Health Information Technology Advisory Committee (HITAC)

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

Meeting Note | September 16, 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)(3) Criteria: Transmission to Public Health Agencies – Reportable Laboratory Tests and Values/Results. 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)(3) Criteria. The co-chairs presented updates made to 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)(3) Transmission to Public Health Agencies – Reportable Laboratory Tests and Values/Results
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

Lauren Ritchie, Acting Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the September 16, 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
Jim Jirjis, HCA Healthcare

John Kansky, Indiana Health Information Exchange
Bryant Thomas Karras, Washington State Department of Health
Steven Lane, Sutter Health
Leslie (Les) Lenert, Medical University of South Carolina
Hung S. Luu, Children's Health
Alex Mugge, CMS
Stephen Murphy, The Network for Public Health Law
Eliel Oliveira, Dell Medical School, University of Texas at Austin
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
Rajesh Godavarthi, MCG Health, part of the Hearst Health network
Jennifer Layden, CDC
Mark Marostica, Conduent Government Solutions
Aaron Miri, Baptist Health

ONC STAFF

Lauren Ritchie, Acting Designated Federal Officer
Brenda Akinnagbe, Program Staff
Liz Turi, Program Staff

PRESENTERS

David DiCesare, NYS Department of Public Health
Riki Merrick, APHL
Justin Nucci, Colorado (CO) Public Health State Laboratory Services
Carmen Pugh, LabCorp
Prashant Gupta, LabCorp

Key Specific Points of Discussion

Topic: Opening Remarks

Gillian Haney and Arien Malec, PHDS TF 2022 co-chairs, welcomed everyone and reviewed the agenda for the meeting. Gillian briefly described her experiences with electronic laboratory reporting (ELR) and highlighted several ways in which work on ELR has accelerated, due to recent funding from the Centers for Disease Control and Prevention (CDC) and increased volume and centralization of electronic feeds during the COVID-19 pandemic. She contrasted public health's use of ELR with its use of electronic case reporting (eCR), noting that ELR has been more federated by jurisdiction. She described several challenges (e.g., ELRs that are missing information slow interoperability) and opportunities (e.g., certification of the learning information management system and then information sent on to public health).

Arien stated that, because ELR is used nationwide, there are good examples of its utility and feasibility. He

described several lessons learned and introduced the subject matter expert (SME) presenters.

Topic: (f)(3) Transmission to Public Health Agencies – Reportable Laboratory Tests and Values/Results

The co-chairs welcomed SMEs to share perspectives on ELR from public health labs, the Association of Public Health Laboratories (APHL), and one of the large national labs. He added that hospital and health system members would be invited to share feedback on the "send side" during the discussion portion of the meeting.

David DiCesare, NYS Department of Public Health, presented perspectives from the New York State (NYS) Department of Public Health on ELR. He described how NYS process their intake of public health data and made suggestions for process improvements. He stated that many issues with inbound data from labs are due to a lack of standardization of reporting types. He explained that, though HL7 Version 2.5.1 is the national standard for the electronic data exchange in all healthcare environments, some hospitals and smaller commercial labs, for example, will use old versions of the HL7 standard when sending data. He explained that issues arise because they are still receiving Flat Files. Additionally, they have encountered issues due to a lack of standardization of coding schemes. He explained that facilities that use LOINC and SNOMED also use local codes and tools are not always updated regularly. He noted that lab systems and electronic medical record (EMR) vendor changes have also been an ongoing issue and asked about the status of EMR vendors work on Meaningful Use (e.g., work on one interface that meets everyone's goals creates challenges). Finally, he described challenges created by the lack of completeness of information that is being reported (e.g., maintaining demographic information). He shared several possible solutions, which were detailed in his presentation slides.

Riki Merrick, APHL, presented on ELR standards and certification. She described the current state of ELR and its use by public health agencies, including gaps/challenges around functionality and implementation of the (f) Criteria, which were detailed in her presentation slides. She shared a list of recommendations for advancing the Criteria, testing guidance, and/or standards and implementation specifications to address the gaps. She shared suggestions related to improving and supporting ELR data exchange functions, workflows, and data flows, which were also detailed in her presentation. She invited Justin to share information on the APHL Informatics Messaging Services (AIMS) platform.

Justin Nucci, Colorado (CO) Public Health State Laboratory Services, presented on challenges of ELR for public health labs. He described the different flavors of HL7 that Colorado supports, and highlighted challenges public health laboratories (PHLs) have encountered because they are not the primary provider of patient demographic data (e.g., challenges with patient matching). He explained that PHLs report data for surveillance testing that may not have standard coding or large value sets. Because PHLs support standard data fields but also non-standard information, they often need to support non-standard coding and must use workarounds; this creates challenges. He recommended continued support for electronic ordering, collecting demographic fields, and supporting the ELR team downstream.

Carmen Pugh and Prashant Gupta, LabCorp, shared perspectives on recent uses of ELR from the point of view of a national commercial lab. Arien commented that they are intermediaries in a complex flow and have experienced state-by-state variation, especially in recent years. Carmen, who is responsible for LabCorp's state reporting program, described LapCorp's centralized mainframe (laboratories flow into one main LIS) that allows them to have one corporate state reporting office with one file for each state. She described her experiences working on LabCorp's state reporting program for over 16 years and stated that she is a Lab Tech and Clinical Laboratory Scientist. Prashant explained that he is the Vice President of Architecture and Informatics. Carmen noted that LabCorp has about 14 processes in place that allow them to accommodate the various state requirements, about eight programs that will create HL7 files, four programs that can create faxed files, a program that creates a non-HL7 limited file, and a program that creates paper reports that are mailed. They can report 200-400 HL7 ELR files daily and report to every state, separate cities and counties,

and to most US territories. They use HL7 Version 2.3.1, and she acknowledged that they are behind, and described what information is included in their reports and how files are transmitted. She commented that they have been sending deidentified patient information in reports to the CDC's National Genomic Surveillance Programs for over a decade. She shared gaps with implementation, noting that because they often do not come face-to-face with the patient, which leads to gaps in information. She suggested that this is due to a lack of regulatory information around what states must collect and put into a lab order. Between/more information would benefit states and public health. Also, she described how reportable diseases and lab tests vary from state to state and this makes it difficult for national laboratories to understand each state's public health reporting needs. They agreed with previous presenters' suggestion that there should only be one HL7 implementation guide (IG) in use; she explained that all states can accept HL7 Version 2.3.1, so that is why they continue to use it, despite it being outdated. She also recommended the use of one standard set of patient demographics with no variations between states and that the recommendation that labs must collect and store patient demographics should be dropped, unless they are necessary for the testing algorithm and results. She stated that there should be standardization across vendors, EMRs, and states with a minimum standard amount of data that is stored (without extra fees) by EMRs with the ability to transfer this information, including to labs. Finally, she called for the improvement of case reporting (do electronic reporting daily for suspected and confirmed reportable diseases) to give all parties the necessary information for surveillance.

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

Discussion:

- Arien shared a comment he added to the chat in Zoom about the report the Interoperability Standards Priorities Task Force (ISP TF) put together on Orders/Lab and described several of the recommendations the TF shared in its report to the HITAC. He encouraged everyone to review the recommendations.
- Arien invited the presenters to share more information about the state-by-state variations that are not accommodated in the latest Lab Results Interfaces (LRI) specification:
    - Riki stated that HL7 has evolved the public health component of the LRI to accommodate needs/changes as they surface. She shared examples of state variations, including differences in demographic information collected.
    - Arien summarized recommendations to account for state-based variations, and Riki responded that another big problem is making sure that everyone knows about the variations and that they are easily accessible.
    - Carmen explained that they have received requests from states to place HL7 data in fields that are not designated for that use. Then, the variations that LabCorp has made to the specification for one state ends up applying to every state. Sometimes, states ask to collect unique types of information (e.g., demographic data) and make requests to use specific fields to hold the data.
- Bryant asked Carmen or Prashant to common on their statement about using an older version of HL7 due to requests from states. He suggested that states should do a full implementation to Version 2.5.1 and then states that do not want all the specific demographic data fields should ignore them.
    - Carmen responded that LabCorp has been working for years to convert to Version 2.5.1, but they have not pushed states to burden themselves with an implementation to the newest version due to concerns around the already present burden of the COVID-19 pandemic. Ultimately, they will proceed to the national standard and will not follow the state flavors.
    - Bryant commented that they must be inclusive of what states require by law and should use a multi-state working group to develop this process.

- Erin explained how problems with the implementation of parent-child relationships in ELR (for public health, sender, and receiver sides of the interface) create issues and special effort to consume and interpret the information. Also, she noted that there are challenges related to the adoption and usage of SNOMED-CT. She described how public health has either pushed back (e.g., requiring the use of LOINC or SNOMED) or has completed mapping locally, leading to local flavors.
- Hans thanked others for their discussions and SME presentations and commented that many of the themes echo the recommendations made by the ISP TF and other previous TFs of the HITAC (e.g., issues with quality and completeness, the need for a resilient approach that can adapt to changing requirements and priorities). Alignment and optimization are critical. He commented on the need for patient matching, noting that a unique identifier is absent, and asked the TF to consider other methods arrive at a singular/linked set of patient records. The discussion must focus not only on the individual standards but also on how they fit with the other data flows. He suggested taking advantage of national networking efforts that are already in place.
    - Arien described the need to get the basic demographic information in the order to the lab and suggested that PHDS TF members review the previously created and submitted ISP TF recommendations and report.
- Hung stated the TF should also concentrate on the fixing the existing infrastructure and ensuring that the functionality supports all data elements. He disagreed with the notion that labs should foot the bill for updates adding functionality to system they already purchased. The mandate for public health reporting should by funded, with no additional expenses.
    - Arien commented that certified systems must have transparency of purchase and described several lawsuits the FTC has put out related to the False Claims Act. The issue is that the Meaningful Use incentive for electronic lab results was removed due to the belief that it was topped out. Also, certification dropped certain things so, now, there are no certification criteria attached existing electronic health record (EHR) programs for Lab Orders/Results. There are also no certification that apply to LIS vendors (no incentives or requirements programs). Currently, it is permissible for vendors to require health systems to pay extra to purchase additional capabilities.
- The co-chairs thanked the presenters for their time.

Topic: TF Topics Worksheet

Gillian thanked all who had already updated the PHDS TF 2022 Topics Worksheet and noted that she had not added her comments yet. She invited TF members to share feedback, using their full names with comments and briefly reviewed new information TF members added to the background/supporting references, observations, and recommendations columns of the working document. The co-chairs facilitated a discussion and shared comments.

Discussion:

- Bryant asked ONC about the scope of the recommendations that the TF could make around opportunities to tighten existing criteria, as well as making recommendations that new criteria should be established. He asked if the TF/ONC must wait for the completion of the full rulemaking process for the recommendations to drop into certification.
    - Arien commented that the TF could recommend that ONC coordinate with the CDC. He explained that a previous TF was in the middle of the Interoperability Standards Advisory Publication Process. However, they now have free reign to made recommendations, and ONC will determine how to proceed.
- Arien commented that several recommendations were similar, including that ONC update the (f)(1) Criteria to recognize the HIMSS-IIP as the test method used for certification, while depreciating the current test method.

    - Hans agreed that the TF could make the recommendation and added that the Electronic Health Record Association (EHRA) has not determined that they need to comment on the topic yet.
    - Arien described how the EHRA is working with HIMSS on the test method.
- Hans agreed that several rows could be consolidated and discussed how to do so. Arien suggested that they work offline to simplify and consolidate suggestions.
- Hans suggested consolidating any suggestions on improving patient matching and demographic data sets into one recommendation, with sub-sets. The TF could consider adding a recommendation to improve patient matching, and he shared several ideas (e.g., the role of state and national networks as links).
    - Bryant suggested highlighting learnings from the COVID-19 pandemic, including those around the use of the multistate IZ Gateway Immunization Hub for COVID-19 Vaccination Reporting. He asked if the TF could recommend the use off a national patient identifier, even though it is not legally possible now.
    - The co-chairs and Hans responded that the TF could indicate that this rollout would be helpful, though it is a large and difficult topic. Hans and Gillian suggested pursing the national patient identifier in parallel with the use of demographic data and network alignment. Gillian shared opportunities for improvement to reduce manual processes.
    - Arien suggested that the IGs should updated to mention Project US@ and recommendations made by previous TFs.
- Vivian commented that there are testing tools that can cut down on the variation in terms of the implementation of IGs. The tools can be used to tighten the guides. She agreed with a suggestion from Arien to consolidate several topics.
- TF members agreed that several areas in the worksheet could be consolidated/tightened up, and the co-chairs offered to complete this task during offline work.

Next Steps

Homework for September 21, 2022, Meeting – due by Thursday, September 20:

- Please read and familiarize yourself with (f)(2) Transmission to public health agencies—syndromic surveillance (https://www.healthit.gov/test-method/transmission-public-health-agencies-syndromic-surveillance).
- 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:

Noam Arzt: Thank you so much, good discussion. I have actually a request, not so much as a comment. I did send it in via email, as well, under the guise of full transparency. It would be great if you could post even just a

read only version of the spreadsheet that you are working on between meetings, so that those of us out here could sort of see a little more closely exactly what you guys are thinking about and have an opportunity to comment on it is sort of before it is too late at the end or before it's too long at the end. I don't know if that is possible, but it would be useful, thank you very much.

Gillian: I will defer to ONC on the rules for that. But noted.

Arien: Generally, the way this works, Noam, is that as we get towards a draft, all of the information is presented and gets attached to the meeting notes. Then we have ample opportunity between when we're finalizing the recommendations and then they go to the full HITAC. There's an opportunity there as well. The the extent that anything comes out of our recommendations, between the HITAC to the National Coordinator and then gets placed into rulemaking. There's opportunity there. We can look at what we can do internally to have the sausage making more transparent, but there is plenty of opportunity to get a view on what the recommendations out of this task force are then also review them prior to their discussion and eventual approval by the HITAC. Appreciate the comment.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT

Arien Malec: Starting with p17 here Steven Lane & I facilitated findings and recommendations on orders/results at an ecosystem perspective

https://www.healthit.gov/sites/default/files/page/2022-07/2022-06-16_IS_WG_Phase%202_Interoperability%20Standards%20Advisory%20%28ISA%29_Transmittal%20Letter_508_0.pdf

Hans Buitendijk: Certification against various criteria are open to any HIT, not just EHRs. However, use of certified EHRs by providers is incented through CMS while use of certified HIT for others (PH, Labs, etc.) is not.

Arien Malec: And sadly we excluded LRI when incorporation of results was "topped out" that's why we focused on an ecosystem approach in our ISP recommendations.

Hans Buitendijk: While the order flow was not included, and over last couple of years it was taxed with increased data requirements not relevant to the actual performance of the tests, but important to the reporting, with jurisdictional variations in a short time frame to respond. Creating an emergency response proof approach that can reduce the delay and variations would be tremendously helpful. That includes not using ELR for certain data flows and not using .csv / flat files for submissions.

Riki Merrick: In case folks don't know the NIST tooling link for ELR R1 certification: https://hl7v2-elr-testing.nist.gov/mu-elr/

Fil Southerland: It would be interesting to see if there are any uptake stats for certified HIT in alternative settings like LTPAC, labs. We need all settings participating.

Hans Buitendijk: When the lab becomes the "patient provider" for walk ins, labs would need to support that aspect of patient data collection, but further context data would be beyond their scope of collection and remains with the patient's care team members.

Gillian Haney: @Hans- what type of reporting message would one use to support laboratory reporting if not ELR? During the pandemic, so many pop up providers were doing the testing and could not use HL7- thus the .csv need.

Riki Merrick: Good points Hans! APHL created the National flatfile (csv) that David mentioned - it uses excel macro to convert to ELR R1 and that has helped smaller pop-up labs to report COVID-19 results.

Hans Buitendijk: @Gillian: for the additional data the eCR would be the primary method to focus on. A critical topic for aligning and optimizing the flow. Had eCR been robustly in place, the extra data would already have been flowing or better added to that flow rather than adding to lab orders for labs than to transpose to lab results reporting.

Arien Malec: Again, consistent with our previous recommendations -- use LRI to capture the lab specific information and rely on eCR to capture the clinical context…

Gillian Haney: PHA still need patient name, dob and complete address information in order to deduplicate reports. It is absolutely critical.

Riki Merrick: Master patient index would help with the deduplication efforts

Arien Malec: yep -- the key here is to certify on LOI and include labs in the certification chain -- the issue is that labs don't get demographic & contact info b/c it doens't come in the order.

Hans Buitendijk: @Gillian: Completely agreed that data for patient matching is essential. But that is already flowing through lab orders. For labs that would imply when the are the "patient provider" for walk-ins, that they serve the role as context, thus use eCR as well for that data.

Gillian Haney: @Hans - sadly it is not. A significant percentage percent (15-20) of lab results are often sent w/o demographics.

Hans Buitendijk: Without all demographics (understood), or not enough to match?

Arien Malec: The minimum on the order is just what's required for the specimen and billing.

Riki Merrick: What Carmen is talking about the variation of regulation: that is where having the rules for lab reporting be updated in RCKMS would be helpful to all labs

Sheryl Turney: Very helpful input.

Hans Buitendijk: And would the additional demographic data beyond that needed for matching/billing/test performance be better sourced through eCR from the originating ordering provider?

Arien Malec: Standard person matching attributes & minimum contact information on the order, remaining information in eCR IMHO....

Riki Merrick: I agree with Arien

Hans Buitendijk: Completely agreed with Erin. The question is whether we should focus on that more and less on adding data beyond matching/billing/performance to a more complicated workflow (order - result - report).

Steven (Ike) Eichner: One challenge is that the more systems that are in the data chain, the more systems need to be tested/reviewed when a data need changes. Implementation and testing takes time and other resources.

Hans Buitendijk: @Ike: Agreed. Keep the communication lines as direct as possible to the target from the best source of truth.

Noam Arzt: If lab demographics are so limited, how would PH effectively match an ELR and eCR submission? Isn't that the whole point and the core problem being discussed here? See NYC RFP recently issued for an MPI for this.

Hans Buitendijk: Where national networks (e.g., TEF) can help bolster matching as they role out robust, comprehensive RLS capabilities that can only work with high fidelity matching for Treatment purposes that Public Health can then build on as well.

Noam Arzt: But TEF does not have RLS particularly, does it?

Hans Buitendijk: TEF QTF has the requirement of a QHIN to provide comprehensive record location.

Noam Arzt: I'll have to go back and look at that...

Hans Buitendijk: Various networks (national, state, etc.) effectively provider that and in combination can build effectively build that "national MPI" But that requires continued push for QHINs to provide such comprehensive capability.

Steven (Ike) Eichner: One other component, outside of public health agencies' receipt of data, is getting data back to the patient's regular care team. For example, during Covid-19 response, individuals may have gone to drive-through testing, not provided by the patient's PCP or a member of their regular are there approaches that can help get results data back to the patient's team, and how can patients' privacy and data sharing preferences be recognized and supported?

Hans Buitendijk: https://rce.sequoiaproject.org/wp-content/uploads/2022/01/QTF_0122.pdf "The exchange functions enabled by QHIN-to-QHIN exchange depend on accurately determining which entities maintain relevant information. Query functions, in particular, rely on accurate and comprehensive record location"

Hans Buitendijk: +1 Erin.

Noam Arzt: Yes, Hans, but it also says on p. 29 "This QTF does not specify a particular technology or standard for QHINs to use to locate patient records." Does not sound like a strong direction to me...

Hans Buitendijk: Agreed, but the technology and standard used still should yield a comprehensive list. I.e., how vs. what.

Noam Arzt: SHOULD, right...

Hans Buitendijk: Whether one uses an MPI, RLS or other innovative approach that is comprehensive, that is fine.

Bryant Karras: +100 Erin

Jamie Pina: Agreed Erin!

Steven (Ike) Eichner: +100 on standards, Erin. The standards must include direction on acceptable data and what is required and what may be empty And clarify what "optional" means.

Hans Buitendijk: @Noam: The "rely on accurate and comprehensive record location" seems to be stronger than a "should". Particularly when reading the actual conformance statement "QTF-072 A Responding QHIN MUST be capable of identifying which, if any, of its Participants and/or Subparticipants are the Responding Source." which includes a "must". However they achieve that.

Riki Merrick: the standards already do that: optional (O) = local partners must discuss (this is where variation comes in for NEW data elements); Required, but may be empty (RE) = system MUST support this data element, but may not have data every time; Required (R) - must be sent EVERY TIME

Noam Arzt: Sorry, I didn't mean that "SHOULD" in the "must/should/may" context. Only that without specifying HOW to do this TEF is no magic answer to handling this thorny problem. That's all.

Bryant Karras: were LIMS systems and Labs eligible for ARRA HITECH stimulus? I think they might not have been unless they were part of an eligible Hospital system

Hans Buitendijk: @Noam: Fair, Writing standards capital SHOULD has a very particular meaning to me.... :) TEF does not prescribe the how, rather the what. If somebody thinks they can do it using blockchain, fine.

Arien Malec: @Bryant -- "it depends" -- historically LISs that were attached to hospitals that were eligible for incentives were covered by certification requirements...

Noam Arzt: On #3, might be useful to break those up. Race/ethnicity has its own drivers and inventory issues are different.

Steven (Ike) Eichner: Bryant, good question! Do/did LIMS systems independent of an EHR meet all applicable certification criteria? They are relatively special-purpose systems that may not include the full range of capabilities of an EHR (recording vitals and generating a broad range of CQMs, for example).

Vivian Singletary: Agree Bryant! This is also true for what is needed for USCDI +

Hans Buitendijk: @Ike: Good point that LIMS do not need to support all that an EHR would need to. Challenge today is that any HIT wanting to be certified need to support all USCDI through supporting standards (C-CDA and FHIR US Core). LIMS should not have to support all.

Noam Arzt: Bryant, remember that incentives were focused on hospitals and providers, not labs per se.

Noam Arzt: More common than you think: Many people live in one state and work in another and got COVID shots near where they work. IZ Gateway There was no mention of IZ GW in the IIS session you had earlier. National Patient Identifier is possible and legal; just that Feds can facilitate the discussion. This is a subtle but important nuance.

Arien Malec: Project US@:
https://oncprojectracking.healthit.gov/wiki/pages/viewpage.action?pageId=180486153

Noam Arzt: IZ GW Project has been very focused on the variation as we work to bring VHA and DoD facilities on board with IIS. On #30, CDC CDSi project has reduced much of the vaccine eval and forecasting differences Don't think Les is on today Never hurts to ask... not sure given the timeline that there will be much opportunity to comment.

Hans Buitendijk: @Noam: agreed NPI is possible, but only through a private effort, and the closest that could be realized is through linked "RLS" capabilities and/or person identity solutions as an approximation.

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

There were no public comments received via email.

Resources

PHDS TF 2022 Webpage
PHDS TF – September 16, 2022 Meeting Webpage
PHDS TF – September 16, 2022 Meeting Agenda
PHDS TF – September 16, 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 encouraged TF members to continue to use the Tracking Document spreadsheet to capture comments. They shared a list of upcoming PHDS TF 2022 meetings, including dates the TF will present to the HITAC.

The next meeting of the TF will be held on September 21, 2022. The meeting was adjourned at 11:59 a.m. E.T.