Health Information Technology Advisory Committee

The Office of the National Coordinator for Health Information Technology

Transcript

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

July 1, 2021, 10:30 a.m. – 12:30 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
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 Akinnagbe	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
Thank you very much and good morning everyone. I am Mike Berry with ONC. And I'd like to welcome you back to the Public Health Data Systems Taskforce. We really appreciate you being with us today. I'm going to open up today's meeting with rollcall of our taskforce members. When I call your name, please indicate your presence. Let us start with our co-chairs. Carolyn Petersen?

Carolyn Petersen
Good morning.

Michael Berry
Janet Hamilton?

Janet Hamilton
Hi, good morning.

Michael Berry
Danielle Brooks? Denise Chrysler?

Denise Chrysler
I'm here.

Michael Berry
Jim Daniel?

Jim Daniel
Here. Thank you.

Michael Berry
Steve Eichner?

Steve Eichner
Present. Good morning.

Michael Berry
Claudia Grossmann?

Claudia Grossman
Present.

Michael Berry
Steve Hinrichs? Jim Jirjis?

Jim Jirjis
Here.

Michael Berry
John Kansky?

John Kansky
I'm here.

Michael Berry
Bryant Karras?

Bryant Thomas Karras
I'm here.

Michael Berry
Steven Lane

Steven Lane
Good morning.

Michael Berry
Nell Lapres is off today. So, she'll be rejoining us next week. Leslie Lenert?

Leslie Lenert
I'm here. Good morning.

Michael Berry
Denise Love?

Denise Love
Present

Michael Berry
Arien Malec?

Arien Malec
Good morning.

Michael Berry
Clem McDonald? Aaron Miri? I think Aaron's still on vacation. So, he'll be back with us next time. Larry Mole? Abby Sears? And Sheryl Turney? Thank you everyone. I'd now like to turn it over to the co-chairs, Carolyn and Janet.

Danielle Brooks
Danielle Brooks just joined.

Michael Berry
Great, thank you everybody. I appreciate it. Carolyn, Janet?

Opening Remarks (00:01:59)

Carolyn Petersen
Thanks. Good morning everyone. I want to thank you for all the work you have been doing in the Google Doc. I am moving us to finalize or at least get ready for review our recommendations to the HITAC. I know the holiday is coming up and it's kind of a time we are all looking forward to getting a break. But I appreciate your hanging in there with us through this last week and helping us to go down the home stretch strongly and bring something good forward.

Janet Hamilton
This is Janet. I will just echo Carolyn's comments. I know we have had a lot of robust discussion on these calls, but really working towards finalizing the recommendations and really getting your thoughtful input so that they are crafted as we would like them to be. So we very much appreciate folks doing the homework outside of the meetings, but also your thoughtful comments and your robust discussion and dialogue here. We are excited to be moving forward and presenting the recommendations to the HITAC and also recognize we still have quite a bit to do between now and when we do that. So, thank you for your time and energy. I'm really looking forward to the discussion today. This is Janet. I'm not sure if folks are able to hear me or if I have been disconnected. It sounds quiet.

Unknown Speaker
You are back now.

Michael Berry
We can hear you, Janet. There was silence for a bit.

Review Recommendations Under Consideration (00:04:19)

Janet Hamilton
So, we do have some recommendations that we want to go through today. I think Carolyn, I will just see if maybe you want to start with those or if you would like me to and then we can pull up that section of recommendations. I think we had identified three major areas for discussion today. And I am happy if we want to move over to the Google Doc and start to review those and see what other thoughts and considerations we have on those draft recommendations. Or Carolyn if you have something else in mind please let me know.

Carolyn Petersen
On the schedule that we sent out earlier this week, we did identify some sections where we wanted to review some recommendations today. And we will get to that. I thought you had wanted to do a discussion about immunizations and a few other things first, Janet.

Janet Hamilton
Okay great.

Carolyn Petersen
To ensure you had feedback to work on those over the weekend.

Janet Hamilton
Super. So, one of the items, so we have just for folks to be thinking about, so we had identified the areas of syndromic surveillance lab and piece reporting for a little bit of additional discussion today and reviewing those recommendations. One area where we maybe have not had as much robust discussion, although it certainly has come up during some of the calls is related to some thinking around the immunizations space and the recommendations that we would like to make and have included in the document. So, we did want to have some discussion specific to that and see what input and feedback folks have. So, maybe as a starting point, if we actually want to go into the recommendations where we already have a handful related to immunizations, that might give folks sort of what we have heard thus far. And if we want to go in there and while we are bringing that up as well, we can then think through what big things are missing and then when we come back to the immunizations section, which we do have up for discussion again next week, we will at least have captured some of your immediate thoughts on some of the gaps.

So, if we can go ahead and bring that section up on the screen that would be great. And I am seeing it in a tiny box on mine. And for folks on the line, we are working to share the document on the screen. And many thanks to all the expert staff on ONC who work on bringing these things up in real-time.

Leslie Lenert
And this perspective from past task forces, task force members may want to access the docs directly on Google at the same time if you have a second screen. It can be handy to be able to navigate yourself around while they are working the keyhole on the data connect.

Janet Hamilton
Great, thanks for that comment. So I am seeing it on my screen, but if you could make it a little bigger that would be helpful. Okay great. So, as you can see highlighted on the screen, this is a topic that we really have not covered but we have captured some comments that have been made through other portions of the discussion. So, I want to go ahead and really read for people the recommendations that are here. Since this is such a critical piece in this response to COVID-19 ,but also certainly in any other responses as well as immunizations is one of the foundational public-health control measures. We wanted to be sure that we were having some discussions now as well as into next week. So, for those who were just on the line I'm just going to read out this docket of recommendations that we have captured thus far.

So, the first one is ONC should work with CDC and state, tribal, local, territorial health departments to advance the adoption of the HL7 implementation guide both by provider systems and public health agencies. There are some subcomponents to that. Consider utilizing federal funding mechanisms to require providers to transmit data electronically in HL7 format. Provider systems shall also be designed to capture all CDC core data elements for Information Immunization Systems or IISs. ONC should also work with partners within HHS and STLTs to develop a national implementation plan for the rollout of standards. Implementation support should be provided to state and local public health agencies. So, that is the first one.

The second one is ONC should work with CDC industry associations and STLTs to identify and prioritize a core set of data elements for providers to collect and report to public health as it pertains to documentation within the IIS.

The third one is ONC should work with CDC STLT and industry associations to define a minimum set of IIS functional standards. The standard should include the ability to receive immunization in agreed-upon format, accept messages using a standard transport mechanism, error reporting, scalable infrastructure, quality patient matching, and patient access to data. And if you could scroll down. This one actually goes on to the next page. The use of a set of criteria that public-health systems are measured against should be established. If the system fails to meet expected performance standards the jurisdiction will be encouraged to correct deficiencies. Then there are two others. ONC should work with CDC and industry associations such as AIM and ERA to establish a certification process to bring all IIS to the minimum functional standards defined through other recommendations. The certifications should focus on standards adoption and uniform implementation of those standards, transport mechanisms, and infrastructure.

Then we also have ONC should work with CDC and industry associations to expand the availability of certified lightweight immunization management systems for use by ad hoc vaccination providers. Systems should be SSO compatible for provider organizations and they should be able to store and maintain medical records and should conform to minimum functional standards for collection and reporting of immunization data. These system should not be used to replace workflows for providers using certified software capable of exchanging data with the IIS. Are there others or does that capture all of them? I can't see in the rest of my screen if there are some.

Okay, it looks like we do have one more. Thank you. This one is pharmacies, fire department, EMS, and employee or school-based clinics. It is a specific recommendation directed at that audience. ONC and CMS should invest in pharmacies and other healthcare partners that were not part of the meaningful use incentives and PI incentive programs to incentivize pharmacy systems and MEMSIS to use Health It standards adoptions to be equipped for data exchange via HIE for public-health reporting like clinical health systems. IIS reporting should be explicitly included as a standard for use.

So, that is the large bucket of recommendations that we have thus far for IISs and I really want to open the floor up for folks. It does look like we're having a little bit of editing on the screen, so thank you task force members. But also, I really want to ask people if there are big bucket areas that we are missing that we really need to address. I think we can also look at potentially finessing some that are here, but I think really to ensure that we are not missing big bucket areas. So let me stop there and see if folks have comments. If you could please raise your hand. And for some reason on my screen, I am not seeing the hands being raised if they are. So, let me see if I can try to adjust that.

Carolyn Petersen
Steve Eichner, why don't you start.

Steven Eichner
Thank you so much. Janet, thank you for that wonderful overview. I think there are several ways we can improve the recommendations in several directions. One, I am not sure that we need to focus exclusively on the existing HL7 implementation guide. We can certainly use that as a starting place. But there may be places we need to improve the existing guide looking at whether race and ethnicity is optional or required, for example. I think the opportunity to leverage health information exchanges is very useful for augmenting data and routing data. I'm not sure that we need to constrain it only to nontraditional providers. I want to make sure that our recommendations in that space facilitate the use of HIEs for all providers that are interested in using it for the technologies available and it is consistent with state law.

That being said, I do think that national standards need to be harmonized with state law. Di4fferent states do have different requirements at the state and potentially at the local level for immunization data. Whatever we do needs to respect states' rights, states' responsibilities, and state data needs, as well. Looking at integration with other systems one of the things that we experienced in COVID-19 response is one component to actually track immunizations. But perhaps equally important is providing adequate services for individuals to register for immunization events, and for that to be part of a standalone system or include interoperability functions around the appointment setting. I think would be kind of the natural and logical exploration or extension of the standards. So, if an individual is registering for an immunization event, that information can also be passed between systems. The immunization registry data can also be passed to that registration system so the individual can be validated with their name, address information, without having to reenter the data.

I fully support the idea of a prioritized set of data standards. But I do think we need to look at how do we evolve the standards before we implement a new approach or at least have a timetable established where we are looking at system transformation to better meet our future data needs. I would love to hear other comments. Thank you.

Janet Hamilton
Thanks, Steve. Jim Daniel, please?

Jim Daniel
Hi, thanks. I have a few recommendations that probably go beyond the current recommendations. I think, number one, working from the provider perspective and some of the challenges that providers have when integrating with immunization information systems, we are not meeting their business needs. Often a provider may have a patient that has received vaccinations in multiple other states. But a provider really only has access to the data that is in the state based on the provider location. So we really need to develop standards and implement the infrastructure for what I would call a provider initiated multi-jurisdictional query. Number two, I believe we need to continue to develop the standards and promote consumer access to immunization information system data. Number three, develop the standards and functional requirements to promote cross-jurisdictional exchange of IIS data just between states. Even if we don't have a query initiated by a provider, the IIS need to continue to exchange data as people move from state to state so that the states have the most up-to-date information on all of the immunizations for that person. I would say

sort of an overarching way to approach all three of these is to continue the development of the immunization gateway and encourage states to connect it to the immunization gateway.

And I want to do a plus one on Steve's very important comment on the standards for scheduling vaccine appointments. I don't think that need is going to go away. We are looking at potential boosters as the Delta variant continues to expand in the United States. We don't want to be behind the eight ball again if we have another round of mass vaccinations. USDS has started to develop some great standards for at least available vaccine appointments. I would encourage us to further build on that so that those APIs are not only available or not only there for available vaccine appointments, but also for a consumer to actually register for vaccine appointments through those APIs.

Carolyn Petersen
Thanks, Jim. Let's go to Arien.

Janet Hamilton
Before we go to Arien, I'm sorry Arien, Jim, I just wanted to ask on the scheduling of appointments, do you have any other comments on that? There's been a lot of discussions around the scheduling of appointments and the need to ensure that the process is equitable. We have seen some limitations where not everyone has certain types of technology available to them. So, did you have any other high-level thoughts that you wanted to comment on related to the scheduling of appointments?

Jim Daniel
Yes. I think for equity, it is really important that those APIs can be extended to multiple ways for a consumer to register, whether that might be through text messaging, phone calls to a call center that are automated. There are multiple ways I think that you could get to that API, so that we are ensuring that we are not furthering the disparities with vaccine distribution. I think that is a really important point. I think another issue that goes along there that I think is probably more of a policy issue is when vaccines are available and distributed, are the policy issues around opening up those vaccine appointments beyond your current patient population. I think in the beginning of vaccine distribution with COVID-19, I know at least in my jurisdiction, there were several large provider organizations that we see vaccines that were only seeing their patients. I believe that sort of policy led to inequity where many of the people we wanted to reach are not people with primary care providers who are part of those large systems, and thus had a large swath of vaccine appointments not available to them.

Janet Hamilton
Okay great, thanks, Jim. I just wanted to be sure that we capture that multimodal piece so that it was clear and explicit. And Arien, thank you so much.

Arien Malec
No problem. Maybe I will just take the opportunity to jump on top of that comment and, shame on me for not thinking about the needs of scheduling. To your point about social disparities, much of the disparity that we experience in our vaccine rollout was secondary to A, the need to schedule, but B, the fact that scheduling was tied down to particular systems and that the way that scheduling was done was done in a way that made it more advantageous for people who could sit there and wait for schedule slots to open and jump on them. A better approach to scheduling, as Jim said, that was API driven and made schedule slots available across a wider geography would help us connect open scheduling slots to call centers, would help us create reservation systems that hold slots for high priority groups, and would better enable us to address disparities. So, I actually think scheduling standards, particularly scheduling standards that allow for consolidation of slots across multiple systems and decouple scheduling from some portals would be a useful way, actually, to address some of the unmet disparities that we saw.

An unmet need that is not called out here is the need for population level immunization queries. And again, we need to be privacy sensitive about this. We need to make sure that query retrieve is a universal need and that the query retrieve is open to the needs, for example, of a health system that is trying to schedule,

as we have seen in COVID, their population panel but are unaware that their population has been immunized in other settings. So, I think all of us have the experience of getting outreach when we have already been vaccinated. So, the need to look at a population level synch to see whether we can address the population health needs, as well as the individual query needs for an individual being vaccinated. And then finally, I think there is a recommendation down that says something on the order of ONC should support or something to that nature. I think when we are thinking about recommendations for ONC, it's either going to be a certification requirement or a funding need. I think in this case we are looking for expanding certification to a wider range of actors including pharmacy, long-term post-acute care, and some of the other settings where we have seen the need for vaccination. So, I do think we should be calling for a wider and more expanded certification program that is not limited to the HRs. Thank you so much.

Carolyn Petersen
Thanks, Arien.

Janet Hamilton
Great, excellent. Bryant? I'm sorry Carolyn, I will let you manage the Q&A. You do so well at it. Thanks for your help.

Bryant Thomas Karras
Thank you so much. Janet, I wanted to explain the insertion. So, right below the previous last recommendation there, I inserted one that could be merged with the ad hoc, the discussion of expanding to ad hoc vaccination providers. So, this and the one above it could be merged. But I think we need to be thinking more sustainably then just these ad hoc pop-up sites for vaccination and thinking about integration in these other health partners that we are going to use again. Pharmacies, fire departments, large employers that operate their own clinical environment or higher learning or large school systems that have clinics based within their facilities. I think that it's an investment worth making to not just think of these as ad hoc, but as ones we want to have properly connected and robustly connected so that they are already ready for future events.

The content there was borrowed from the situational awareness or a lab one related to long-term care facilities, which I think is another one that did not have as much investment from the meaningful use in promoting interoperability incentive programs to get them on board ahead of time. And it led to it being a larger lift than it needed to for all of these environments.

And I just want to second the discussion around scheduling. I think the scheduling and I would say especially age-related gaps in terms of access and comfort with online scheduling systems led to challenges. Even call centers as an assistant, having difficulty getting people in because by the time folks were finished with the phone call for the spot they have been trying to reserve had been filled. So, we need to come up with ways of making the scheduling process more supportive for all people who are trying to access it. And another forgotten component of that is when people get more than one appointment it was difficult for people to cancel the one they didn't need. We figured out ways to get the schedules made but not to cancel unneeded ones, so vaccine slots went unused. Thank you.

Carolyn Petersen
Thanks. Let's go to Steven Lane.

Steven Lane
Thanks. I wanted to go back to a comment, I think Steve Eichner you made this, about the need to respect states' rights and local needs. And you know, excuse me for being blasphemous, I do have an MPH but I'm not a public health by trade, I think part of the problem we are facing is our 100-year history of, for today's world, too much of a focus on states' rights and local needs. I mean truly, this is evidence-based science. We have national guidelines for immunization, etc. I think that we really should, somewhere in these recommendations, include an overarching statement that state and local needs may be important in certain rare and unique circumstances, but in general national standards should be the way to go. And that we

should be supporting state and local variability if and only if there is a documented need for that. I think we could save so much time, energy, resource, heartache if we got rid of as much of the local differentiation that is possible, that is out there. Thank you.

Carolyn Petersen
Thanks Steven. Let's go to Danielle Brooks.

Danielle Brooks
Hi, good morning. I actually would agree with the need for the federal overarching piece. I do agree that in rare cases there should be variability which should be documented. That has to be flexible to the time at hand because I think making sure those federal standards are there, respected, and funded has to be up front so that there can be less excuse for state variability. I wanted to go back to the previous comments about scheduling. I think one of the things that are often missed in this conversation is there's an assumption that everyone speaks English. Which is a ginormous barrier in some of the scheduling, as well as some of the outreach and access to care for individuals, particularly when English was not either their preferred or their primary language. So, we really do need to make sure that this is not only scheduling and availability of appointments and access to care is done in more than just English and Spanish, but really take time to think about how that can be expanded to the masses.

With this population review I hear a lot about geographic variability, age. Let's not keep race out of the conversation. Ethnicity, that was a driving factor of a lot of disparities, particular for the Latinx and Black communities. So, we also need to make sure there's a recognition and prioritization of these disparities that are impacting populations just not by a geographic, but really by that demographic information, as well as really making sure these public health crises, there is a safe opportunity to collect information, particularly for those that are undocumented. That is also a huge barrier. But we know that something like COVID does not care about your immigration status. It only cares about where it can infect. So we need to think broadly about in collecting this data and making sure that populations are able to be immunized and receive this care, that there is some shielding in that collection of information, particularly for those that are undocumented. We also need to make sure that we keep race and language in the forefront of the data collection and scheduling and outreach because the disparities will continue in as long as we're in our current health system. So, thank you.

Carolyn Petersen
Thanks Danielle. Bryant?

Bryant Thomas Karras
Hi. I have two comments. One, I just wanted to chime in on the nationalization of immunization. I think we need to be very cautious and careful, and I agree, I would not so much call it states' rights as states responsibility to the folks that live within our jurisdictions. Making sure that we are collecting that data and protecting their data, not to create silos or vaults that the data cannot move from, but to make sure that those records are fully compliant with the rules and assurances and priorities that are put forward within a state.

So, putting that aside, though, I think one of the things that may need a separate recommendation, and this is one that I think ONC should work with CDC and perhaps organizations like the Center for Public Health Law to identify policies rather than laws that are culturally preventing health departments from fully interoperating the immunization data with other data systems within the walls of the Department of Health. Perhaps part of what I am hearing from our clinical partners are frustrations with the utilization of immunization data. I think that in an effort to protect that data, sometimes it is taken to the extreme. The perfect example of, you know, a disease reporting case management system not having ready and easy access to the information in the immunization registry. You know, these kinds of interoperability's between traditionally separate systems within the health departments really needs attention. Yes, CDC in the last couple rounds of the ELC funding has pointed out availability of funds to create interoperability between

these systems but a lot more work, I think, needs to be done to break down the policies, and maybe not even policies, but just the culture or perceived barriers to doing that work. Thank you.

Carolyn Petersen
Thanks, Bryant. Are there any task force members on the phone who have comments who could speak out so that we can recognize you?

Clem McDonald
This is Clem. I would like to reinforce are double down on the last set of comets because there's just a deep cultural perception of diseases as separate worlds. It has been a big problem for forever. I don't think it's just going to be by putting in some technology it is going to change. So, I think emphasizing they really have to revamp their thinking pretty heavily in public health to get rid of those laws. Thank you.

Carolyn Petersen
Thanks Clem. Are there other comments from task force members on the phone or in Adobe? I think we have completed the discussion, Janet.

Janet Hamilton
Okay, great. This is really helpful. Thank you everyone. I would just encourage folks, again we wanted to capture broad missing areas coming into the refinement process here. So, if there are things that folks identify maybe as they digest this discussion, areas that we need to capture more fully, please do put those in the chat. Or we can always receive those in other ways via email, etc. So, thank you all very much. With that, I think we will go ahead and move on to our next set of discussion topics. So, we also wanted to talk about recommendations related to syndromic surveillance today. So, if we can look for those within the document, that would be great. We have had some discussion in the areas of syndromic surveillance on previous calls, but not a lot. So, currently we just have one recommendation that has been put forward. So, we did want to take the time to also look at this specific area and identify overarching gaps. We are certainly happy to take comments on this one recommendation that has been included here as well. But I think there's probably several others. So, we wanted to look at this area for syndromic surveillance.

So, for folks who are maybe only on the phone, I'm going to go ahead and read this out and then we would like to open the floor for comments. So, please do raise your hand so we can capture those. And again we really want to be sure that we are capturing gaps, unmet needs, and missing items. So, the recommendation as listed here currently is ONC should collaborate with CDC and state health departments to further explore nontraditional data sources and surrogate markers that could be leveraged to assist in the identification of early clusters and outbreaks of disease incidence or provide additional inputs as the event unfolds. So, that is the only recommendation that we have at this point in the process. So, looking forward to our discussion, and let's go ahead and start with John Kansky. John?

John Kansky
Thank you. I attempted to make a suggestion in the comment to the right. But I do think, I agree that there are some gaps we have not made recommendations on. One I suggest is that the country is not making good use of the automation of reporting for syndromic surveillance purposes. I actually include a site to an article that pretty simply shows how we can use clinical data streams in an automated way to dramatically increase the accuracy and completeness of reporting and lower the burden on clinicians. I think that would be a worthy recommendation. Thank you.

Janet Hamilton
Okay, great. Let's go next to Les.

Leslie Lenert
Two points. The first point is the word syndromic surveillance, the phrase syndromic surveillance, syndromic in particular. This stems from a history of using the chief complaint to define 10 or 12 predefined syndromes of a presentation to an emergency department. I think this view is too narrow for real-time. What we are

interested in here is in real-time healthcare data from ADT feeds. We have talked about this before, what is needed is real-time transactional data of some kind from them. Now the syndromic surveillance feed is particularly valuable because it is available before coding. These days, there is a lot of preliminarily coded data available from provider notes that probably could be much more valuable than the chief complaint as captured by the nurse at the emergency department intake. Secondly, the scope of this really needs to include all outpatient services so that the admission surgeon transfer coding or the preliminary coding from outpatient services as a whole and not just emergency departments. So, that this syndromic surveillance recommendation needs to be expanded to include, I put it in quotes because I do not like that word, I think we should move on, to include all outpatient sources. Thank you.

Janet Hamilton
Okay, great. Thank you, Les. Bryant?

Bryant Thomas Karras
Hi. So, I think, Les, I agree with you by definition, syndromic surveillance has evolved and has moved beyond a pure uncoated syndrome. But I think what we need to clarify is the HL7 standard that is the syndromic surveillance standard has evolved from the early days and it does now include coded information and does include capabilities of inpatient and ambulatory outpatient reporting. So, the capabilities of the syndromic surveillance community of practice as a methodology has really moved beyond the initial use.

So, one discussion might be, down on page 13 of the document I made comments related to the situational awareness recommendations and I think there is the potential of organizing the document so that syndromic surveillance and situational awareness components are kind of pulled together or sequentially listed so that the use cases in both of those situations are better understood. The inter-capabilities or the exploration that's needed to expand syndromic surveillance further or augment syndromic surveillance with additional standards that can track PPE utilization, and bed capacity utilization, and ventilator availability can be tied together with the syndromic surveillance real-time feed.

Leslie Lenert
I think that's a very important. But we also have to remember that there is a meaningful use certification for syndromic surveillance, which probably cites an older standard and that is what we are trying to push for healthcare environments.

Bryant Thomas Karras
It was updated more recently, I think I will let the ONC folks confirm that, but I believe that was updated halfway through meaningful use to a newer standard.

Janet Hamilton
We can work on flushing that specific piece out. It sounded like Steve, you maybe had a comment on that, and you had a hand raise. So, if you could maybe go ahead, Steve Eichner, and make your thoughts.

Steven Eichner
Thank you so much. Yes, the standard has been updated throughout meaningful use of promoting interoperability program and there is a work group, I believe, that is also working on future updates. One of the things in syndromic surveillance that I think would be very useful, and we worked with extensively as part of promoting interoperability and supporting providers working with public health to submit data and exchange in the proper format, is looking at a definition of urgent care. Now, while it might be able to define urgent care in a hospital setting using a location code, the same does not necessarily exist for ambulatory care centers. And we would love to be able to define nationally what urgent care is from a delivery framework, so that jurisdictions can collect data and categorize data in the same way. One of the things we have observed during COVID-19 response is there's been a shift in usage patterns of emergency department and urgent care facilities by individuals. We want to make sure that we are doing a good job as public health while collecting information from the places where individuals are going to seek care in the shortest time period, so that we can use it as an early detection system. If we are only capturing data from

a single venue, if you will, we may not be getting adequate data. I think it's also important, perhaps, to describe we use syndromic data as early warning detecting system, but we have also found other valuable uses for leveraging the content that comes in through the syndromic surveillance systems for other public health purposes and understanding or developing understanding of some aspects of health equity among other situations looking at co-occurring conditions and diversion programs and lots of other really important uses that go beyond strictly serving as an early detection system for emergent conditions. So, I think that is probably we need to recommend is that we are using it for more things and that is a good thing. We have evolved. Thank you.

Janet Hamilton
Thank you, Steve. Let's go next to Steven Lane.

Steven Lane
Thank you. A couple of comments. One, just building on what was just said, as a PCP myself I can tell you that much urgent care is accomplished in the primary care setting. I think, especially as we have more robust and automated means of accessing data beyond people filling out a form or going to a website or uploading diagnoses or chief complaints from emergent care settings, as we can do this in a more automated way we should probably be looking at primary care in addition to urgent care as a data source. The other comment which I actually put into the Word document that is in response to John Kansky is as we have this more robust data, we should really be looking for opportunities to apply machine learning and AI tools to them to identify signals before we can do so with more traditional methods. And then I guess the question would be where and how would such tools be applied. It seems one place to do that with looking at the data that is housed within HIE/HIOs or looking integrative systems as a starting place. Not so much expecting each of those system to come up with their own analytical tools sets, which of course some will try to do, but perhaps looking at the development of a best practice toolset at the national level which could then be applied to data sets that are held within large systems and HIEs. So, I think there really is an opportunity to build on this greater interoperability that we have started to see over the past 10 years.

Janet Hamilton
Okay, great. Jim Daniel?

Jim Daniel
Hi, thanks, Janet. I will keep my comment brief. I just want to point out that during the early stages of the pandemic, Farzad Mostashari, and Duke University, and some others on this call put out some detailed recommendations on modernizing syndromic surveillance. I dropped that link in the chat. I think it is worth whoever is doing the homework for syndromic surveillance, and actually I might be on that list, to review that document to see if there are recommendations from there that we should be pulling out.

Janet Hamilton
Great, thanks Jim. Let's go next to Arien.

Arien Malec
Thank you. With regard to syndromic surveillance, the ADT symptoms for syndromic surveillance I think behave pretty admirably. We saw massive signal in the places we expected to see massive signals at the time we expected to see massive signal in the areas that were wired up for ADT based syndromic surveillance. So, I think when we call for enhanced syndromic surveillance, it is important to note that we are not calling for ripping and replacing the existing ADT based syndromic surveillance but augmenting them. I think the folks on the phone who have noted that we want to make sure that syndromic surveillance encompasses primary care, urgent care settings, pharmacy care settings, and other sources of syndromic information and is more able to use things like ESMD and automated chart abstraction and ML as additional ways using the interoperability folks that we have, such as HL7 Fire, as additional mechanisms for collecting emergent information out of the electronic health information network that we have. So, I think sometimes people think syndromic surveillance, they go straight to the existing syndromic surveillance standard which is an ADT based standard and then interpreting everything in the light of that standard. I think we ought to

be clear that we are not calling for the ADT based, those of us calling to expand syndromic surveillance are not calling for the ADT based approach to be thrown away. But our calling to augment that important broad ED based signal with additional signal capture that is more expansive to the needs of primary care, urgent care settings, pharmacy care settings, so broader, and has layers on top of it that go deeper.

With respect to Jim Daniel's comment on the Duke Margolis work, we really were calling there for some tactical updates to make sure that we expanded the applicability of the syndromic surveillance ADT based standards outside of an ED setting to encompass an inpatient setting, so when there's an admit, that we are sensitive to that. Again, I think that is in line with making sure we go broader as well as going deeper. I know this blows people's minds, but I do think we ought to call it something other than syndromic surveillance because I have gotten into more than enough people who just put the word surveillance into the frame of the government watching over you as individuals. We ought to come up with a broad safety net early warning system word that does not immediately trigger that. So thank you.

Janet Hamilton
Great, thank you so much. I think I would just echo your comments on how to involve the terminology and the discussion. This did start in a very pre-decisional chief complaint kind of way. But I think the practice now is much more integrating data from multiple data sets. It also includes information about a person who actually have diagnosis codes and we're still sort of stuck with the terminology from where the work started, but not necessarily where it has evolved to. So, I think those are excellent comments. Let's go now to Denise. Denise Love?

Denise Love
Yes, thank you. I agree with many of the comments, but I wanted to get back to something earlier on the burden. I think the providers are overburdened. I'm hearing from states that changing recordings of the COVID requirements just overloaded them. So, I wanted to emphasize the comments about using existing data to augment the recording. We get to ADT, and this gets at best practices. Could we highlight what's happening in the field already? We are seeing the ADT data blended with hospital discharge data. to build near time use of patient health and patterns. This is alerting providers to some of the COVID related signals. We have 50 states with hospital reporting systems. And 20 and growing states of all payer that have urgent care, primary care, and other. So, I just think highlighting some best practices of what's actually happening out in the field to augment these signals would help public health physicians how to use nontraditional data sources. Thank you.

Janet Hamilton
Great, thanks, Denise. Excellent comments and I think one of the hallmarks as we look at the history of syndromic surveillance was the near real-time to real-time transmission of data, so that some of these other practices have been more delayed. Maybe public health could only access some of those data sets monthly, quarterly, etc. And so really trying to bring the timeliness piece into this discussion as well as highlighting some of these best practices, and I think some of that timeliness has evolved over time, as well, where some of the things that maybe were not as timely have become a lot more timely and how do we capitalize on that.

Denise Love
Right. I have struggled over the years describing real-time and near time and not every data system will be real-time. But again, these blending of data sources are helpful and I think highlighting those best practices will help envision the recommendation.

Janet Hamilton
Great. Thanks, Denise. Let's go now to Danielle.

Danielle Brooks
One of the things in the observation of the surveillance or needs or however we are changing the terminologies, I think there's also an opportunity for public health to look at the infrastructure of

complementary needs of health. So, thinking about social determinants of life information, housing information, food, water, transportation. I think also having an understanding of what that looks like from a population health sense can also help shape and drive some of the actions that are needed. So, I'm not quite sure how the best data capture can be created from an infrastructure standpoint but having knowledge on the ground is also essential to be able to place resources and know the barriers like transportation, technology, digital issues, food, those things that people need underlying while they are sheltering in place or other types of catastrophic issue will also be important to know. Because I think we also kind of have to think about that natural way people move and their needs in addition to trying to reduce any type of disease, catching of the virus, or if there is a climate change issue or something to that extent. I also kind of implore us to think about that in a wide sense from that public health angle, not just the immediate access to care but what are those underlying social needs that's going to help kind of predict the populations that will be impacted, but also how to serve the populations as well.

Janet Hamilton
Okay, great, thank you. Let's go next to John.

John Kansky
Thanks. I actually wanted to circle back to Denise's comment a moment ago about the burden on providers and citing best practice and create a linkage to the recommendation. The comment I made in the document recommending automation that is a little bit mysterious. Hopefully I'm not belaboring this point, but I want to be clear, there are best practices out there whereby existing data streams, such as lab data flowing in real-time to an HIE, that have been shown that monitoring those lab data streams and automating the reporting off of those lab data streams requires no human intervention and works a lot better than telling providers nationwide that they have to have a burden of reporting certain diseases. So, it is kind of a double thing, lowers burden and works a lot better. Obviously, those data flows don't exist everywhere, but where they do there's a great opportunity. Thank you.

Clem McDonald
So this is Clem. Could I make a comment?

Janet Hamilton
Yes, go ahead Clem. Then we will go to Bryant.

Clem McDonald
I want to reinforce what was just said about the existing data streams. In Indiana, and John Kansky can reinforce this, I we have a fivefold increase in the disease reporting when we just used direct lab feeds, and everything was better. But I'd also like to emphasized that Leslie's ideas about not depending on case reporting forms, but getting a system that will pull from the medical record system is critical because that's going to be a huge burden if different public health organizations send different request to the same kind of thing to providers and ask them to do that instead of seeing patients. Thank you.

Janet Hamilton
Great, thanks, Clem. I don't think that public health has intentions of asking for providers to fill out forms, even in case reporting. The thinking behind that is that it needs to happen behind the scenes.

Clem McDonald
Okay, good.

Janet Hamilton
Without distracting from providers, but I do think we are blending the conversation a little bit between report identifiable information, which is sort of the hallmark of traditional electronic laboratory and case reports with some of this flavor of syndromic surveillance, which has often been deidentified data and looking at multiple data streams. So, there's definitely some complexities here. Let's go ahead now to Bryant.

Bryant Thomas Karras
Thanks Janet. I wanted to kind of actually go back to the original use cases of syndromic surveillance and emphasize, if you will permit, thinking about these recommendations going beyond the immediate COVID response and thinking about a more all-hazards investment in how it can be used. Timely example here in the Pacific Northwest, you know, use of these systems to monitor the impact of severe heat events or other natural catastrophes like a windstorm taking out power and resulting in carbon monoxide poisoning from people bringing fires indoors or fires themselves. Wildfires creating smoke inhalation and the exacerbation of chronic diseases. This kind of real-time or near real-time monitoring of the impact of events that can guide public health recommendations, public service announcements, emergency declarations to make sure that people understand the potential life-saving interventions or preventions that can be utilized.

So, I do have one other comment related to that reversal of the flow. If I can make a second comment?

Janet Hamilton
Yes, go ahead. And just in the interest of time, we are going to leave the syndromic space and turn it over to Carolyn for the next set. So go ahead.

Bryant Thomas Karras
I will make this really quick. I think that syndromic surveillance has been that real-time reporting from emergency rooms, and we have expanded it to urgent care and in-patient in Washington State. We found it incredibly valuable. I think some of the advances that Fire and bulk Fire could bring into our capabilities would be for public health to be able to query back into our partner systems to get an understanding of how many cases of a certain diagnosis or resulting activity are occurring. There was some early research from Harvard in ESP providing these kinds of capabilities, and I2B2 activity, and bedside and be on investments from NIH that I think public health could turn to and think about are there use cases for public health to leverage those kinds of capabilities. Thank you.

Janet Hamilton
Okay, great, thanks. Carolyn I will turn it over to you.

Carolyn Petersen
Thanks, Janet. We are now going to move on to the recommendations related to laboratory reporting. That is separate from case reporting. This is the section in the document immediately underneath the syndromic surveillance if you are following along. And in this section we have three recommendations and then a couple additional paragraphs of text that reflect some comments in previous sessions I will just read it really quickly the three recommendations and we can discuss whether there are additional recommendations we need to add or if we want to do a bit of revision on these basic statements.

First, ONC, CMS, and CDC should explore providing incentives for labs and public health agencies to adopt certified public health systems that accept standardized ELR notifications and add a corresponding certification for lab resulting and ordering to address and to end data flows between order, lab, and public health. That is the first one. The second one has to do with reporting for nontraditional testing sites. This recommendation is that ONC should work with CDC and FDA on mandatory reporting requirements to be addressed by vendors testing outside of provider offices. Things like a drive-through pop-up testing or at home testing. And then the third one, this has to do with pharmacies, fire departments, and EMS, and employee or school-based clinics. ONC and CMS should invest in pharmacies and other healthcare partners that were not part of the meaningful use and PI incentive programs to incentivize pharmacy systems. **[Inaudible] [01:12:10]** to use IT systems to be equipped for data exchange via HIE for public health reporting such as clinical health systems. For example, you could expand the meaningful use promoting interoperability program. ELR and ECR should be explicitly included as a standard for use.

So, we have about 15 minutes to look at these. Go ahead please and raise your hands. Okay I do not see any hands in the Adobe yet. Do we have any task force members on the phone who have comments? Let's go to Bryant.

Bryant Thomas Karras
Hi. I put a comment in the margin but I wanted to make sure that the second recommendation was the drive-through testing, pop-up testing, and at home testing, the non-traditional outside of provider offices really needs to be nuanced a little bit to make sure that we are accurately reflecting how testing is occurring Perhaps talk about traditional laboratory testing rather than provider offices because provider offices themselves might be using rapid test kits that don't provide the reports to provide public health like traditional laboratory specimens sent to a CLIA certified lab would. I made some suggestions in the comments on how that could be expanded And made more accurate. At home testing is misleading because there are at home test kits that are still performed and sent into CLIA certified labs and results do make it to public health. But there are also at-home testing kits that are rapid testing and don't interface with public health very easily. So, thank you.

Carolyn Petersen
Thanks Bryant. Let's go to Steve Eichner.

Steve Eichner
Thank you so much. To build on what Bryant was just talking about, I think it's important, perhaps, to leverage the FDA and their authorization process to include reporting requirements and authorization, including authenticating who may actually be taking a test outside of a traditional environment. So, that there is a potential to ask for public health to have confirmation regarding some of the demographics around who is taking one of these at-home or tests in a different environment.

Looking at the first recommendation, there needs to be some clarification about what needs to be certified for what purpose. Currently, a provider may send a lab order to a laboratory and the lab results may be delivered back to the ordering provider. That may be different than the lab report to public health as a notifiable condition. So, we want to be sure that we are including and focusing in on both components, so the public health is getting the appropriate data, whether it be directly from the laboratory or through an HIE, or back from the ordering provider. There may still also be benefits in supporting laboratory certification for exchange with providers. I think we should support that. I do not want to detract from that at all. But I do think both aspects are important.

also think we need to perhaps look at measuring and tracking an activity with public health and measuring public health receiving systems capabilities rather than perhaps a certification system. Public health really does two different things. Public health labs often use a commercial laboratory information management system or a public health purposes, very much the same product as being used in the private sector. We do have different systems for receiving laboratory results reporting, both from our own internal labs and from other labs. So, I think that is really the focus perhaps of where we need to have interoperability standards, or I would call it interoperability certification, to ensure we can receive data in standardized format and the data coming in meets public health purposes. Rather than necessarily looking at certifying all of our internal functions as to what we are doing with the data once we receive it. Thank you.

Carolyn Petersen
Thanks, Steve. Let's go to Steven Hinrich

Steve Hinrichs
Yes, thank you. I'm wondering if we lost some of the recommendations if these are the only two I'm seeing now. Because back to the comment from Steve, we did recommend that there was a process for incorporating FDA in the initial review and approval of laboratory test, so that they would have standards. And I'm surprised that one has gotten lost. And then the other one related to commercial LIMS and HRISs, I also thought we were going to encourage and leverage those, so they would incorporate the automated reporting systems that we need to be able to capture lab test results. And the third issue is that it seems everything got wrapped into the HIE paragraph, which is we need to encourage and support the HIEs. But that is separate from the reporting systems that public health laboratory use for CDC. There is a reference

to AIMS, but it was originally supposed to be a much bigger role and a separate role from the way in which HIEs operate. So, I am just wondering whether or not we should relook at how we originally put the recommendations together.

Carolyn Petersen
What is in the document right now reflects the feedback we have had in previous meetings. And what I have read is the highest level of those recommendations. Our goal and expectation has been that task force members would work in the document, to align those in the way that you envision them fitting into the overall sections and the overall reports. We do have access in the documents for another week. I'm hoping that those who have an interest in reshaping this will do that.

Steve Hinrich
Okay. I don't think they reflect the first meeting or two we had about laboratory reporting. But I understand what you're saying though.

Carolyn Petersen
Okay. Janet and I will work with ONC to ensure that all the comments are in there. I know sometimes they don't maybe fit into the workplace in the category that one would expect. And there are some comments at the very bottom of the draft that are waiting to be slotted in places or would benefit from some movement by task force members. But absolutely, it was not our intention to leave anything out or to influence it in some way with what's brought forward and what is not. So, I will work with ONC to ensure it is all there.

Steve Hinrich
Thank you.

Carolyn Petersen
Let's go to Danielle Brooks.

Danielle Brooks
Hello. Just a quick comment. As I am looking at this paragraph that we are reviewing about the reporting requirements for the other, I guess, access to public health, I think we can also think about adding some language in there about securing privacy and making sure that those privacy recommendations are also captured as well as the storage of this information for nontypical entities or nonstandard entities. Just to make sure that we are supporting the public trust in being able to go and send in their testing from a home kit or from a nontraditional space. But also there is some kind of recourse for the storage and perhaps sharing of information, as well as information on the privacy. So, who is able to access it particular if they are CBO actors. So, thank you.

Carolyn Petersen
Thanks, Danielle. Clem?

Clem McDonald
Yes, this is a theme I brought up before. There is another difference between the public health, at least at CDC side, and laboratory, standard laboratory. So that standard laboratories typically assume the code, or the meaning of the specimen will be embedded in the testing, serum glucose for example. In some cases the CDC will not and does not want to get those kind of codes. So, that is a problem. I think Janet Hamilton found that the specimens were not mentioned in so many reports because the SDC segment, which is a new segment, which carries specimen information, was never present and Janet can maybe clarify that. So, I think that we ought to have not the tail wagging the dog, but both wagging each other so not trying to do things different for its own sake when industry does it another way. It doesn't mean you have SPC segment for extra stuff of unusual specimens, but it is a difference that does not make things easier for communication.

Carolyn Petersen

Thanks, Clem. Bryant?

Bryant Thomas Karras
Hi. So, a couple of comments. I think those early discussions led to recognition of the importance of the collection of demographic information and complete address and phone number information. Those used to be in the section, but I think they got moved to the equity section down below. Perhaps there needs to be some kind of cross-referencing of the importance of that complete patient information being part of the initial laboratory or eCase report so the public health can do its job. It is really hard to do contact tracing if you don't know where the person is or how to reach them. So, let's please make sure that the core and fundamental feature of this does not get lost.

I also wanted to provide some depth and give, ONC please figure out how to best wordsmith. It is both nontraditional testing sites but also testing partners that were left out of the meaningful use and promoting interoperability investments of high tech. Regional labs, pharmacy-based testing, and even the national labs I think were not really incentivized or required to fully comply. So, it has made it a challenge for public health to get the information it needs in the standards and transport mechanisms that our systems depend on. So, some thought really should be put into how some of these ancillary health partners get brought to the table and do so in a way that gets us the complete set of information. ETOR is an acronym I put in my comments. Electronic Test Order and Result is a process that perhaps some development needs to be put into thinking about how public health can leverage the actual ordering of the test itself from the provider being put someplace where it can be merged back together with the result when it comes back from the laboratory. If the lab does not have the capability of maintaining all of those ask and order entry questions or a complete set of demographics then we need to come up with more sophisticated ways or an investment in those laboratories so they can do it and meet our needs. So, thank you.

Carolyn Petersen
Thanks, Bryant. I agree about how I think some of the previous comments have been located in different sections. We will look to see how best to cross-reference or to lay out headings, so that it is clear what is where, and it fits together more cohesively than in its current draft form. Seeing no more hands, I will pass the microphone back to Janet to address case reportings.

Clem McDonald
I put my hand up I don't know if you see it. It is Clem.

Carolyn Petersen
Okay, Clem, I saw it before but if you have another, go ahead.

Clem McDonald
I wanted to comment on two things. First, the national labs are actually the best in terms of following standards. From my experience, the little hospital labs are the ones that are the worst. So, I don't think I would pick on them. But I would emphasize everybody has got to do it. They have been very good about the standards, the big ones, and the little hospitals often have not. The second thing is about getting the registration data, demographics sent. We understood from a previous call, that maybe it was on a different committee, but the primary problem is the institutions that get the orders just do not send it along with, it is just sort of an accident. They do not send it along with the order, so the labs don't get it. So, they have to focus on that because that is an easy fix if that is simply the case. We got that from one of the experts from one of the big medical information systems. Thank you.

Carolyn Petersen
Thanks, Clem. Go ahead, Janet.

Janet Hamilton
Great, thank you. And just sound check, I got disconnected for a little while. Can folks hear me?

Carolyn Petersen
Yes.

Janet Hamilton
Okay, great. I'll just maybe add on to Clem's comment about the order process. We have referenced a couple of times, I think in the setting, some work done in the Duke Margolis paper and this was highlighted there. So, that is maybe a space that we can ensure to reference and pull that out for the ONC folks.

So, let's go ahead now and we're going to move on to the last section. We have about 20 minutes for this portion of the conversation. This is going to be related to case reporting activities. So, again want to take thoughts and comments here. So, I will go ahead and just read out the recommendations that we have thus far. And then we can move on from there to take thoughts and comments from the group. So, the first recommendation about electronic case reporting is ONC should require ECR and ECR Now within health IP certification programs. CMS should explore making ECR implementation a condition of participation for hospitals. Further inclusion of non-hospital-based providers is necessary. I will just add I think the intention here is the initial case report, as well. That is implied but maybe not explicit.

And the second one, electronic case reporting. ONC should work with CDC to support public health jurisdictions to implement full ECR for all reportable conditions to receive the data into their surveillance systems and improve the efficiency of reporting as well as relief providers and public health of the burden of parallel manual reporting. And I think we have another one down on the next page? If you can scroll down please? Okay, great.

The next one is ONC should coordinate with CDC Asper, the assistant secretary for preparedness and response, and HHS in working with state and local partners to align reporting and notification requirements at federal and state levels to avoid duplicative requests, or failure to meet their surveillance goals at the local level, and redundant requests across federal agencies.

Then there are some subcomponents under that. ONC should collaborate with CDC, CSTE and STLT, which is state territorial local tribal health officials, to work to harmonize reporting requirements roles and capabilities across jurisdictions and states, including data elements, timelines for submission, and communication with providers. ONC should collaborate with CMS to explore using CLIA and EHR certification authority to require the use of electronic orders, use CMS payment levers to require reportable data at lab. That actually looks like it needs to go into the lab section. ONC should work with CMS and NVLAP to incentivize adoption of ONC ALT certification across all care settings, private and commercial labs. Again that is a lab piece. ONC should collaborate with CMS and VLAP to require adoption of ONC ALT certification that incorporates HL7 standards. ONC should work with CDC to standardize reporting technical capabilities across states and jurisdictions to facilitate sharing of lab results through the adoption of standards. Sorry, there's quite a few lab ones under here.

And then, the last one actually also looks like a lab piece. So, just to summarize I think we are looking at the first buckets and we will get these lab pieces moved into the lab section. So, let me open it up here for comments. And if folks can raise their hand to make comments that would be great. It looks like our first comment is from Steven Lane.

Steven Lane
Thank you. I know that Arien added in the first recommendation, the inclusion of ECR Now. And I just put a comment in the document. I'm not sure it's necessary that we call ECR Now out separately. My feeling is that ECR can be very effective whether it is generated by a higher process or EHR. Alternate EHR base process, that it can be sent via direct, by eHealth Exchange Hug, via Fire transport eventually. I think we should be happy to be able to get ECR in. And so, I just wonder, Arien, in particular why you felt like it was worth pulling out ECR Now and why you thought it should stay there.

Arien Malec

Thank you. I would raise my hand, but I'm having computer problems. So, I will just chime in and explain. My understanding, and to the extent that we think about ECR as a holistic program that includes both the Fire and the CDA based components, than I think that is exactly what I am pointing to, Steven. What I was reacting to was discussion with CDC folks where they historically thought about ECR as the CDA based standard and ECR Now as the Fire base standard. So, I think you and I are saying exactly the same thing and I'm using terminology that may not be in alignment with your terminology I know you have been incredibly close to the ECR work with your work at piloting ECR, etc. So, you are probably more correct than I am, but that was the thought process.

Steven Lane
Got it. You know, I had a little bit more of a comment. So, Arien, if it's okay with you, I think we could probably drop those three words, the "And ECR Now." The other comment is I think we should probably have a recommendations specific to EHR vendors and supporting or requiring their ability to receive back from public health APHL the reportability response to receive and integrate and route that data. Because ECR is a bi-directional exchange of data from providers out to public health and back from public health to providers. We have had some real challenges getting the providers and specifically EHRs to receive and meaningfully utilize the reportability response, which is part of the ECR model. So, one might argue that it is redundant to say it. But it is really an EHR or certified health IT requirement to be able to receive and utilize that because there are a lot of opportunities once we have that bidirectional transmission in place to really facilitate the collaborative care management between public health and providers that we have discussed in another recommendations. So, I think we need a separate recommendation for that.

Janet Hamilton
Great. Those are excellent comments. I think maybe going back to some of the discussion about the ECR and ECR Now, maybe it would be worthwhile when we say ECR to define what that is in this context. And that might be a way to reference both the ECR CBA as well as the ECR Now. I think additionally, a definition could also help us in the sense that this is a process that happens in the background. It does not happen in a way or in a space that interrupts the provider workflow. It is truly something that just allows the provider to continue with their normal processes and interactions with their EHR and then submits the information to public health without interruption once established. It's probably worthwhile to reference that definition or footnote that in some way, as I do think there's often confusion about that. Okay, let's go ahead and move on to Bryant. Bryant do you have a comment?

Bryant Thomas Karras
Yes, thank you. I was kind of surprised that there is no mention in the entire case reporting section of ONC and CDC sustainably investing in APHL, the AIMS Hub, and CSTE's operationalization of RCKMS. I think that is core, and maybe it is down in the infrastructure component. We can't do national eCase reporting without these tools being properly invested in. That investment goes beyond CSTE and APHL themselves. It needs to extend out to the states and locals who need to keep up to date the content within our RCKMS in order for it to be an effective tool. Let me know if you want me to try to craft something or if, Janet, I don't know if it is self-serving for you to put in some guidance for how CSTE can be properly funded to maintain reportable conditions knowledge management system.

Janet Hamilton
I mean, Bryant, I think it would be useful for you to submit something. But I think broadly ECR is a process that needs to have sustainment and support for national infrastructures, as well as incentives for providers to be able to adopt and use the system. So I think it is a broad recommendation.

Bryant Thomas Karras
Thank you.

Janet Hamilton
Great, thank you. Okay, let's, Clem, take your comments please.

Clem McDonald
So, I had trouble finding the detailed specifications for ECR and HL7, but I did find them. I think my confusion while I was worried about interruptions, is the classic case report, is a form someone has to fill out. It's made up and often various different public health use different things for the same purpose. This is not that. It really is a push. So, I don't think you should use case reporting in the description in some sense because it's really quite a different thing. It's really pushing a whole set of data it might be a medical record and I can put up in the comments the actual URL, which I finally found, for what it is in the Fire case. I assume it's pretty similar in the CBA case. But I don't know if people are worried about the case report traditionally is quite a different thing than this electronic critter we call electronic case reports.

Janet Hamilton
Thanks, Clem. I think it probably would be worthwhile to reference the specifics. I think here what this is, is really the initial case report. That is a push that allows for that immediate identification and submission and should include a minimum amount of information. I would just invite this group, also, to comment on the bidirectional communication. So, we did hear some reflections already on the reportability response and incorporation, but I think we have also had discussions, as well, about potentially the need to some queries, as well. So, now there's an initial case report, public health is able to say these are people we know that we need to focus on. And potentially there's other information within the EHR that is not part of that initial transmission. How is that information gathered? That is almost bi-directional kind of communication and process. Maybe I would just invite people to maybe make some comments or thoughts on that piece after the initial case report has been received. And it looks like Steve Eichner maybe has a comment. Steve?

Steven Eichner
Yes, specifically looking at the follow-on to the EICR. There's a lot of really good work going on for the USCDI. We need to be able to leverage the USCDI, perhaps at an element or class level, not strictly retrieving the entire patient record to support a case investigation and making sure we have got APIs and a framework to access the data would be really helpful.

Clem McDonald
This is Clem. If I could just add the structure that is sent now includes pieces of the medical record. Large numbers of them, like pregnancy, drugs, etc. So it is a pretty comprehensive set, if they are there, things that would pull and send.

Janet Hamilton
Great, thanks, Clem. And thank you Steve for those comments. Go ahead Steve.

Steven Eichner
I just want to say that we are managing patient privacy appropriately because public health may not need the entire patient record to conduct an appropriate investigation. If it is not information that is relevant to the situation, it may not be necessary or appropriate or useful for public health to have the data.

Janet Hamilton
Okay, great, thank you. Let me check and see if we have folks only on the phone that want to make comments here?

Operator
If anybody would like to make a comment... Is it public comment or still with HITAC? I'm sorry.

Janet Hamilton
Sorry, I was looking just for HITAC comment. thank you. We are getting close to public comment, though. Okay, it does not sound like it. So, I think we are due for public comment at 12:20. I am looking to bring up the agenda as well. And so maybe we can actually go to public comment a couple minutes early.

Public Comment (01:45:42)

Michael Berry
Sure we can do that. Operator, let's go to public comment. Would you mind opening the lines?

Operator
Yes, thank you. If you would like to make a comment please press star one on your telephone keypad. A confirmation tone will indicate your line is in the queue. Please press star 2 if you would like to remove your line from the queue. For participants using speaker equipment, it may be necessary to pick up the handset before pressing the star keys. Once again, it is star one on the telephone keypad if you would like to make a comment.

Michael Berry
Okay, and while we are waiting I just want to remind everyone that we have an added meeting to our schedule on Tuesday, July 6th at 10:30 Eastern time. Of course, we will meet next Thursday as well, July 8, at the same time. Operator do we have any public comments?

Operator
We do not have any comments at this moment. Let's pause for one brief moment.

Michael Berry
Thank you.

Operator
Our first public comment is from Debbie Condrey with Sequoia project. Please proceed.

Debbie Condrey
Good afternoon. Thank you so much for the opportunity to comment. As mentioned, my name is Debbie Condrey. I'm the Chief Information Officer for the Sequoia project. The Sequoia project, as you might know, is a nonprofit public-private collaborative initiative to advance secure health IT interoperability for the public good. Prior to joining Sequoia, I worked within Virginia state government for 32 years, the last 12 spent in leadership roles at the Virginia Department of Health, including the chief information officer position. Sequoia project has supported the patient unified lookup system for emergencies since 2018 by facilitating an advisory Council. We have recently expanded that workgroup and convene to the emergency preparedness information workgroup. That membership includes public health experts around the country as well as others who are subject matter experts in emergency preparedness and response. The group's main focus is discussed insights pertaining to the responses as a country to the pandemic and make recommendations based on the collective experience of our members who are boots on the ground experts. During our workgroup meetings we have discussed data and access to data needed in order to respond to an emergency such as the pandemic. Bidirectional flow of data is key to ensuring the data is where it needs to be in order to respond appropriately to an emergency. Whether that might be a pandemic or weather emergency or if it is just atypical public health syndromic surveillance type situation.

Three areas that seem key to freeing up the data, so that bidirectional exchange can take place, include a focus on accuracy, quality, and clarity of data, policy law and regulatory constraints within states that must be addressed. This includes the need to support state and local policy staff to identify their specific policy constraints and explore ways to better align policy to support national data sharing goals. The third item is appropriate sustainability funding, in addition to the initial grants available to public health, is very key. We would like to congratulate you on your work to date and would welcome the opportunity to provide a resource to the task force and to the full HITAC as you work on resolving these complex issues. Thank you very much.

Janet Hamilton

Great. Thank you so much. This is Janet Hamilton. I will just say that for you and for others if there are written things that you would like to submit and have us consider we are certainly welcome to accept those. And thank you again for your comments and for the great work of the Sequoia project. Operator, do we have other public comments?

Operator
There are no comments at this time.

Janet Hamilton
Okay, great. Thank you. So I think, Mike, I'm going to turn it back over to you for next steps in the ONC staff?

Michael Berry
I'll go to the program leads, Brenda, Brett, Katie.

Next Steps/Final Remarks (01:50:48)

Brenda Akinagme
Thanks, Mike. This is Brenda Akinagme with ONC. Thank you all for the really great discussion today. As Mike mentioned, we are going to have an additional meeting on Tuesday, July 6th where we will focus on funding mechanisms, policy infrastructure, situational awareness, and individual engagement. So, please do continue to use the Google Doc where the draft recommendations are kept to make sure your comments and input can be in the prior to the meeting. I know that a lot of work has been going into this document and we would just like to have as much of your contributions as possible prior to. Brett, if there's anything else you would like to add on, please feel free to do so. That's all I have to add at this time. Thank you.

Steven Eichner
Janet, this is Steve Eichner. I have got one question.

Janet Hamilton
Sure, Steve.

Steven Eichner
On the 25th, ONC sent out a list of focus groups or subgroups to work on. Is there any instruction about how we should circle up with those groups or contact those groups?

Janet Hamilton
I would invite ONC staff to comment here. I think what we were hoping was to identify a few core people to work across the different domain areas. Certainly, if you don't have each other's contact information we would want to be sure to support. Whether you all do it individually or as a group, I think that is up to you. But we really wanted to assure that individuals who are looking at key areas, so that we don't have gaps. As well as, I think the other really crucial part is to look at the specifics of the language as well, which we don't necessarily have the ability to do that in this larger group setting.

Steven Eichner
Fantastic, thank you.

Janet Hamilton
Great, thanks, Steve. Let me just invite the folks from ONC to make comments or Carolyn, please add in your thoughts, too.

Carolyn Petersen
This is Carolyn. I agree. We know that many individuals are working different schedules and have sometimes in the field, sometimes in offices, sometimes managing childcare, or other kind of personal

responsibilities. So, we really did not want to try to force people into specific groups meeting at specific times. Our goal really is to be able to take the comments that are already placed in the document from previous meetings as well as whatever you put in the next few days and refine those into recommendations that can be carried forward to ONC, to the HITAC meeting, which is on July 14. Practically speaking, we need to have everything in the document pretty much by the end of the day next Thursday, the eighth. So, I appreciate that it is a weekend coming up with a holiday and this may be challenging but we hope that you will do your best to ensure that your feedback is in and you helped to align those to the degree that you're comfortable with, so Janet and I can go through with ONC and really put the final touches on the document.

Brenda Akinnagbe
This is Brenda again. Just to add on to that, if anyone does need email or contact information for someone who has been in their subgroup, please reach out to Brett and myself and we will try to get you connected that way.

Janet Hamilton
Great, thanks everyone. Thanks for that useful discussion. If other HITAC members maybe are not sure which group they are in, also please reach out and maybe that is something we can just resend to folks today. Obviously, we are trying to get a lot of work done in a short amount of time and maybe everyone can't participate in all of the sections, but at least to focus a few of you in on those, so that our compile document represents our community and body of work. So, thank you all so much. Let me just check in with ONC staff. Did you have anything else before Carolyn and I close out the meeting?

Brenda Akinnagbe
This is Brenda. Nothing else from me today. Thanks.

Brett Andriesen
Nothing here. thank you.

Janet Hamilton
Okay, great. This is Janet Hamilton and I really want to thank everyone for a really robust discussion and all of your energy and commitment to this work and this important effort. And remind folks we did add another meeting next week on the sixth. I hope some of you will at least be able to participate in that. I'm really looking forward to working with you to get this document finalized. Carolyn do you have any other thoughts?

Carolyn Petersen
Thanks so much everyone for your work. I look forward to completing this with you in the next week. And I wish you a relaxing holiday as well.

Janet Hamilton
Great, thank you. Happy Fourth of July. This concludes our meeting today. Thank you so much.

Adjourn (01:56:37)