



Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) PUBLIC HEALTH DATA SYSTEMS TASK FORCE 2021 MEETING

June 3, 2021, 10:30 a.m. – 12:00 p.m. ET

VIRTUAL



Speakers

Name	Organization	Role
Janet Hamilton	Council of State and Territorial Epidemiologists (CSTE)	Co-Chair
Carolyn Petersen	Individual	Co-Chair
Danielle Brooks	Amerihealth Caritas	Member
Denise Chrysler	Network for Public Health Law	Member
Jim Daniel	Amazon Web Services	Member
Steven Eichner	Texas Department of State Health Services	Member
Ngozi Ezike	Illinois Department of Public Health	Member
Claudia Grossmann	Patient Centered Outcomes Research Institute (PCORI)	Member
Steve Hinrichs	Individual	Member
Jim Jirjis	HCA Healthcare	Member
John Kansky	Indiana Health Information Exchange	Member
Bryant Thomas Karras	Washington State Department of Health	Member
Steven Lane	Sutter Health	Member
Nell Lapres	Epic	Member
Leslie Lenert	Medical University of South Carolina	Member
Denise Love	Individual	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
Larry Mole	VA	Member
Abby Sears	OCHIN	Member
Sheryl Turney	Anthem, Inc.	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Cassandra Hadley	Office of the National Coordinator for Health Information Technology	ONC Staff





Brett Andriesen	Office of the National Coordinator for Health Information Technology	Staff Co-Lead
Brenda Akinngbe	Office of the National Coordinator for Health Information Technology	Staff Co-Lead





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

Operator

All lines are now bridged.

Michael Berry

All right. Thank you very much. And welcome, everybody. We appreciate you joining the public health data system task force this morning. I'm Mike Berry with ONC and we are going to get started because we've got a packed agenda. I'm going to call roll. So, when I state your name, please indicate your presence. And I'll begin with our co-chairs. Carolyn Petersen.

Carolyn Petersen

Good morning.

Michael Berry

Janet Hamilton.

Janet Hamilton

Hi. Good morning.

Michael Berry

Danielle Brooks.

Danielle Brooks

Hello. Good morning.

Michael Berry

Denise Chrysler. I don't think that was Denise Chrysler. I think Denise is joining us at about 11:00. Jim Daniel.

Jim Daniel

Good morning. I'm here.

Michael Berry

Steve Eichner.

Steve Eichner

Good morning.

Michael Berry

Ngozi Ezike. Claudia Grossman. Steve Hinrichs.

Steve Hinrichs

Present.

Michael Berry





Jim Jirjis.

Jim Jirjis

Present.

Michael Berry

John Kansky.

John Kansky

I'm here.

Michael Berry

Bryant Karras.

Bryant Karras

Good morning.

Michael Berry

Steven Lane.

Steven Lane

Good morning.

Michael Berry

Nell Lapres.

Nell Lapres

Good morning.

Michael Berry

Les Lenert.

Les Lenert

Good morning.

Michael Berry

Denise Love. I think Denise is with us but she may be on mute. Arien Malec.

Arien Malec

Good morning.

Michael Berry

Clem McDonald. Aaron Miri.

Aaron Miri





Good morning.

Michael Berry

Larry Mole. Abby Sears.

Abby Sears

Good morning.

Michael Berry

And last but not least, Sheryl Turney. All right. Thank you, everybody. And I'd like to now turn it over to Carolyn and Janet for their opening remarks. Thank you.

Opening Remarks (00:02:07)

Carolyn Petersen

Good morning, everyone and welcome back to our next meeting of the public health data systems task force. I have appreciated all of the feedback that you have been putting into the questions we've been sending out each week. Our intention today is to pull up the crosswalk on the screen and start to review some of those items and some of that feedback. I will be clear that we have quite a lot to do. And if I am more assertive than usual in asking you to keep your comments brief and moving along, I hope you will forgive me. It comes from a place of wanting to be sure that we continue to stay on course and move through the work and not from a place of disrespect or disagreement with your opinions. With that, I will pass the mic to Janet.

Janet Hamilton

Great. Thank you so much. And welcome, everyone. I, too, want to echo Carolyn's comments and appreciate everyone's time that they are putting into the homework and the questions. We are very excited to be having this convening today and are going to focus some of our conversations a little bit more in detail on pieces around electronic laboratory reporting for our discussions today as well as thinking through key issues to really support improved data collection to address issues around health equity. I will also just say from the homework perspective, it is really helping us on the tight trajectory and timeline that we are on to get our thoughts coalesced so that we can have recommendations to put forward. So, just thank you all for your time today and also for all of your efforts outside of these meetings. And I will turn it back over to you, Carolyn.

Carolyn Petersen

Thanks, Janet. So, our agenda for the day is to dig into the crosswalk and then, our ONC partners, Brett and Brenda, will walk us through the next steps. We'll have a public comment period and an adjournment. So, if we could advance the slides please. As you see, we've gone through our roll roster of members. And this is our charge. Just very briefly to review for the folks on the phone, the PHDS task force will identify and prioritize policy and technical gaps associated with the effectiveness, interoperability, and connectivity of information systems relevant to public health and also, identify characteristics of an optimal future state for information systems that are relevant to public health and their use. And the next slide please. So, now we will be starting into discussion of what is in the recommendations crosswalk. You will recall this is being formed based on the feedback you are giving us in the homework, the information and commentary that you are submitting. That is still a work in progress.





So, we thought today, we would put it up on the screen and talk through what has been submitted so far. We are looking primarily for clarification and brief comments and considerations about how we might modify this. We will be asking that you keep your comments quite brief and stick to the point because we want to be sure that we have a robust and comprehensive discussion but are able to continue moving through the items. With that, I will ask ONC if you could bring the crosswalk up on the screen for us please. We're still here. There's a bit of a lag in the technical on the Adobe. We're trying to get it large enough that you can read it.

Review Recommendations Crosswalk (00:07:16)

Janet Hamilton

This is Janet. And while we're working on the technical issues to get the crosswalk a little bit more readable, I just want to take this opportunity also to remind people in addition to the overarching charge and the framing, which I think we can all appreciate is a broad charge that, as a group, we have also refined the scope in terms of what we're really thinking about the place for comments and for this group to have meaningful recommendations. And so, we really want to focus our recommendations and your thoughts and comments on the place where there are interactions between clinical data systems and the clinical healthcare sector and public health the provision of that data to public health as well as, of course, opportunities for public health to be providing data back. So, thinking very thoughtfully and carefully around how that process and interaction should happen. We realize, of course, there's a lot that happens internally once the data is received but really trying to think about the public health healthcare connection.

Carolyn Petersen

That's a great point, Janet. Thank you for bringing that up and encouraging us to focus on the interactions and the work that HITAC can inform that ONC can inform as opposed to the very broad, broad venue of public health where there are things that health IT can't really address. We now have the crosswalk up on the screen. The first topic, syndromic surveillance, ILI, the gap is that there is an availability of rich data that is not tapped into to support syndromic surveillance. The opportunity is to consider better use or surrogate markers such as employee absenteeism to identify early clusters and outbreaks. And a recommendation that was first posted is that CDC should explore nontraditional data sources and surrogate markers such as employee absenteeism and others that could be leveraged to identify early clusters and outbreaks of disease incidents. There is a comment here that this is not new and that CDC has piloted monitoring of Google Search for the flu even back 12 years ago.

What would be novel is a system for monitoring absenteeism or changes in driving patterns or any number of areas. Of course, these are not very specific signs of problems and you could have false positives. So, if you can, what do we want to say about looking at nontraditional data sources or looking for surrogate markers? Please raise your hand in Adobe and we'll get the discussion started. Go ahead, John Kansky.

John Kansky

Yeah, Carolyn. Super quick comment is I assume ILI is influenza-like illness and I was surprised, too, that that was the narrowness of syndromic surveillance. Do we really need ILI in there when from the term public health data, we'd want to be surveilling for stuff beyond this ILI?

Carolyn Petersen





Les Lenert?

Les Lenert

I agree with that. I think syndromic is really also not the right word because we're not really talking about chief complaint monitoring. We're really talking about early data from Emergency Departments and other outpatient systems. So, it may be just preliminary codes rather than the traditional 12 or so syndromes that have been used in syndromic surveillance. So, early data from the health system produced early real time data from the health system.

Carolyn Petersen

Thanks, Les. Let's go to Bryant Karras.

Bryant Karras

Hi. Can you guys hear me?

Carolyn Petersen

Yeah. Go ahead.

Bryant Karras

I wanted to give just a bit of thread on the ILI. So, in the early days, influenza-like illness was the closest we had to identifying Coronavirus-like illness. And the syndromic surveillance community quickly stood up a workforce to make modifications to the detection algorithms within the syndromic surveillance feed. So, I think that's why ILI was used as a shorthand there. My comment would be yes/and. We can look at other alternative data sources. But I think the bigger opportunity that we found incredibly valuable is that we were getting data feeds from ambulatory care and primary care settings, not just Emergency Departments and Urgent Care and that that data coming in through our syndromic surveillance feeds were able to be analyzed to look at what the impact of what COVID was on the population. We had much better situational awareness than we would have had had we not previously stood up those connections to ambulatory care or primary care.

Carolyn Petersen

Thanks, Bryant. Let's go to Denise Love.

Denise Love

Yes. Thank you. I support this recommendation but I think some criteria for what sources would be appropriate. And so, my recommendation would be for the nontraditional sources to assess them on their availability, the continuity, and just the evaluation of the quality of the sources before they are accepted as use for alternative or early indicators.

Carolyn Petersen

Thanks, Denise. Steve Eichner.

Steve Eichner

Yes. Thank you very much. Very quickly, I'm not sure looking at what data sources you're going to find that are timely looking at absenteeism. Most of the time, that's data that's a week old or two weeks old rather





than instantaneous or same day data like we're seeing out of syndromic surveillance out at ED's. One easy thing that we can do to help maintain the data that we have is in looking at the current proposed final draft rule for promoting interoperability modifies reporting to not include urgent care setting data. And if we want to make sure that we're continuing to get good, quality data, we probably want to make sure that urgent care data is excluded in that reporting and that hospitals and other providers are encouraged to supply data. And it might very well be that through regulatory action, we can expand the collection of data to additional centers beyond urgent care to more normal ambulatory care settings and, potentially, include data from EMS calls. Thanks.

Carolyn Petersen

Thanks. A quick follow up from Les Lenert.

Les Lenert

Yeah. Just to comment that in addition to ambulatory EHR data, the data from point of care testing that much of ambulatory infectious disease now can be managed through a strep swab or an influenza bedside test.

Carolyn Petersen

Okay. Thanks. And Steven Hinrichs?

Steve Hinrichs

We have quite a bit of experience with this with our preparedness program. And we found that in large employer, absenteeism preceded the Emergency Room and acute care by several days and, in fact, found that the most beneficial predictor of absenteeism was the railroads because they have to staff the railroad 24 hours ahead of time. And so, that correlated very well with the subsequent outbreak of disease. So, bottom line, I totally endorse the idea for nontraditional sources.

Carolyn Petersen

Thanks. And let's go to Jim Jirjis.

Jim Jirjis

Yeah. I noticed we're talking about alternative sources. I'm just curious whether there is a direct ability to monitor, for example, Walmart, CVS, etc., to the prescriptions filled as an indicator of outbreaks regionally.

Carolyn Petersen

That I don't know. I see Clem McDonald's hand is up. If someone has an answer for Jim's question –

Clem McDonald

It is. I think it should be trivial. Something like 70 or 80% of all prescriptions go through Sure Scripts on the fly. And they should have real time data. So, I think that's an easy one, unless they don't want to play. I think they probably would.

Janet Hamilton

This is Janet. I think the recommendation then that we're hearing here is to explore additional data sources and develop the criteria around which of those data sources are worth exploring. So, the timeliness, I think,





is one big issue when it comes to how the data will be used. If it will be used for early detection and/or how it can be used during an event and over the course of the event to monitor things like situational awareness.

Carolyn Petersen

Thanks, Janet. I see Bryant's hand is up. One quick follow up and then, we'll move to the next one.

Bryant Karras

A quick follow up on the pharmacy. I think pharmacies and laboratories, for that matter, we had less traction on getting them to submit syndromic surveillance feeds because they weren't incentivized under meaningful use and promoting interoperability. There was no financial reward for them complying with the public health reporting. I think creating those incentives to do the work is important.

Carolyn Petersen

Thanks, Bryant. Let's move to the next recommendation. ONC, if you're able to slide the slide over a bit so we can see the topic and the gap in opportunity, slide it to the left please. Thank you. So, our next one has to do with ELR, the adaption of IG. The gap is incentives in meaningful use were minimal and directed at providers. And some states still have not onboarded. The opportunity is that ELR could be improved through lab and public health agency adaption of IG's. So, the recommendation here is ONC, CMS, and CDC to explore providing incentives for labs and public health agencies to adapt certified public health systems that accept standardized ELR notifications with an edge to add corresponding certifications for lab resulting and ordering to address end to end data flows between order, lab, and public health. So, I see Arien Malec's hand is up. Please go ahead.

Arien Malec

Thank you. So, I added text and add corresponding certification criteria. The point here, as we found in the ISP task force, is that we have intentionally adopted a sort of piecemeal, non-standards based approach for lab ordering and resulting for ambulatory care providers. And because of that, we're not capturing information at source in ways that flow to lab with complete information. So, this is the point that upgrading those systems helps lab achieve more complete information on order. That helps address demographic information. And then, I probably should have added that we need certification criteria on the lab and the public health side to make sure that we have testing certification for the lab to public health end of the window. And I've got a comment later on relative to implementation guidance on this topic as well. Thanks.

Carolyn Petersen

Thanks, Arien. Let's go to Jim Jirjis.

Jim Jirjis

Yeah. I just wanted to comment that addressing the incentives and the certification standards for the relevant data for labs and public health systems is fantastic. And there were other things that turned out to be important like PPE, staffing, absenteeism that each of the players in this space should be identified and then, incentives and data certification standards would apply. So, I wouldn't just limit it to lab and public health. I would consider other sources, namely PPE and staffing.

Carolyn Petersen

Thanks, Jim. Let's go to Steve Eichner. Steve, you might be on mute.





Steve Eichner

In addition to considering certification criterion, I think we really need to look at how they are routing information for lab reporting. The fact of the matter is that most labs are really not that interested for their business purposes in whether I went to Aruba or other facts about my demography. They're interested in the data they need to process my specimen. By routing information through the labs, we're asking the labs or requiring the labs to modify their systems and store data that's not really relevant to their business.

If we were to explore other options of routing data leveraging HIE's where the HIE's could then populate the demographics and additional information, we're then going to get more complete data for public health to reduce the need to modify systems that don't really need the data for anything other than a passthrough with the added benefit of reducing identify theft because you're not going to get as much information if you were to get information from a laboratory with an additional benefit of providing test results back to a patient's regular care team if they had a test that was kind of out of cycle like many of the drive through tests the people got during COVID-19 from third parties where the ordinary provider or the testing facility was part of the patient's usual care network. So, those results were kind of lost, if you will, from the continuity of care perspective. I also think from an incentive perspective, it really needs to be fully funded on the public health side or perhaps the regulatory act that needs to take place on the vendor side so that the vendors are selling certified technology rather than on public health looking at having to validate their certification.

Thank you.

Carolyn Petersen

Thanks, Steve. Let's go to Bryant Karras.

Bryant Karras

I still haven't gotten the access to the Google Doc for some reason. It references meaningful use were directed towards providers. It was exclusively directed towards hospitals, not eligible providers. So, I think we need to correct that in new comments that are coming forward to ONC. I think our ONC colleagues can't comment on that but I think that's something important that public health needs to extend, especially with point of care testing becoming so important. And as we saw with drive through tests and atypical test pop up locations, hospitals were not sufficient for incentivizing the reporting of public health. I agree with Steve that there are better ways to, at the point of registering for the specimen collection, linking that patient with their medical record system and with their primary care provider so that the results are viewable to everybody. We had a couple of pilot attempts to do this but it should have been easier. There are processes that we could implement to make that work.

And I think it's only going to get more complicated now that we have true, at home test kits that aren't even administered at a laboratory.

Carolyn Petersen

Thanks, Bryant. Let's go to Clem.

Clem McDonald





So, a number of points. Firstly, I think when we talk about extending certification to all of these other places, I think we've got to be careful of what's in the law. I don't think every place can be constrained or controlled by certification. But I'd like to hear from people who know better. Secondly, I think about some of this, we're too diffuse. So, we want to do good and save world hunger and all of that other stuff. It's all good and well and I think they're good positions. But in terms of the ordering, the main problem is the registration segment doesn't go along with it but it could easily. So, if we focus on that, it could be fixed. We heard earlier that some systems just forget to send it along. And the third thing I think a really major, giant problem is point of care testing because no matter what you do, they're not, typically, an instrument with electronics on it. And it just won't happen unless we figure out some ways.

There is work underway now to figure out ways that maybe with bar codes or various kinds of gizmos, you could take a picture of that, a picture of something else and you could send it. But we've got to really focus now because that's going to be half of testing.

Carolyn Petersen

Thanks, Clem. Let's go to Steven Hinrichs.

Steve Hinrichs

I want to speak, specifically, to the data elements that should be included in the certification process. As you just heard, it could be registration. But as most people know, right now, there are only two data elements required for identification. And we need to add more. And I would say that should be in addition to contact information, possibly including the physician's office but, certainly, contact information of the individual being tested. Thank you.

Carolyn Petersen

Thanks, Steven. Are there any other comments from task force members, please raise your hand in Adobe? Let's go to Danielle Brooks.

Danielle Brooks

Yeah. I just wanted to piggyback with the contact information. I just think that there need to be specificity around that information because one of the biggest challenges is current information. So, we just want to make sure that there is some type of static way of connecting with people. Typically, addresses are very flexible and phone numbers easily get disconnected. So, as we think about this contacting component, we want to make sure that there is a universal methodology in that respect so that that contacting piece can be consistent because, from a downstream impact, that was one of our biggest hurdles was up to date information even upon registration that tends to shift, particularly with populations that may be underserved. Thank you.

Carolyn Petersen

Thanks, Danielle. Any other hands? Any other comments from the task force members, please raise your hand. Okay. I see no other hands so let's move to the next recommendation on the list. And this is in the topic area of improved funding. The gap here is that there is insufficient funding in public health and funding structures are too rigid when responding to emergencies. The opportunity is funding for public health across states but when truly necessary, shared resources are available. And the draft recommendation is that CDC should develop plans or cross program funding of technology investments that support interoperability





across public health platforms with edits that public health data systems should be certified for interoperability and incentive payments should be made to state and local public health departments to support adaption of certified systems. CDC should allocate funding for capability development such as contact tracing that serves multiple public health goals separately from disease specific funding.

So, if you have comments, task force members, please raise your hand in Adobe. And let's go to Nell Lapres.

Nell Lapres

I added a comment in here as well. But I think I agree with the goal of the certification for public health. I think I would want to be more specific in the language around it though. I completely agree that certification around interoperability is important. But I think there should be a minimum functional standard that we're looking to that focuses, not just on interoperability through consistent adoption of standards but also focuses on things like infrastructure and scalability so we can, actually, scale to handle some of the volumes that we've seen in the pandemic but, in some instances, public health may not have been able to scale to. So, I agree with the goal. I think maybe just updating the wording around that would be good.

Carolyn Petersen

Thanks, Nell. Let's go to Danielle Brooks.

Danielle Brooks

Yeah. I think there also just need to be a consideration of equity around the funding. We know that several states are under resourced and do not have the current standards. So, I think within this kind of allocation, there should be equity considerations just to make sure that we are having at least a consistent set up and standard for the availability of being able to respond to this and recognition that not all states, counties, departments are funded equitably at this time.

Carolyn Petersen

Thanks. Let's go to Bryant Karras.

Bryant Karras

Yeah. I think that we have to be careful on the certification of what because I believe 49 out of 50 states have a certified product in their possession that was purchased by CDC for all of the states that can do interoperability. So, the challenge is not the certification of the product itself, it's the appropriate implementation because you can take that certified system and only implement it crippled behind too many firewalls or only connected to one of the five systems that you needed to be connected to. It's the devil is in the implementation. And it's a certification not of the product itself but of the functionality and how that product is implemented.

Carolyn Petersen

Thanks. Let's go to Steve Eichner.

Steve Eichner

Thank you. In addition to funding, not only technology, there also needs to be funding directed to public health for participation in broader environments and support, potentially, in modification of those





environments like TEFCA. There is, certainly, the potential to leverage the TEFCA technology and the TEFCA approach to support public health reporting. But public health has a very, very small voice in the development of TEFCA because of the way the TEFCA work groups have been set up focusing on QHIN's without a substantial public health voice at the table. There also needs to be better linkage and perhaps leveraging Medicare and Medicaid funds to support public health activities. Many health departments have worked diligently with their Medicaid counterparts to leverage APD funds and high tech funds to implement technologies to support meaningful use and providers and connectivity.

The process for public health to access those funds was a bit cumbersome. If there is a way of streamlining that effort and making it easier to request and implement those technologies that would be fantastic. Thanks.

Carolyn Petersen

Thanks, Steve. Do we have other comments from task force members? If so, please raise your hand.

Steven Lane

Sorry. Steven Lane here. I don't have the hand raise function in front of me. But I think that point about more robust engagement of different public health subject matter experts and stakeholders in the TEFCA process is one that we should clearly include in this so that feedback goes back to ONC. They, certainly, have the power to do that. I think perhaps, Steve, some more specifics around what types of public health actors could best do that would be helpful.

Carolyn Petersen

It would be good to put in the homework in one of the spreadsheets so that we can record it that way and not move into the tangential discussion right now. That's a good point. And I see Clem has his hand raised. Go ahead please.

Clem McDonald

I think we hear a lot about the fact that public health is not involved. But I think it's got to be a mutual involvement. There was a problem that occurred with specimen identification because CDC at least tends to not want to name the specimen in the test name. But they would expect it comes in segmented. That's the specimen segment. From what I understand, the specimen segment is hardly ever there. So, that's a big disconnect. And you can just say well, make everybody do it. But both two sides have made different choices more or less. And there should be some dialogue in those choices and not be one way.

Carolyn Petersen

Thanks, Clem. Let's go to Denise Love.

Denise Love

Yes. And I agree that public health needs to be involved with TEFCA but also the broader national standard process. And so, I've often thought that HHS or CDC should fund a small cadre of public health experts to attend all of those meetings much like the specialty societies and payers and others pay their folks to go across all of the meetings and weigh in on all kinds of standards development, not just TEFCA. And this would be that X12, HL7, and CPDP and others. But a public health group that is tasked with bridging these gaps would be very important.





Carolyn Petersen

Thanks, Denise. And with that, I think we will move on to the next recommendation. If you could scroll up please. Great. Thank you. So, the next draft recommendation is formation of a standing public health group. And the gap here is many important topics are out of scope for this task force. No surprise. I think we've run into that several times. So, the recommendation here is that CDC and ONC should explore creation of ongoing public health task force or work group to address topics that are out of scope for the HITAC public health data systems task force to ensure preparedness for future high consequence public health emergencies. And I see Steve Eichner's hand is raised. If you would be brief, please.

Steve Eichner

Absolutely. Thank you. There, actually, already is a task force established under the CDC and ONC, the public health task force on interoperability. I currently serve as co-chair and staff support is provided by Sangeev Tandon out of the CDC. We focused for the last two years mostly on supporting, promoting interoperability, and meaningful use activities and have regularly supplied comments when new final rules have been published as well as some other documents and strategic plans and the like out of ONC. That task force, certainly, could have its scope improved or modified to address additional issues. I think another important component of that, however, is making sure that there are good listening sessions and opportunities for the task force to provide feedback to ONC, CDC, HITAC, and other relevant entities. Thanks.

Carolyn Petersen

Thanks. I see Denise Love's hand is up. Please go ahead, Denise.

Denise Love

Yes. Sorry to talk so much today. I also think whatever is modified or established should consider also the National Committee on Vital and Health Statistics, which is FACA committee. And I know there is work that we're doing with ONC right now on convergence of clinical and administrative data. So, I would just like to put in that NCVHS should also be involved in any eventual public health task force.

Carolyn Petersen

Yes. I think some of the HITAC members that are on this task force have been involved with the ICAD work. So, we already have bridging in some senses for that. Let's go to Bryant Karras.

Bryant Karras

I think that, in addition to the task force that Steve mentioned, which has done some incredible work in putting recommendations out to help public health agencies learn how to adopt and have a roadmap towards standards adoption, I think one of the other key things that needs to be prioritized is getting more participation in the standards body development process. Currently, the HL7, for example, has a public health work group that only has two or three states represented on it. And we really need to see broader participation. And somebody mentioned earlier NCPDP. I think there is some opportunity to get state involvement to ush a migration towards a common standard across these different bodies, HL7, NCPDP, and others.

Carolyn Petersen





Thanks, Bryant. Let's go to Danielle Brooks.

Danielle Brooks

Very brief comment. And also, just making sure that we keep kind of that insight and foresight to make sure that we include health equity components within this public health body. Again, just trying to make sure that we are learning from past instances in terms of how these pandemics, typically, impact communities. And so, as these opportunities evolve, this will allow a health equity by design and thus just making sure we keep that in the conversation and that awareness as we support the development of this as a body.

Carolyn Petersen

Thanks, Danielle. We'll be sure we include that in the revision to this recommendation. That's an important point and an important consideration, not just at this point but across other recommendations as well. Seeing no other hands up related to this recommendation, I think we will move ahead and tackle the next one. It has got several parts to it so I imagine we may have a robust discussion on the next one. If you could scroll up slightly, ONC, it will give us all a better view. Thank you. So, this recommendation has to do with major gaps in standards adoption for key surveillance use cases. And the gaps are many. I will start reading the list. Lack of adherence to existing standards, ELR, IIS, and so on. A low uptake of newer standards, ECR. And a lack of certification requirements for ECR. Missing data can be due to a lack of or variance in reporting standards across jurisdictions. Areas duplicative or misaligned reporting requests that add to provider administrator burdens.

There is a lack of incentives for standards adoptions. Providers struggle to send information, even through the immunization gateway as there are variations in the data sent in each state. ADT based surveillance is not fully leveraged due to a lack of incentives for adoption by providers and EHR vendors. There is a standard for syndromic surveillance messages referred to in meaningful use regulations, however. Demographic and SDOH data come from the EHR but this is often not included in what is sent to labs. And then, there are still additional gaps. But I think we get the picture. The opportunities here are to think differently about the intent and use of data to and from laboratories so that, not only billing data is captured but also demographic and SDOH data. And second, there is a need for case data to go to public health agencies but also a great opportunity for bidirectional data flow from public health to providers. So, here we have seven recommendations drafted.

It's quite a lot. I think I will read through them and then, we can just have some comments about them taken as a whole since this is one area. And we can tease out which goes where as we draft the written version. So, Draft Recommendation 1, ONC should support the development of IG's clarifying and specifying standard data sets and mnemonics for reporting public health data and accompanying testing and certification both for senders and receivers. 2.) ONC and CDC should work with provider and standards community to ensure use of standards and implementation guidance that include demographic and contact elements that are required in public health reporting. For example, race, ethnicity, and contact information. 3.) ONC should require ECR and ECR Now within it's certification program. 4.) CDC should work with state and local partners to standardize reporting requirements at the federal and state level to avoid duplicative requests.

5.) ONC and CMS should explore incentives for the adoption of ADT based surveillance standard. 6.) CMS should explore making ECR implementation a condition of participation for hospitals. 7.) CDC or others





should incentivize or support public health jurisdictions to implement full ECR for all reportable conditions to receive the data into their surveillance systems and relieve providers of the burden of parallel manual reporting. So, we've got a lot of ideas about what different actors and stakeholders should be doing, public health, providers, health system, ONC. I think we'll probably have a number of comments. We can sort out which goes where. So, let's start with Arien Malec.

Arien Malec

Thank you. I think had a lot here because this is a pretty meaty recommendation. But just to go off a couple of these things, one is, and this is an overarching set of recommendations, I think public health has been best integrated in the information sharing systems of the country when it's leveraged standards and implementation guidance that are lined up with, for example, USCDI and implementation guidance that are associated in the provider community. And the rest of my comments on, for example, lab orders and lab results to the extent that we build a system of which public health is a part, that's going to drive a better outcome than having public health specific standards. And I think we saw in the reportable conditions standards a set of rather bespoke CDA standards that were implementable but were sort of dropped in out of context and hard to leverage. So, the comment on ECR and ECR Now are an inherently much better approach.

I'd like to see ECR transition from a CDA based standard to a FHIR based standard only because I think that helps as we move EHR's more to a FHIR based API approach that helps public health tap into EHR data more flexibly. I have the same comment relative to ADT. I think encouraging the use of ADT based surveillance is a fantastic thing that we should be doing. I'd also recommend that we explore leveraging the ECR and ECR Now triggered based approach to be able to capture more finely grained data and specific data both from registration systems and from EHR's. That could provide a better means for upfront surveillance. But, in general, the overarching comments are line up our certification standards and our implementation guidance associated with the corresponding work to be done in the EHR community so that we view public health as part of a broader ecosystem and leverage the standards and workflows that are already being leveraged and really jump on the FHIR bandwagon in order to take maximal advantage of the broad investment that we're making in health information interoperability. Thank you.

Carolyn Petersen

Thanks, Arien. Let's go to Steve Eichner.

Steve Eichner

Good morning, again. Thank you. I think there are a variety of reasons that standards that have been released haven't been adopted. And that is in part that they may not meet the requirements or the needs of states or other jurisdictions. So, to release IG's that clarify the standards requirements may not be really good if the standards requirements don't reflect the actual data needs of incorporating state and local health departments' needs and data standards, I think, becomes terribly relevant. And looking at working with providers in the recommendations, I think it really needs to be CDC, ONC, working with state governments and local health jurisdictions on developing data standards that support the broadest range of public health needs and working with providers to also develop and implement those standards. On occasion perhaps, compromising on what a particular standard is if it is being collected in a different way and that way is acceptable. I think we also need to look at having standards that are flexible where we can add additional elements at the state level and support the national framework for supporting those standards.





If you look at disability, while we've got a lot of focus recently on race and ethnicity, there really aren't any national standards to collect any information about disability status, except perhaps are you disabled without additional drill down information about the nature of the disability and how it impacts their lives. That can be particularly valuable as we're looking at supporting services for evacuation in response to national disasters but also becomes relevant as we're looking at issues in accessing healthcare. So, I think that's an area that we really need to explore and come up with a good national standard that supports syndromic surveillance and other data collection efforts. Thanks.

Carolyn Petersen

Thanks, Steve. Let's go to Clem McDonald.

Clem McDonald

So, a couple of issues. One I think it's not always clear to discussants that a standard is, typically, a definition of a set of slots where later one can specify what questions or what specific data elements, questions really, go into those slots. So, typically, an HL7 standard will, typically, just define places to put the things you might want to send or ask for. The second thing is that, again, I think we need more mutuality between public health and practitioners because I've seen many data collection forms for public health purposes that are very painful. And they differ from site to site. And they're painful in that the data could be inferred from other data if you explain it differently within the medical record. So, I think there has got to be some sensitivity to the overburden in primary care at the present time. And you can't pile on. But if there is a discussion back and forth, I think one could get better data and get better cooperation.

Carolyn Petersen

Thanks, Clem. Let's go to Les Lenert.

Les Lenert

Yes. I saw some comments here and discussion about electronic case investigation or case reporting. And I want to emphasize that that may not be the ideal future state. What I think we want to do is automate case investigation using EHR data. And we want triggers for that, which might be very simple. But then, we want the ability for public health to be able to dig deeply into EHR's and into things that may not have been previously anticipated to be able to rapidly investigate emerging infectious disease. So, the thought here is that case reporting probably reflects this paradigm of information supply chains. And we need to think more about information ecosystems. And so, a simple trigger with the tooling for the standards for automated investigation for queries via FHIR of EHR's by public health.

Carolyn Petersen

Thanks, Les. Do we have additional comments from public health data systems task force members? Please raise your hand in Adobe. Are there any task force members on the phone who can't raise their hands that have a comment? Let's go to Bryant Karras. You might be on mute, Bryant.

Bryant Karras

Sorry. I think one of the challenges is that this section is titled Standards Gaps but I think that one of the challenges is really full execution of standards as opposed to what's deemed as the bare minimum. And I think there is a disconnect between the provider community, hospital community, and the public health





community that when a standard is agreed upon by all of the states on these public health standards, the optional data elements that are listed in the standard aren't optional for the vendors to implement. All of the capabilities need to be there. And then, it's up to the states to decide which of the data elements are required within their jurisdiction. It shouldn't be optional for the vendors to choose to or to not have that capability in place.

Carolyn Petersen

Thanks, Bryant. Let's go to Sheryl Turney.

Sheryl Turney

Sorry. I couldn't get off of mute. I just wanted to pile onto what Leslie said earlier because I do agree that we would want to have the intelligent query capability but really not just limited to EMR systems. It should be extended to any of the authorized qualified entities within the ecosystem that are authorized to perform this research because we have our research arm that's, basically, been tapped by CDC and others multiple times to do research and getting the data is extremely difficult. So, I do think we need to look at all of the partners in the ecosystem when we're looking at that.

Carolyn Petersen

Thanks, Sheryl. Any additional comments from task force members? Jim Jirjis, go ahead please.

Jim Jirjis

I just wanted to echo what a lot of people have said about the state to state variation. I think Clem talked about the burden. In our 20 states, you could identify a subset that you could, actually, adhere to implementation guides and federal standards, not local. But then, there was a tremendous amount of variation in additional elements and often with the very challenging almost lack of understanding of what it takes to, actually, get reliable data. So, just a plug to use whatever levers HHS has to go beyond just optional methodologies because the burden is enormous.

Carolyn Petersen

Thanks, Jim. Any additional comments from task force members? I know this is one of the meatier sections with a lot of recommendations. And, certainly, we will be looking at some of these again after we incorporate the feedback we're getting today. But as this is a pretty critical part of our work, I'm going to be sure that we have an opportunity for a good first pass.

Arien Malec

This is Arien. I apologize for jumping back in the cue. But there is a really interesting discussion going on in the public comment that may warrant some future discussion. And this is really around the point of, I think, states believing that they have the authority to do some tailoring around standards and implementation guidance. And I think the national actors, cross state health systems, folks who develop information technology systems and the like see that approach as leading to fragmentation and high cost and, actually, low data access and would prefer a national approach where we have a standards based ecosystem that allows for maximal information flows at minimal overall investment. And it feels like this is something with a strongly held belief on both sides. And it might be worth, at some point, just explicitly having a discussion about this point because it feels to be pretty foundational to where we are right now as a country. Thank you.





Carolyn Petersen

Thanks, Arien. I see there has been quite a lot scrolling through the public and task force chat. Thank you for bringing that forward to us. I agree. It will be something that we will wind up incorporating into our recommendation someplace. Do any of the task force members have points about that or cross questioning to Arien's comments? Please raise your hand in Connect. I know we have quite a lot with this group of recommendations around standards. And, certainly, this is a key part of our work. Are you able to reshare the screen, ONC? I think some of us have lost view of it probably with all of the comments going in and out. I think we're not able to see.

Janet Hamilton

This is Janet Hamilton. And while we're waiting for the screen maybe to be reshared, I would just echo I think this is an area for additional exploration. And I think, as we look at this and the discussion going forward, it will be critical that we think about the different surveillance goals at the different levels within public health. And then, that corresponds, of course, to the different data needs in those places. And so, as we look towards trying to have more harmonization, it will also be really critical that we still support the state laws and activities that, of course, govern public health surveillance.

Carolyn Petersen

I agree. I see Jim Jirjis has loaded a number of comments into the chat. Jim, do you want to go ahead and speak to that please?

Jim Jirjis

No. What I was going to do was just comment that one idea would be to take advantage of the COVID-19 pandemic and do a survey of all of the different questions and interpretations that each of the states ask for during that because that will give a broad data set whereby you could identify whether they were key areas of focus beyond just the lab. For example, Florida had 50 or 70 additional questions. And because we had that reality, there may be opportunity to analyze that and then, determine if more than one state asks for additional data, understanding why and making sure that we don't miss those data sets in our recommendations.

Carolyn Petersen

Thanks, Jim. Being that I see no more hands related to this group of recommendations, at this point, if we can scroll up a little it and see what comes next. It looks like that's quite a large group of recommendations. What time are we doing public comment, Mike?

Michael Berry

About 12:25.

Carolyn Petersen

Okay. If we could scroll back up slightly, why don't we go ahead and get started on the technology and infrastructure factors? There is a good bit here but just four recommendations so we might as well start thinking about that. So, here we go with this group. This has to do with technology and infrastructure factors that affect the key surveillance use cases. And it looks like the gaps are numerous. Some of those include the lack of central patient identifiers and ability to link patients across care settings and public health.





Current processes to set up data exchanges place burden on providers in public health for testing new interfaces as well as a lack of centralized national infrastructure that leads to duplicative and burdensome reporting. Also, a lack of clarity on how to protect patient privacy while promoting interoperability. A lack of infrastructure funding across public health leading to data silos. Provider administrative overload and a perceived lack of value in data reporting.

A lack of consistent HIE's and capabilities for public health reporting. A lack of standards on describing SDOH and where SDOH data should be collected. Differences in social service data systems will create difficulty in connecting to public health and clinical. And some additional ones as well. The opportunity would be direct messaging capabilities within public health jurisdictions could facilitate efficient secure communications with providers in support of case reporting, investigation, and management. So, here we have four draft recommendations. I'll read those as a group and then, we can discuss. First, CDC and ONC should incentivize implementation of FHIR request retrieve standards within public health departments. 2.) CDC and ONC should explore the development of centralized reporting gateways to avoid duplicative reporting workflows for providers. 3.) CDC should investigate how current funding streams may impeded data sharing. And 4.) CDC and ONC should support pilots of direct secure messaging with providers.

So, a very brief overview. Let's start raising hands and we'll get into the discussion. Bryant Karras, please go ahead.

Bryant Karras

This is a question for our ONC colleagues. I need some clarity. Is that direct messaging in all caps direct as in the direct standard or the English definition of the term direct? I think one of the challenges with direct messaging as a standard is that it doesn't support some of the bidirectional public health messaging that's needed to successfully get information back and forth for both E-case reporting and syndromic surveillance. So, could someone clarify? Is that direct in all caps referring to the direct standard or is that just talking about –

Carolyn Petersen

Yes. That's direct with a capital D.

Bryant Karras

Well, it's all caps.

Steven Lane

No. This is Steven Lane. I, actually, submitted that one into the spreadsheet so I can tell you what I meant. It's a capital D. It's not, actually, all caps. It's not an acronym for anything. But we're talking about the direct messaging that is supported within the direct trust framework. And that type of messaging is quite flexible in terms of how it can be used. The advantage that it has over say future FHIR based messaging is that it's here today and that all certified health IT supports both the sending and receiving of direct messages. It's already being used as part of the initial implementations of electronic case reporting. The challenges that the public health entities themselves are not yet enabled, for the most part, to leverage direct but all of the providers in APHL are. So, that was the source of this suggestion.

Bryant Karras





I think we ended up going with more advanced standards that were advocated through the IG protocols rather than direct. And so, I think that, to a certain extent, yes, I agree with you. It's available today but it's not necessarily available on both sides of the communication channel. So, I think there are some challenges there in advocating for that as opposed to first determining what is the best approach that's available in all states and jurisdictions.

Carolyn Petersen

Thanks, Bryant. Let's go to Nell Lapres.

Nell Lapres

I wanted to comment a little bit on the FHIR recommendation. I think FHIR is definitely a great long term goal for many of the exchanges that we're talking about. One of the concerns I have is if there is a workable standard existing in use today that is solving the need, I worry that focusing broadly on incentivizing FHIR is going to force change and force funding to go towards enabling that change unnecessarily instead of focusing on use cases that, specifically, have a need and are a gap right now. So, I think if we're going to be talking about incentivizing FHIR, I do want to make sure that we're trying to define use cases so that we are addressing the gaps that exist instead of replacing standards that exist and are used and are working today.

Carolyn Petersen

Thanks, Nell. Let's go to John Kansky.

John Kansky

Thanks, Carolyn. I think this is a quick logistics question. In the Google Docs, I added some potential recommendations that are responsive to Gap No. 6, lack of consistent HIE and capabilities for public health reporting. Is that sufficient to have those recommendations considered or do I need to reiterate?

Carolyn Petersen

Let's see. I see your comment here up on the screen, John. If you can briefly reiterate, that's probably helpful for those who aren't able to see these.

John Kansky

Sure. Quickly, so it's true that HIE's do not have consistent capabilities for public health reporting today. And I suggest a few recommendations. 1.) It's probably redundant elsewhere, which is that ONC and CDC should standardize a set of public health reporting nationally so that HIE's and, frankly, any other approach to public health reporting can build to that standard. More on point are two recommendations related to 2.) federal policy barriers and 3.) state level policy barriers. I'll give an example. In the state of Indiana, there is a law that allows immunization data to be shared with the health information exchange so that we can do good things with that. But that doesn't exist in other states preventing the HIE's from having that role and those barriers prevent flow in both the directions of reporting and the directions of receiving and sharing with the provider community. Thank you.

Carolyn Petersen

Thanks, John. Let's go to Clem McDonald.





Clem McDonald

So, this may be the same old song but people talk about that we should get CDC and CMS and public health together to decide to get this done. What about the people you're asking to give you the data? What about practice communities to get some sense? I think we'd get a better output and more cooperation if they had some say in how the questions were defined and asked, especially if they're defined more formally across local boundaries. But we just can't leave them out. They got no time left. And so, data collection costs. So, we ought to give some input to them to kind of modulate what the questions are and how they're asked for case reporting. And this may also speak to Les's point that it's better if you can just pull it out of the medical record. You save everybody time and effort.

Carolyn Petersen

Thanks, Clem. Let's go to Abby Sears.

Abby Sears

I didn't notice just on the face value of the recommendations that one of those would solve the issues around patient matching that we're experiencing. And so, I guess I would like to recommend that we do something, whether it's a national identifier or that we find something that will help with that patient matching algorithm.

Carolyn Petersen

Thanks, Abby. I see we are getting quite close to our public comment time and our wrap up of the meeting. And I also see that Steve Eichner and Jim Jirjis have your hands raised. So, I will ask each of you to wrap up in no more than 30 seconds. Go ahead, Steve. Steve, I think you may be on mute.

Steve Eichner

I was. I think FHIR standards are important to look at as we look at patient privacy and managing that as well. One of the challenges, I think, for at least some public health departments would be looking at responding to a population level request for data. If they receive, for example, a request from every provider in Texas for the entire patient population on a nightly basis, I'm not sure that we've got enough server capacity to respond to those requests. I think we also need to be very cognizant about the reasons public health is collecting data and our responsibility to patients and individuals about sharing that data and what happens once that data is shared to something like an HIE and how that's being reused. Public health is in a unique position to require data submissions. We need to be careful about how we're releasing that data to protect patients' privacy and their interests.

Carolyn Petersen

And let's go to Jim Jirjis.

Jim Jirjis

I'll be brief. This gets to the bidirectional. In the middle of the pandemics, etc., having a record locator be part of the solution so that when providers are encountering patients, they don't have to do the work of figuring out where the patient has had testing done, whether it be public health departments themselves or elsewhere. But in the course of seeing a patient, when the patient's records could be located and then, information automatically retrieved to assist in care. So, I'm plugging adding record locator capabilities to the suggestions to ONC.





Carolyn Petersen

Thanks, Jim. And with that, I will pass the mic to Mike Berry to take us into public comment.

Public Comment (01:19:01)

Michael Berry

Great. Thank you, Carolyn. I appreciate that. And operator, we'd like to open up the line for public comments.

Operator

Thank you. If you would like to make a public comment, please press Star 1 on your telephone keypad. A confirmation tone will indicate your line is in the cue. You may press Star 2 if you would like to remove your line from the cue. And for participants using speaker equipment, it may be necessary to pick up your handset before pressing the start key. One moment while we poll for comments

Michael Berry

And I just want to mention while we're waiting, we do have the next public health data systems task force meeting during this time next Thursday. And I also want to mention that our monthly HITAC meeting is next Wednesday. We have a full day planned from about 9:30 to 2:40. And Steven Lane and Arien Malec who are both on this task force will be presenting the USCDI's task force's recommendations from the Phase 2 work. And Arien and David McCallie will be presenting their recommendations from the ISP task force. So, we'll look forward to that and the HITAC's vote. With that, operator, do we have any comments?

Operator

There are no comments at this time.

Michael Berry

Okay. Thank you. Carolyn, Janet?

Next Steps (01:20:23)

Carolyn Petersen

Thanks, Mike. I will just briefly thank everyone on the task force for the good work you're doing in filling out the homework and getting into the spreadsheets and taking care of that for us. We had a great discussion today with a lot of helpful feedback. I think that will definitely inform the presentation that Janet and I make to the full HITAC next week. And we will work with our colleagues at ONC to ensure that information about the time of that presentation is sent out to you. So, if you want to call in and listen to the discussion, you're able to do that efficiently. I will now pass the mic to Janet for her comments and next steps. Thank you.

Janet Hamilton

Thanks so much, Carolyn. So, I will just highlight for folks that we do have more homework coming based on just the volume of comments received in the crosswalk. Some of the discussion items or, actually, all of the discussion items that we had planned for today we did not get to. So, we really would like you all to take an opportunity to put your thoughts in the homework and we will continue to use that process to really help





shape and form the comments that we have and are able to share with one another during the meeting time.

Carolyn Petersen

And Brett and Brenda, did you have any further comments or clarifications about our next steps?

Brett Andriesen

Yeah. I just thought watch your inboxes from the HITAC team to be sending out new Survey Monkey links to complete. Those will likely be going out by tomorrow and then, if folks can have those back in by Tuesday morning around 10:00 a.m. Eastern Time, that will allow us to get things turned around. We'll also be sending along the Google Doc link to allow folks to further comment on new areas or existing areas that are already listed in the crosswalk document.

Michael Berry

All right. It looks like we are wrapped up for today. So, thank you, again, everyone, for joining us and we will adjourn and see you next week. Have a great day.

Carolyn Petersen

Thank you, everyone, for your participation.

Adjourn (01:23:22)

