Health Information Technology Advisory Committee (HITAC)

Public Health Data Systems Task Force 2022 (PHDS TF) Meeting

Meeting Note | September 9, 2022, 10:30 a.m. – 12:00 p.m. ET

Executive Summary

The Public Health Data Systems Task Force 2022 (PHDS TF) is a joint task force that consists of HITAC members, federal representatives of the HITAC, and several other subject matter experts (SMEs). The focus of the meeting was to review and discuss (f)(5) Criteria: Transmission to Public Health Agencies – Electronic Case Reporting (Cures). Gillian Haney and Arien Malec, PHDS TF 2022 co-chairs, provided opening remarks and reviewed the agenda for the meeting. The TF received presentations on the (f)(5) Criteria. The co-chairs presented the topics worksheet for use in developing TF recommendations to the HITAC and held discussion periods. There was one public comment submitted verbally, and there was a robust discussion held via the chat feature in Zoom Webinar.

Agenda

10:30 a.m.	Call to Order/Roll Call
10:35 a.m.	(f)(5) Transmission to Public Health Agencies – Electronic Case Reporting (Cures)
11:00 a.m.	Discussion
11:25 a.m.	Topics Worksheet
11:50 a.m.	Public Comment
11:55 a.m.	Next Steps
12:00 p.m.	Adjourn

Roll Call

Mike Berry, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the September 9, 2022, meeting to order at 10:30 a.m.

Members in Attendance

Gillian Haney, Council of State and Territorial Epidemiologists (CSTE), Co-Chair
Arien Malec, Change Healthcare, Co-Chair
Rachelle Boulton, Utah Department of Health and Human Services
Hans Buitendijk, Oracle Cerner
Heather Cooks-Sinclair, Austin Public Health
Erin Holt Coyne, Tennessee Department of Health
Steven (Ike) Eichner, Texas Department of State Health Services
Joe Gibson, CDC Foundation
Rajesh Godavarthi, MCG Health, part of the Hearst Health network

John Kansky, Indiana Health Information Exchange
Bryant Thomas Karras, Washington State Department of Health
Steven Lane, Sutter Health
Jennifer Layden, CDC
Leslie (Les) Lenert, Medical University of South Carolina
Mark Marostica, Conduent Government Solutions
Alex Mugge, CMS
Stephen Murphy, The Network for Public Health Law
Jamie Pina, Association of State and Territorial Health Officials (ASTHO)
Abby Sears, OCHIN
Vivian Singletary, Public Health Informatics Institute
Fillipe (Fil) Southerland, Yardi Systems, Inc.
Sheryl Turney, Carelon Digital Platforms (an Elevance Health company)

MEMBERS NOT IN ATTENDANCE

Charles Cross, Indian Health Service
Jim Jirjis, HCA Healthcare
Hung S. Luu, Children's Health
Aaron Miri, Baptist Health
Eliel Oliveira, Dell Medical School, University of Texas at Austin

ONC STAFF

Mike Berry, Designated Federal Officer
Avinash Shanbhag, Executive Director of the Office of Technology, ONC
Brenda Akinnagbe, Program Staff
Liz Turi, Program Staff

PRESENTERS

Ann Kayser, MN Department of Health
Laura Conn, CDC/CSELS/DHIS

Key Specific Points of Discussion

Topic: Opening Remarks

On Gillian Haney and Arien Malec, PHDS TF 2022 co-chairs, welcomed everyone and reviewed the agenda for the meeting. Arien noted that the topic of the current meeting is impactful and described the importance of work to refine the workflow for Electronic Case Reporting (eCR) and its usefulness for public health. He described how the standard for eCR changed before and during the onset of the COVID-19 pandemic and was eventually deployed across multiple jurisdictions. He noted that improvements to the use of eCR create positive impacts for the transmission of data to public health and described the two SME presentations related to the (f)(5) Criteria.

Gillian commented that eCR is in its infancy compared to other public health information streams, like syndromic surveillance and electronic laboratory reporting (ELR). She described how public health entities came together to determine which data elements were important for eCR and how these entities also worked to create a centralized location for public health data. She summarized the objectives of the SME

presentations and welcomed the presenters.

Topic: (f)(5) Transmission to Public Health Agencies – Electronic Case Reporting (Cures)

The co-chairs welcomed SMEs to share perspectives on eCR and public health.

Ann Kayser, Electronic Onboarding Coordinator, MN Department of Health, presented on perspectives from the Minnesota (MN) Department of Public Health on eCR. She explained that the MN Department of Health has been using eCR since July 2021 and noted that they currently receive for COVID-19 and some Monkeypox eCR using the Association of Public Health Laboratories (APHL) Informatics Messaging Services (AIMS) platform as a centralized hub for routing and receiving eCRs. She described the process, which was detailed in the presentation slides, and shared use cases as examples. She described how the extraction of data from Electronic Initial Case Reporting (eICR) is burdensome for public health agencies and how and why trigger codes are not implemented on all lab data. She shared several recommendations, which were included in the presentation, and invited the TF to share comments and questions.

Gillian thanked Ann for her presentation. For clarity, she defined eCR and described the process by which an eCR can be triggered and investigated by public health. She noted the challenges of working with unstandardized coding and the need for the implementation of trigger sets.

Laura Conn, eCR Program Lead, Centers for Disease Control and Prevention (CDC), Center for Surveillance, Epidemiology, and Laboratory Services (CSELS), and the Division of Health Informatics and Surveillance (DHIS) presented on eCR certification needs. She briefly described the original 2015 “Functional” Certification criteria and discussed the current state of certification for eCR, noting that the public health community has advocated for more stringent, standards-based certification criteria. She echoed previous comments about the enormous accomplishment of a single interface that serves as a way for eCR data to move between public health agencies and healthcare and described the workflow, which was depicted in the presentation slides. She shared the current version of the eCR standards and links to their locations on HL7’s website, which were also included in the slides. She discussed certification challenges and needs for eCR, including the automated uptake of trigger codes in electronic health records (EHRs), data quality, and bidirectional communication. She described use cases and explained how these needs are supported using eICR, Electronic Reporting and Surveillance Distribution (eRSD), and Reportability Response (RR). To inform the TF’s decision-making process on possible public health certification needs for health systems and commented on the use of eCR by public health agencies (in states, territories, and local jurisdictions), noting that the use of eCR data is not the barrier. Rather, the challenges now come from processing this data quickly and routinely at public health agencies. She emphasized the need to ensure that data specificity that is needed can be addressed by enhancing certification for eCR.

Steven Lane, Sutter Health, described the progress made on eCR and discussed the changes that have occurred just since the beginning of the COVID-19 pandemic, which served as an impetus to drive implementation of eCR at Sutter Health. He explained that providers, public health agencies, and EHR vendors have all engaged in the process to make eCR part of the foundation for public health interoperability. He described opportunities to move eCR to the next level and challenges/burdens for provider organizations (e.g., manual reporting). He emphasized the need to include specific technical standards in EHR certification as soon as possible. He explained that eCR is a model for customized interoperability and the bidirectional exchange between clinicians (send the eICR, get back the RR) and public health. He shared several opportunities and challenges, including the ability to streamline the data requirements between eCR and ELR so that they do not overlap, causing duplicative information to be sent through multiple streams. He thanked everyone for their hard work on eCR and advocated for requiring its utilization. Finally, Steven discussed his experiences at Sutter Health using the centralized model for sending and receiving eCRs, noting that they hope to use eCR exclusively for all conditions (stopping manual reporting) in 2023. The California Department of Health will do a system upgrade to better support eCR and is receiving data while working with healthcare

systems to check on the data quality. Gillian thanked him for his presentation and expressed interest in the lessons Sutter Health learned from its more rapid deployment of updated sets for trigger codes.

The co-chairs facilitated a discussion session following the SME presentations.

Discussion:

- Gillian shared a comment from the chat in Zoom about the specificity within the trigger codes and how that is applied to case counts within each jurisdiction. She responded that trigger codes are established to report a case as either a suspect based on a lab result or a probable or confirmed case, depending on the disease. She described use cases that highlighted the need for public health to get the clinical data from the EHR or the actual case to confirm each case and get the true counts of cases of diseases within jurisdictions. She noted that cases of high-volume diseases are more likely to be missed in counts than smaller volume diseases.
    - Laura commented that the single interface for public health is useful because it handles the complexity of the reporting variation for healthcare. She explained how two steps (trigger and decision support) must occur to facilitate the appropriate reporting to public health agencies.
    - Gillian noted that the decision support tool routes cases to the appropriate agency automatically.
- Leslie Lenert thanked everyone working in public health for their dedication to eCR and for getting data out on a national level. However, he shared several pieces of feedback on current challenges, including:
    - At a state level, public health cannot agree on the definition of a reportable case, so there are unique reporting data requirements for each state that constantly evolve.
    - Until states have a unified standard for notifiable conditions that can be used and updated at a national level, there will be issues.
    - The core problem is that public health must agree upon its own data needs before moving forward, and this problem predates eCR.
    - Gillian commented that the Council of State and Territorial Epidemiologists (CSTE) has set the criteria for establishing what those case definitions are in terms of what makes a probable or unconfirmed case (specific lab and clinical criteria). However, the challenge for public health is identifying the clinical criteria to support meeting the case definition, because it is often embedded in notes within EHR systems, not easily extractable or readable.
    - Leslie thanked the CSTE for their work in this area but suggested that one national standard for notifiable conditions reporting and a national routing system are necessary. He noted that the architecture of eCR supports diversity, rather than eliminating it. He highlighted issues with the architecture of eCR and explained that public health should be given access to the EHR following a trigger event instead of just receiving a static/one-time transmission of data.
    - Standards should be used to allow public health to investigate cases. Examples could include querying via Fast Healthcare Interoperability Resources (FHIR), ensuring that United States Core Data for Interoperability (USCDI) data are available, and making Bulk FHIR routinely available to public health for queries. Then, public health can ask for any necessary data via health information exchanges (HIEs) or other systems. Better solutions should be built instead of stringing together old ones.
    - Bryant responded that he agreed and disagreed with Leslie's comments and described the value of supporting flexibility across states with unique needs. He agreed that eICR was never intended to be the end of the reporting process (the "I" stands for "Initial), so he suggested that work should be done next to retrieve missing

data elements from EHRs. He described his experiences onboarding facilities to the use of eCR between 2020 and now and suggested that the TF make recommendations to support low-hanging fruit while bringing along the remainder of clinical entities that have greater challenge.

- Arien suggested that the TF frame its recommendations with support for a common nationwide floor while enabling provider organizations in local jurisdictions to raise the ceiling. He referred to comments he made in the chat via Zoom around the framework for standards certification criteria. He summarized previous comments around challenges related to coding, which are secondary to lab order sets/results not being encoded via LOINC and maintaining trigger conditions (lack of standardized data prevents enabling of trigger hooks).
    - Laura discussed the example of vendors that do not use SNOMED codes, noting that, though there are issues in the lab space, there are other coding set issues.
    - Arien highlighted the need to ensure that certification criteria include the ability to update terminology sets. Also, he spoke about the lack of operating rules and latency of data refresh/code sets, which could better establish nationwide interoperability.
    - Laura agreed, noting that more support is necessary for emergency response use cases.
- Rachelle shared her experiences working on eCR in Utah since 2015 and described the parts of eCR. She described how eCR often uses data from rapid testing or syndromes (not from a lab) in an initial notification and discussed how demographic information is used by public health. She explained that challenges remain around the variability and complexity of clinical information and parsing the data. Public health has also seen significant benefits, despite the challenges, and she thanked providers for their engagement.
    - Gillian thanked her for her comments and noted Utah's engagement and wealth of real-world experience with eCR.
- John suggested that there is a cross-cutting need across the TF's potential recommendations to accommodate both the direct from EHR path and the HIE/Health Information Network (HIN) intermediary path. He briefly highlighted use cases in which the use of HIEs/HINs would work better than relaying directly on the EHR. Examples included reducing burden on providers, lowering costs, recoding data to standards, and addressing health equity challenges. However, he noted that there are dangers to bypassing the EHRs.
    - Gillian commented that there is eCR flowing through several HIEs.
- Hans supported Bryant and John's comments and described the different methods for using eCR (embedded in the EHR, use of FHIR-based apps, and use of an intermediary). However, there should be an expectation of consistency with a standards-based approach, despite the flexibility. The approach to get more information should remain balance and not move toward query-only. He highlighted HELIOS' recent work with its Optimization and Align track, which includes case reporting, lab reporting, and syndromic surveillance and their relation to one another.
- Ike highlighted comments in the discussion and noted that data should be addressed all the way through the process, as well as how to assure that public health departments are validating the data from a quality standpoint. He suggested that having standards across public health would ease provider burden by eliminating the need to meet multiple quality standards, some of which may be in conflict with one another.

Topic: TF Topics Worksheet

Arien explained that he updated the PHDS TF 2022 Topics Worksheet and asked TF members to share comments. The TF will establish a cadence of having members add comments between meetings and then reviewing the worksheet during meetings. He highlighted draft proposed recommendations to the HITAC for the (f)(1) Criteria that the TF discussed at a previous meeting and invited Hans to review the comments he

entered in the worksheet. Hans noted that some of the comments aligned with some of the pending Adopted Standards Task Force 2022 recommendations (denoted with the names of the AS TF co-chairs), which will be presented to the HITAC at its September meeting.

Arien clarified ONC's Standards Version Advancement Process (SVAP) for updating the standards via the evaluation and addition of versions of upwardly compatible standards to the established floor. As the SVAP advances, the standard named in regulations serves as the mandatory floor, and the SVAP standard is the ceiling to which most organizations will update. Then, ONC will eventually phase out older versions of the standards. Hans and Arien discussed the relevance of the (f) Criteria to named standards and regulation standards, as well as those available in the SVAP. He also clarified that the Interoperability Standards Advisory (ISA) is a catalog of potential, useful standards that can be made available for reference; the SVAP will draw from ISA, and, over time, the older version of the floor for certification criteria will be updated.

Discussion:

- Hans provided greater context for his recommendations and suggested that the PHDS TF weigh in on the direction for referencing case reporting in the standards.
- Ike commented that public health systems should be referenced in the standards and should also begin to be certified. However, he stated that attention should also be paid to ensuring that public health content and quality needs are met.
    - Arien responded that certification criteria should come with appropriate means to update public health data systems. The TF should assume that there is funding for updates, as well as a requirement to certify to later standards.
- Vivian commented that she made several notes on the worksheet, and Arien suggested that they harmonize the comments.
- Arien discussed comments that he and Jamie made regarding the collection of race, ethnicity, and sexual orientation and gender identity (SOGI) data. Arien stated that updates to the USCDI will bring the updates to the SOGI data. He invited TF members to comment on recent work on a minimally useful data set for collecting race and ethnicity data (for better tracking disease burden).
    - Gillian responded that she would investigate recent CSTE efforts and could share at a future meeting.
    - Gillian summarized an update Bryant shared on Washington state's recent efforts to expand the required list of what is included in their race and ethnicity data set. Arien invited Bryant to share additional information and commented that there should be a nationwide floor for this data set that is more expansive than the OMB list that is also useful for tracking disease burden for public health needs.
- Gillian shared thoughts about the TF discussions, noting that there is common agreement in public health about the eCR standard for transport as well as data elements. However, there is are opportunities to tighten standards within eCR adoption, consider a phased approach to certification, and for further discussions around meaningful certification.
    - Arien agreed and noted that there is a need to be thoughtful about upgrading the USCDI and associated vocabularies to ensure that data flows capture the source vocabulary that triggers eCR.
- Joe commented that most work on eCR development has been at the state level and stated that there are still many stakeholders who should be included in the process. He shared his experiences and challenges in Indianapolis.
    - Arien explained that the process for certification and detailed the roles and opportunities for CMS and other stakeholders to develop programmatics, funding, and incentives.

- Jim asked a question in the chat via Zoom about the meeting series, and Arien responded that all the meetings will be public.

Next Steps

Homework for September 16, 2022, Meeting – due by Thursday, September 15:

- Please read and familiarize yourself with (f)(3) Transmission to public health agencies—reportable laboratory tests and value/results (https://www.healthit.gov/test-method/transmission-public-health-agencies-reportable-laboratory-tests-and-valueresults).
- Continue reviewing and adding comments to the Topics Tracker worksheet. Instructions on how to use the worksheet can be found on the instructions tab within the spreadsheet. The spreadsheet is accessible through Google Docs.

If anyone has questions, please feel free to reach out to the co-chairs or the ONC program team.

Public Comment

Mike Berry opened the meeting for public comments:

QUESTIONS AND COMMENTS RECEIVED VERBALLY

There was one public comment received verbally:

Jim St. Clair: Thank you I was just following up. I'm just happy to admit I'm doing something wrong, but in looking at the schedule as it is on the ONC's website, this was the meeting that was available for registration. Maybe it is just listed as the next meeting goes closer, then they will open it up for public registration. But, it didn't appear that way as it's currently listed.

Mike Berry: Registration links are posted one week in advance of each meeting. If you log on after basically each task force meeting, than the next meeting will be up.

Jim St. Clair: Excellent. Thank you, Mike. I appreciate the guidance.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT

Mike Berry (ONC): Welcome to the Public Health Data Systems Task Force. We will be starting soon. Please remember to set your chat to "Everyone" so that we all can see your message. Thanks.

Arien Malec: @Steve -- can you speak without slides to the experience you had on the provider side getting eCR up and running?

Leslie Lenert: https://academic.oup.com/jamia/advance-article/doi/10.1093/jamia/ocac133/6651845

Mike Berry (ONC): Meeting materials can be found here: https://www.healthit.gov/hitac/events/public-health-data-systems-task-force-2022-9

Leslie Lenert: Gillian: can you talk about the trade offs between high precision definitions and a best estimate of actual case counts in a region?

Hans Buitendijk: For OIDS, we should consider national networks as well to have relevant OIDs in directories for PH use as the PH use cases are being build out, not only addresses. Alternatively, as CDC has established OIDS for IIS-s, is there an opportunity for CDC to enable look-ups? Challenge will always be keeping it up-to-date as we unfortunately see with all types of identifiers and addresses.

Steven (Ike) Eichner: The list of reportable conditions may vary by jurisdiction, supporting variations in health issues across the country.

Arien Malec: Please tag comments to "Everyone" rather than “Hosts and Panelists" to better support public participation…

Joe Gibson: There are still many challenges in getting eCR data to local (vs. state) public health agencies. 13 local jurisdictions is a small number of US cities, let alone the 2500+ local public health agencies. Many of the smallest agencies may use state systems to do reportable disease surveillance, but moderate-to-large size local PH agencies may have their own systems.

Bryant T Karras: @Les i believe that RCKMS and AIMS does not de-duplicate or track over time. so case definition of repeat presentation within 90 days may not be taken into account. State and Local will need to determine

Annie Fine: Joe, do you think all 2500 local public health agencies should be able to process these relatively complex documents? I would think that local PHAs should have access to some of the data received but not necessarily to every eCR - there is a very high volume of data that need to be filtered, mapped, deduplicated, etc. I would think those processes should be somewhat centralized or shared - although it would be great if local PHAs could receive both structured data and possibly a subset of the eCRs in human readable format too. But it seems like a lot of data processing at the local level to have all local PHAs to receive all eCR. Curious what you think!

Leslie Lenert: Yes…some kind of embedded standard to deduplicate and integrate reports is imporrant (think Datavant or other PP linkage methods)

Annie Fine: Deduplicating, grouping, filtering - all could be shared services

Leslie Lenert: Steve==can you comment on maintaining trigger codes and reporting data in the CCD sent to public health?

John Kansky: To Joe and Annie... robust HIEs can supplement the technical capabilities of LHDs and help them meet needs like the one you call out

John Kansky: I hope to comment later on the need to accommodate *both* the direct from EHR path and the via HIE/HIN intermediary path. The same automation of trigger codes being described also exists via HIEs (e.g. communicable disease reporting)

Abby Sears: +1 for Les's comments

Abby Sears: I agree wholeheartedly with needing one standard.

Arien Malec: I'll just repeat making sure we have a common floor....

Hans Buitendijk: Having a common knowledge source, as demonstrated, can enable different paths: eCR Now on FHIR App, Embedded in EHR/HIT, HIE/HIN Intermediary. The eCR approach has further opportunities to expand on triggers and tailed eICRs based on trigger and source. The latter is relevant as eCR has the opportunity to reduce burden of other workflows, e.g., laboratory results ordering/reporting.

Joe Gibson: @Annie - While most local PHAs would not want to get eCR, many do. As PH informatics improves, I expect that number will grow - I think we all hope that it will, that this data will be used more and more to improve PH at the local level. With case reporting shifting to an electronic stream that goes directly to state HDs, LHDs that had more advanced reportable disease systems now have less direct access to some of this information.

Steven (Ike) Eichner: One potential method of advancing OID association with providers would be to tie it to licensing (get an OID as part of receiving a license- leveraging the licensing process.

Hans Buitendijk: HELIOS is focusing on optimization and alignment of data streams, including what to send/push and how to query for additional data. Query only is not necessarily the only answer for PH to access relevant data. Triggers are important to seed initial data sets and need to investigate further.

Arien Malec: standardizing case reporting push does not mean that PH can not query. These are not either/or.

Steven Lane: Early in the pandemic we developed and delivered a Carequality policy to allow PH jurisdictions to query for CCDs using established IHE protocols to support case investigation but only one jurisdiction took advantage of it for a limited use case. We CAN leverage available networks and the existing framework to support more robust queries via C-CDA and FHIR for USCDI data and beyond.

Jamie Pina: @ErinHolt raises an essential point: be cautious not to conflate "Reportable" and "Notifiable"

Hans Buitendijk: It is indeed never either/or, rather balancing both.

Laura Conn: @Arien yes, doing follow up via query for condition specific data could be very beneficial

Arien Malec: likewise CommonWell & eHX -- we had nationwide networks opening arms to public health but poor ability to uptake and adopt -- should contemplate certification criteria to participate in TEFCA-enabled query.

Bryant T Karras: data quality is a real issue

Steven Lane: There has been understandable reluctance on the part of providers to respond to queries from Public Health, based on the HIPAA Minimum Necessary requirement related to non-Treatment queries. We worked hard to get guidance from HHS OCR that PH queries in the context of the pandemic be declared Minimum Necessary, but we were unsuccessful in getting this. Instead we were left requesting individual states or jurisdictions to make this declaration, but very few were able to make this happen. As OCR is working on HIPAA updates we should try to assure that new rules support more robust allowances/requirements for providers to respond to queries from PH, be they via C-CDA documents or FHIR resources.

Gillian Haney: good point Steve.

Arien Malec: endorse -- we called for this (clear OCR guidance on minimum necessary for query) early in as part of the Duke-Margolis work back in April/May 2020…

Laura Conn: We do have eCR flowing using HIEs in several jurisdictions.

Jim St.Clair: Good discussion, FYI the NIH All of Us Program had an RFI about public health/pop health data from HIEs and it seemed pretty clear they don't fully understand what is flowing through HIEs at present, exp variability btwn *[sic]* HIEs

Bryant T Karras: many EMR EHRs only want to support DIRECT which is not HIE (IHE standard) compatible

Steven (Ike) Eichner: HIE participation, as a percentage of providers in any given area, may vary significantly across the US.

Jim St.Clair: +1 Steven

Leslie Lenert: @steve. FHIR resources seem an apt way to define “minimum necessary” data for PH inqurry

Arien Malec: The minimum necessary issue is that it leaves the definition of minimum necessary to the local PH authority -- for a nationwide reporting fabric, we want to ensure that there is broad deeming that reporting via USCDI to an authorized PH authority request meets the minimum necessary requirement.

Ann Kayser: HIEs tend to be at the state/jurisdictional level. When healthcare organizations cross state lines, there is also some complexity on how this should go to the central platform.

Laura Conn: PH has identified the data in the eICR as minimum necessary for eCR.

Steven Lane: Yes, the advantage of FHR-based queries from PH to providers (including labs, imaging providers, etc.) could /should be deemed to be Minimum Necessary if we, as a country, can simply agree that, if a jurisdiction requests a piece of data they do so because it is Necessary. All of the data represented in USCDI and more would then be available for real time access, even in response to automated queries triggered by a received eCR, eLR or Syndromic Surveillance message.

Joe Gibson: In Indianapolis, where HIE participation is very high, the Marion County PH Dept (Indianapolis) was able to use the HIE as a portal to review partial medical records of potential cases of reportable diseases. Having a clinical background, the PH nurses were able to interpret notes and other fields, avoiding the challenges of having to have that information standardized. This is a very different approach that the automated AIMS & RCKMS-mediated eCR reporting, but had a lot of efficiencies while keeping flexibility. Not something I'd imagine would be a national approach, but valuable where it is possible (thanks to the region's HIE).

Steven (Ike) Eichner: The federal Department of Health and Human Services has this information regarding minimum necessary: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/minimum-necessary-requirement/index.html

Leslie Lenert: There are numerous advantages to case reporting and investigation as well as outbreak tracking through HIEs

Jim St.Clair: Just curious, has this yet translated to asks from HIEs?

Rachelle Boulton: For those interested, Utah has a publication about our experience with a pilot eCR implementation. This occurred before the eICR standard and AIMS/RCKMS centralization, but the overall process is similar. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6788887/

Erin Holt: Recent report from CSTE that might be helpful- https://preparedness.cste.org/wp-content/uploads/2022/04/RaceEthnicityData_FINAL.pdf

Lesliann Helmus: OMB is in process of developing recommendations for race/ethnicity: https://www.whitehouse.gov/omb/briefing-room/2022/06/15/reviewing-and-revising-standards-for-maintaining-collecting-and-presenting-federal-data-on-race-and-ethnicity/

Gillian Haney: Thanks Erin!

Steven Lane: @ Jim - We should consider creating a list of asks from HIEs. What that we had a standard definition of Health Data Utility that included specific capabilities to support eCR and other Public Health Interoperability. I believe that many HIE/HIO/HINs would welcome a set of standards that would allow them to

voluntarily demonstrate specific capabilities and which could be pointed to by regulation. Civitas is working on this presently.

Nedra Garrett: NCHS is working on publishing the latest update on R/E. Should be published in the relatively near future. I don't have a date.

Laura Conn: Oregon also has REALD requirements. https://www.oregon.gov/oha/OEI/Pages/REALD.aspx

Jim St.Clair: Excellent, @Steven, also sounds like a task for our Committee :)

Erin Holt: Agree Gillian. Taking strategic bites of the elephant as opposed to attempting to swallow the perfect elephant...

Steven (Ike) Eichner: PH interests include data quality and timeliness of reporting, Different conditions may have different reporting windows. It is important that public health receives notification in the specified windows to inform necessary response. Some conditions may require immediate notification. Others may have longer reporting windows. These timeframes are important whn *[sic]* considering generating and routing reports.

Jim St.Clair: I believe this is the last public mtg?

Joe Gibson: I'm wondering how we bring the large local PH agencies along in eCR, if they have not been involved in or funded for the AIMS RCKMS eCR system development, and then funding gets tied to having certified systems.

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

There were no public comments received via email.

Resources

PHDS TF 2022 Webpage
PHDS TF – September 9, 2022 Meeting Webpage
PHDS TF – September 9, 2022 Meeting Agenda
PHDS TF – September 9, 2022 Meeting Slides
HITAC Calendar Webpage

Meeting Schedule and Adjournment

Arien and Gillian thanked everyone for their participation. The co-chairs summarized key achievements from the current meeting and shared a list of upcoming PHDS TF 2022 meetings, including dates of presentation to the HITAC. The explained how the TF would develop its recommendations, and Arien offered to share sample recommendations for content and formatting.

The next meeting of the TF will be held on September 16, 2022. The meeting was adjourned at 11:59 a.m. E.T.