hot zone in a couple cities and it may be too late. Every part of the country isn't a hot zone. There's still time if we hurried.

Robert Wah
Thanks, Clem. All right. We're getting close to wrapping up our time for comments from the committee. Any final comments? And to the public, you can start getting on the line that you see in the lower left corner on the screen. Thank you for putting that slide up. And I'm just going to –

Elise Anthony
Hey Robert?

Robert Wah
Yes? Go ahead.

Elise Anthony

Sorry, this Elise. I just want to follow up on the question about OCR. Steve was kind enough to type in the chat box where the information from OCR is related to first responders, so you can access that there. But we also have several links we can send out to members as well.

Robert Wah

Excellent. Thank you very much. Thanks, Steve, for putting it on. Okay. Other final comments from the committee before we move on to the public comments? All right. We're a couple minutes early, but we can see if there are any calls. Lauren, do you want to open up the public comment for us now?

Lauren Richie

Sure. Operator, can we open the public line?

Operator

Yes. If you would like to make a public comment, please press "*1" on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press "*2" if you would like to remove your comment from the queue, and for participants using speaker equipment, it may be necessary to pick up the handset before pressing the star keys. Our first question is from Larry Ozeran with Clinical Informatics. Please proceed.

Larry Ozeran

Good morning or good afternoon, I guess, where you are. I had two suggestions. The first was to start to stem the panic. Adding additional access to accurate information and resources I think would be helpful. So, I would suggest that ONC, either alone or together with other federal agencies like NLM, create an online ring of trust to ensure that every valid COVID-19 resource links to every other valid resource. This could be either be peer to peer or hub and spoke, and this is something that ONC could implement basically by next week if you started working on it this week, and I've submitted more details with that comment through the online forum as well.

And then, the second suggestion is even though HIPAA has been relaxed, we should look at can we develop an opt-in process for members of the public to share identifiable data for research? I think there's a potential silver lining in this crisis that we have an opportunity to re-examine our communal reluctance to getting individual consent for research purposes, and particularly with the stimulus that's in the process of being passed, this might be a good time to pay for some infrastructure that would enable us to do that. I would think that the value of individual data right now would be rather high in this moment of crisis. Unlike the first suggestion, this obviously could take several weeks to several months, but it would have a lasting value for other crises in the future. Thank you for your consideration.

Robert Wah

Thank you.

Operator

Our next public comment is from Scott Stuewe with DirectTrust. Please proceed.

Scott Stuewe
Hi, can you hear me?

Operator
Yes, sir.

Scott Stuewe
Good. So, thanks very much for taking my call. I really appreciate the chance to chat. So, I want to just echo the comments of Steven Lane and John Kansky, who mentioned the importance of utilizing what we have already kind of on the shelf and available, and also kind of highlight Don's point about the importance that we know that what we're providing is of interest and importance to providers on the front line. I think that's very important. And also, Don's point that we need to focus on things that work without regard to how they might advance the business opportunities for this or that organization.

And so, I want to kind of highlight the opportunities that DirectTrust Network represents at this point in time to utilize direct specifically for the problems of care coordination, which I think are going to be unique in the COVID model. There's going to be a need to query for data to find out whether or not the patient is stratified into one or another category. And then, there's going to be a need to push that data to where it needs to go, to the appropriate COVID or non-COVID location. Such a mechanism could be deployed with no additional cost and no additional effort, frankly, for the industry, and with just a little bit of coordination on our part. So, at DirectTrust, we're already trying to work on that and also trying to collaborate with friends at Chic and Carequality, and the other national exercises to try and make certain that we're not out of step. But I also want to stay in step with what the ONC is up to, don't want to get ahead or behind of what the government is proposing.

The notion of a bi-directional channel for communication is actually already in place with direct messaging, so I want to make sure that the group doesn't forget that we have something important in the water that we can use to make this meal, to solve for this crisis today as opposed to running out to the store for something new. Thank you.

Robert Wah
Thank you. Additional callers?

Operator
Yes, our next public comment is from Seth Blumenthal with American Medical Association. Please proceed.

Seth Blumenthal
Hi, thank you. Good morning, everyone. Suggestion for immediate priority action given today's discussion, again, this is Seth Blumenthal from American Medical Association. Maybe a focus on on-the-ground standards, so that the codes that we've been talking about, I know we like to think about data models, but code sets are immediately usable, regardless of the data capture method. So, whether it's manual, mixed-mode, or automated data capture. So, good energy today around existing quote/unquote "business requirements," for example, the CDC forms, but there is a consensus that they're not easily put into electronic form. And so, what can the HITAC, what can ONC do given all of its current resources to public

guidance. Or maybe "guidance" is not the right word, but something that represents the best available recommendations on how to capture and code COVID-19 data for immediate and future use.

For example, the ISA is a good technical reference, but I could envision the ONC or someone publishing a document that has easy to read and understand guides. For those that are familiar with clinical chart extraction, imagine the kind of guidance that you would give a nurse clinical chart extractor, for immediate potential impact in the harmonization and normalization of COVID-19 data regardless of the entry method – again, manual, mixed, and automatic. So, perhaps there's opportunity to take some of the work that's already being done in some of those HL7 groups, the logic of others, and kind of, I don't know, get it together and publish something that's easy to use so that people who want to standardize data and are able to will, and it will help improve the quality of the data without requiring any new infrastructure. Thank you.

Robert Wah
Great. And Operator, do we have other comments?

Operator
There are no more comments at this time.

Robert Wah
Okay. Why don't we go back to the committee? I'm interested to hear other people's comments about – again, we're going to take all this input and try to bring it together to create a task force with a specific number of charges, and we'll bring that back to you with a solicitation for participation. I think it's been pretty obvious in most of the conversations, but if anybody has a specific comment about the timeliness or the natural owner question about what belongs in ONC and HITAC ownership versus others, I'll take comments about that as well.

Clem McDonald
This is Clem. Could I get some clarification on what has been relaxed in terms of the steep privacy rules? I heard they were, something about HIPAA got relaxed for this epidemic, is that correct? Or could someone explain it?

Robert Wah
I'll leave that to ONC. We also have a couple of people that have said they dialed in and can't get through. So, Operator, if you can maybe try to sort that out, there are a couple of people that are saying they're not able to get into the comment period. While we're doing that – and for the people that are trying to get in, please look at the (877) 407-7192 number. Hopefully that line is working. Okay. And Steve or Elise, do you want to comment to Clem's question?

Steve Posnack
Hey, this is Steve. I think Clem and I could probably talk offline maybe to see if there's additional information that we have, I guess, in the department that we could help with.

Clem McDonald
Okay, thank you.

Steve Posnack
And for the transcript, that was Steve Posnack, sorry. As much as I'd love to be Steven Lane.

Robert Wah
Okay. Operator, I think we have a couple people on the line?

Operator
Yes, we do. Our next comment is Janet Hamilton with CSTE. Please proceed.

Janet Hamilton
Hi. Thank you so much for taking my question. This is Janet Hamilton with CSTE. We represent applied public health epidemiologists for the disease detectives working on the frontlines –

Robert Wah
Janet, Your speaker is feeding back. If you could mute your speaker and just talk into the phone, that would be great.

Janet Hamilton
Is this better? I'm sorry.

Operator
Yes, much better. Please proceed.

Robert Wah
Much better. Thank you.

Janet Hamilton
Okay. Thank you so much. This is Janet Hamilton with the Council of State and Territorial Epidemiologists or CSTE. We represent the epidemiologists or disease detectives in state and local health departments that are working on the frontlines related to this response. I'm so glad this committee is convening and thinking about issues that can be done on an immediate basis, and I wanted to highlight a couple of things that are really confronting our members right now. One is the quality of electronic laboratory reporting data. While we have data feeds that are going, there are some very specific challenges related to the inbound data quality, as well as the outbound. One item specifically I'll raise since there's been some discussion about link codes is that we're seeing a very general specimen code, "respiratory," being used and there are identified issues around false-negatives related to the different specimen type. And the general respiratory utilization of that code does not allow us to evaluate that.

Second, we're seeing coming out of the messages from laboratories that many of the specimen types are left completely blank. So, obviously the specimens do arrive, there must be a specimen type. So, getting those feeds updated would be useful. As of this morning, from a number of the commercial laboratory feeds, those non-public health lab feeds, we are also seeing that around 40% of the patient demographic information is missing as compared to about 10% for other laboratory tests for other reportable diseases. So, that means we're missing the critical information to figure out who and where those results are coming from and be able to follow up rapidly to implement those control measures. We're missing address. We're

missing phone number in places where containment is still occurring, we're losing days and hours to be able to follow up.

So, pieces along that data quality that we can really resolve right away would be very useful. I would also encourage this committee to think about other options, like ask on order entry questions with some very basic kinds of information, where that could be quickly and rapidly passed along to public health that would help prioritize the case investigation process. So, information like whether or not the person works in healthcare, whether the individual was hospitalized in the ICU, if they're pregnant or not, and if there are symptoms present, yes or no. Finally, I just want to say that electronic case reporting is critical, and this outbreak with the speed and intensity that it is moving needs electronic case reporting where we're actually able to get data to public health out of the electronic health record. And I hope that this committee can prioritize those actions to support public health surveillance.

Robert Wah
Thank you, Janet. Operator, do we have others?

Operator
Yes. Our next comment is from Brett Blackman with HealthSplash. Please proceed.

Brett Blackman
Hello. Thank you guys for taking my call. So, we have been working very closely with Scott Stuewe and DirectTrust and the CCDA data that already is established inside the industry to be able to communicate between every certified EHR. One of the things that we have worked on for the last two years is to build a real-time pre-authorization diagnosis tool built on those standards. We have the ability to automatically flag particular diagnosis codes, medications and so forth that's inside of those CCDA standards upon transmission of that patient into any facility. We have no interest – we have no idea on the way of how the current endpoint solution can get fixed, which I've been in discussion with Scott over the last two weeks on. But we do feel with very little effort to be able to make sure the end points of inbound and outbound request facilities that are verified would allow the data to be transferred in appropriately to the frontline providers.

Lastly, we are launching the ability for the patient to request that same CCDA data, to hold it, and to be able to deliver to any transmission facility that they may be going to. And then thirdly, we have been working with some telehealths to give them the access to be able to do what we would consider a pre-authorization. We're looking for guidance on this, we're looking for your guys' COVID-19 check form and so forth on the diagnosis codes and actually consume that into a CCDA and deliver it back into the EHR to complete the care loop. So, all those things are available right now. We're just looking for some support to launch them. And mainly just awareness. So, thank you very much for taking my call.

Robert Wah
Thank you, Brett. I see on the public comment period somebody is trying to dial in, but we're not seeing that dialed into our system. Again, the number that I have is (877) 407-7192. Just put it on the public thing as well. All right. Until we get Blackford in, other comments from the committee? We're getting close to wrapping up here. Go ahead, somebody?

Clem McDonald
Not a comment, but it would be good to get a context for the call of Janet Hamilton, to get her connected up with people who can fix what she thinks she needs.

Robert Wah
Sure. That's probably a good idea. Janet, you might want to put your contact information in the public comment. If you're comfortable with something that you can put in there, then that will give us a point of contact for you. Or you can write into the ONC address as well. Do we have Blackford in or not? Operator, do we have anybody on the line?

Operator
No, he is not in the conference tree at this moment.

Robert Wah
Okay. So, he's piping away furiously, but I don't know what our – others were able to get in, so. I don't want to hold everybody up here. I will go over what our plan is. As I said before, I want to thank everyone for your indulgence in what has been a very rapidly put together meeting, and the compilation of all your great input, both before the meeting and during the meeting. Thank you all for your time and input and thoughts. Our plan is to take all of your input that you submitted before the meeting and during this meeting. We will synthesize that. I believe we have enough here then to create a task force. The task force will have some specific charges that we will put on that based on your input here and before the meeting, and our plan is to turn that information back to you as a committee. Probably looking at Monday to do that, maybe even Tuesday. We want to get this turned around as rapidly as possible, and then back out to the committee with a task force and charges, and we'll be soliciting participation on that task force at that time.

And we will let you know as this progresses. Again, thank you for your indulgence as this is a very, very dynamic time for all of us and I know we sort of have done things in a non-traditional way and we appreciate your indulgence with that as well. Carolyn, other comments?

Clem McDonald
Just a question. Can we still see the comments? Because someone's typing, and they haven't come in yet.

Robert Wah
The public comment channel is going to be captured. I'm sorry, somebody else?

Lauren Richie
Yeah, Clem, this is Lauren. If you are referring to the live notes that we were capturing, yes, we're just maybe cleaning that up a little bit and then we'll synthesize everything and get that out to the committee as soon as possible.

Clem McDonald
I was hoping to hear again Janet Hamilton's contact information. I thought she was typing but it isn't in yet. Never mind.

Lauren Richie
Oh. Yeah, we can get that to you.

Robert Wah
Okay.

Clem McDonald
Okay. Thank you.

Robert Wah
So, we'll get you that. Also, maybe we have Blackford in or not?

Operator
Yes, we do. Blackford Middleton, you may proceed.

Blackford Middleton
Can you hear me okay?

Operator
Yes, sir.

Blackford Middleton
Okay.

Robert Wah
Just for you, Blackford. We got you in.

Blackford Middleton
Well, I really appreciate the opportunity. It's a privilege to spend time with the HITAC. And I certainly appreciate this incredibly important work. Just a couple of quick comments. I know many of you, and some on the call are very interested in addressing an issue which I haven't heard addressed yet. That is how do we bring knowledge assets, decision support, measurement to all the different locations of care across the country? My own background is in knowledge sharing and in mobilizing computable biomedical knowledge for CDS and quality measurement, and I'm reminded of the Zika episode where it was very difficult to get Zika guidelines into multiple disparity EMRs.

I currently work at Apervita, which is a platform for generalized clinical computation in the cloud. We have connectivity to over 2,600 hospitals in place today with BAAs. And we have been fortunate to receive multiple CDC research contracts to focus on distributing CDS, and also we have architected a solution for case detection and reporting. So, with a small number of vendors we have been discussing these ideas around eCase detection and having an enhanced eCase report being made available to the CDC. We have a QRDA stream in place now from these 2,600-plus hospitals, going to be 3,000 before long, and to that we could add an HL2.exe stream or a FHIR API stream as COVID bundles are defined.

The folks we're chatting with include Surescripts, Curator, LabCorp, as well as HIEs. There might be a way to curate a novel stream of these data for the purposes of decision support case detection reporting and quality measurement. That's not been measured either. How do we think about measuring our response to the COVID pandemic as it unfolds? We have also thought about demand management. We help with algorithms that are now being published to identify at-risk patients and stratify them for population management, assist with self-management and self-triage, two key resources, as appropriate. That conversation is ongoing with Apervita, PatientPing, and Curator.

And then, the last is demand management. How do we help folks decrease their demand of precious hospital resources at this time when they're being overwhelmed by the COVID response? We have ideas around improving medication compliance, Curator has an application which I think is ready to go, and we could deliver that broadly very, very quickly. It's been mentioned about the patient access, or patient-reported data, patient-reported outcomes and iOS app leveraging the health record data store. That's also a very interesting idea we would be interested in helping with. Thanks again for your patience, Robert, and really glad to have had a chance to collaborate.

Robert Wah

Thanks, Blackford. Glad we got you in. All right. I think we are at the appointed hour to finish up here. Again, thank you all for your input, both the committee, the ONC, and the public. I think this has been a very good discussion. I hope it met your expectation after the call for such a meeting during our last meeting of the regularly scheduled HITAC. Again, Carolyn and I and the ONC have worked hard to try to meet that request of yours at the last meeting, and hopefully we were able to do that here today. But thank you for your indulgence and input.

I will turn it over to Carolyn for her final remarks. I don't know if it was mentioned or not. Normally we would have minutes approved of our last meeting at our next meeting, but this was not a regularly scheduled meeting, so the minutes of our regularly scheduled meeting will be part of our next regularly scheduled meeting, to put that in there. With that, I'll thank you all and turn it over to Carolyn for her final remarks.

Carolyn Petersen

Thanks, Robert. I just want to reiterate Robert's appreciation for all the HITAC members' input, both verbal today and written that we received over the last few days. We do intend to continue working with ONC who also has been greatly involved in this effort, and we look getting something back to you in terms of next steps within the next few days. We recognize this is an important and fast-moving evolving situation and we concur with your desire to move now. Thank you.

Robert Wah

Lauren?

Lauren Richie

Okay, we're set. I'll just remind the group obviously our next scheduled HITAC meeting is for April 15th, but please be on the lookout for another invite before then. We're going to coordinate with the chairs and align schedules and we'll try to get something on the books as soon as possible. If there are any other thoughts as a result of the call today, feel free to forward those to myself. And thank you all again for your time today. And if there are any other closing remarks from Dr. Rucker or Steve?

Steve Posnack
No, just thanks, everyone, as well. A lot of helpful thoughts.

Robert Wah
Thanks, Steve.

Lauren Richie
Okay. With that, we will adjourn.

Robert Wah
All right, you all. Stay safe out there, everyone. Stay separate. Stay safe and separate. Talk to you soon.

Carolyn Petersen
Thank you.

Lauren Richie
Thank you, everyone.