Health Information Technology Advisory Committee (HITAC)

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

Meeting Note | September 28, 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)(4) Criteria: Transmission to Cancer Registries. 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)(4) 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 were no public comments 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)(4) Transmission to Cancer Registries
11:00 a.m.	Discussion
11:25 a.m.	Task Force Topics Worksheet
11:50 a.m.	Public Comment
11:55 a.m.	Next Steps
12:00 p.m.	Adjourn

Roll Call

Seth Pazinski, Acting Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the September 28, 2022, meeting to order at 10:31 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
Erin Holt Coyne, Tennessee Department of Health
Charles Cross, Indian Health Service
Steven (Ike) Eichner, Texas Department of State Health Services
Rajesh Godavarthi, MCG Health, part of the Hearst Health network
Jim Jirjis, HCA Healthcare
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
Hung S. Luu, Children's Health
Mark Marostica, Conduent Government Solutions
Aaron Miri, Baptist 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
Sheryl Turney, Carelon Digital Platforms (an Elevance Health company)

MEMBERS NOT IN ATTENDANCE

Heather Cooks-Sinclair, Austin Public Health
Joe Gibson, CDC Foundation
Aaron Miri, Baptist Health
Alex Mugge, CMS
Fillipe (Fil) Southerland, Yardi Systems, Inc.

ONC STAFF

Seth Pazinski, Acting Designated Federal Officer
Avinash Shanbhag, Executive Director of the Office of Technology, ONC
Brenda Akinnagbe, Program Staff
Liz Turi, Program Staff

PRESENTERS

Stephanie M. Hill, North American Association of Central Cancer Registries (NAACCR)
Jeremy Pine, California Cancer Registry
Chandrika Rao, North Carolina Central Cancer Registry
Nigar Salahuddin, North Carolina Central Cancer Registry
Peter Yu, Hartford HealthCare Cancer Institute and Memorial Sloan Kettering Cancer Center

Key Specific Points of Discussion

Topic: Opening Remarks

Gillian Haney and Arien Malec, PHDS TF 2022 co-chairs, welcomed everyone. Arien reviewed the agenda for the meeting, noting that a panel discussion would present on the state of cancer registry public health data systems and the degree to which there is interoperability and data flowing to support those registries. Arien commented on the importance of the topic to him, as he is a cancer survivor. Gillian noted that though the topic is outside of her area of expertise, infectious disease, she is knowledgeable about public health data systems. She commented that there has been a lack of funding to support cancer transmission data and interoperability. She invited the subject matter expert (SME) presenters to highlight this topic during their presentations.

Topic: (f)(4) Transmission to Cancer Registries

The co-chairs welcomed SMEs to share perspectives on the transmission of data to cancer registries.

Peter Yu, Hartford HealthCare Cancer Institute and Memorial Sloan Kettering Cancer Center, presented on advancing cancer data liquidity. He emphasized the complexity of cancer data and noted that it comes from a variety of sources with other stakeholders being involved (e.g., electronic health record (EHR) vendors, cancer registries, academic partners, real world evidence outcomes, etc.), and he described data liquidity from source to consumption. He explained that data models are necessary to bring together complex cancer data and shared two observational data models that are used to organize the data, which permits data science. This included the Observational Health Data Sciences and Informatics (OHDSI), including the recently developed oncology extension OMOP data model, and the Minimal Common Oncology Data Elements (mCODE), both of which were detailed in the presentation slides. He shared a depiction of the mCODE STU 2, noting that it is a model of policy types of cancer data that are important to capture. He shared use cases for oncology, including for cancer reporting. He suggested that a logical place to start work is with pathology and described the College of American Pathologists (CAP) digital synoptic cancer reports for 98 types of cancer. These have structured data elements and values, and the US adoption rate of 50% for digital capture of pathology reports. He explained that the 21st Century Cures Act (the Cures Act) has mandated data capture using Fast Healthcare Interoperability Resources (FHIR) and described the work being done on SDC on FHIR for the transmission of pathology data. He suggested that this is an area in which ONC could advocate for the use of funding. He shared several key takeaways, which were included in the presentation slides.

Stephanie M. Hill, North American Association of Central Cancer Registries (NAACCR), described NAACCR and highlighted its work to establish collaborative data standards for primarily hospital-based cancer registries. She presented on the current state of ambulatory reporting. She explained that there is a large amount of variability between states in terms of how reporting is used and described the more traditional and manual model for reporting, noting the role of Meaningful Use. She commented that the process is resource intensive and redundant and explained how manual work on both the provider and data registry sides impedes the process. She noted that reporting requirements also vary and described the considerations around capturing cancer data over the course of what is potentially a lifelong chronic disease. She highlighted current gaps and several recommendations, which were detailed in the presentation slides.

Jeremy Pine, California Cancer Registry, presented on the transmission of data to cancer registries. He described the current situation, which was detailed in the presentation slides. He stated that cancer registries are often not getting the data they need or that they are receiving low quality data that is handled and processed as the lowest priority. He discussed the current gaps, including the lack of availability of high-quality primary data from all reporting entities, primary data profile can be used by all programs, and incentives for healthcare entities to meet a higher standard. He discussed ways to make things easier via program collaboration and electronic exchange harmonization, and these suggestions were detailed in the presentation slides. He shared ideas for making interfaces work better and several recommendations.

Nigar Salahuddin and Chandrika Rao, North Carolina Central Cancer Registry (NC-CCR), presented perspectives on Meaningful Use (MU) cancer reporting. Nigar discussed the background (2014 through current) and information on the initial implementation of MU via the NC-CCR, all of which was detailed in the presentation slides. She described the MU2 Data Processing Workflow used by NC-CCR, in which data is exported into their database from the CDC registry database and provided a brief overview of each of the potential steps in the workflow, noting that a great deal of manual work is necessary. She discussed the transport mechanism and highlighted related challenges, which were detailed in the presentation slides.

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

Discussion:

- Gillian thanked the presenters and briefly discussed her experiences in MA, noting that opportunities were constrained due to lack of funding.
- Arien described his experiences applying a clinical trials model to oncology clinical trials and explained

that he learned that oncology has one of the richest and most advanced traditions of applying informatics. He discussed ways in which oncology is at a disadvantage and noted that the SME presentations, for the most part, did not refer to the CDA implementation guide (IG). He commented that the incentives to move to any particular IG are low, due to the move to modular testing, but the CDA IG also seems to be disadvantaged for several reasons (e.g., no built-in transport, no appropriate testing for data semantics). He suggested using one of the other data models mentioned in the presentations or a harmonized data model. He is also interested in hearing more about the use of electronic initial case reporting (eICR), query retrieve, and if the United States Core Data for Interoperability (USCDI) -formatted data (not specific to tumor staging or cycle therapies) is useful enough to capture general information and diagnosis history. What structure of interoperability best suits cancer registries?

    - Peter commented that questions of transmission are secondary to getting clean, usable data automated, which currently requires a lot of manual work by several stakeholders. He described his experiences at Sutter Health working with the California Cancer Registry, noting that though the process can be done with speed and accuracy, the data quality means that it is not worth sending. He suggested that a minimal data set could be sent and then a query could be sent back, if additional information is necessary.
    - Gillian agreed with this suggestion, noting that the infectious disease community has worked to define and standardize the minimal core set of data elements that are initially reported to public health.
    - Arien asked if this could include harmonizing the OMOP data model with mCODE and NAACCR. Peter described how Memorial Sloan Kettering has used OMOP as the base structure and added elements from NAACCR and mCODE to create a common data model to which they now map their information. His organization is considering adopting their model, and he stated that a common data model could work, as long as it suits the needs of academic health centers as well as larger community health networks.

- Ike suggested investigating which fields are being populated by physicians within the EHR and how that connects with data being exchanged. The impact of the use substitute data fields must be considered, and testing must be done on the lab and production versions to ensure data completeness and accuracy prior to exchange.
- John commented on the need to meet the basics (cancer diagnoses are reported and the correct data elements are necessary). He asked other attendees to comment on work being done with health information exchanges (HIEs) to capture unreported diagnoses or fill in missing data fields in incomplete reports.
    - Jeremy responded that they have worked with several HIEs across California, and they are still trying to handle the issue of generating and sharing minimal case data. They have focused on pathology reporting and are also looking to include the final diagnosis for cancer reporting and other data points in the EHR.
    - Nigar commented that, in North Carolina, only immunization measures are using HIEs for hospital-related reporting. Because cancer is only treated in ambulatory and stand-alone physician offices, HIEs have not been as interested in participating.
    - John stated that the capabilities of HIEs vary across states but that it could be a useful task to initiate conversations between HIEs and cancer registries. Gillian suggested building off of the infrastructure used for infectious disease operations.
    - Bryant commented that Washington state has a robust HIE system but that the vendor for cancer case reporting only enabled direct messaging for the reporting infrastructure (did not build in capabilities to transport messages to HIEs). Providers who wanted to share could not. He added that the Making Electronic Data More Available for Research and Public Health (MedMorph) project demonstrated that the eICR infrastructure (the core trigger mechanism in EMRs) could be used for detecting and transmitting cancer diagnosis data.

- Gillian commented that the Reportable Conditions Knowledge Management System (RCKMS) tool can be used for cancer reporting. She suggested exploring this further, especially the triggering mechanism for longitudinal data. Ike commented that the backend FHIR listener for electronic case reporting (eCR) is the same that is being used for MedMorph.
- Chandrika noted that one of the main challenges is the minimal support for this work by physicians due to a lack of incentives and resources. Also, the EHRs oncologists and hematologists use do not natively support the necessary reporting capabilities.
- Hung commented that the infrastructure is not sufficient to capture and transmit the data necessary to support the ideal model. There is an opportunity to focus on ensuring that the correct data elements are in the infrastructure.

- Hans suggested looking at variations that need to be addressed for the output (additional data standards or guidance needed?), beyond eICR.
  - Gillian and Arien agreed, noting the benefits of a phased approach. Arien commented that the eICR model could be beneficial if it became the standard. However, it does not cover all situations, so a "yes and" approach is necessary.
  - Hans responded that the optimum flow and standards need to be addressed.
  - Gillian highlighted Sandy Jones' valuable comments in the chat via Zoom.
- Bryant commented that the influx of infrastructure funds has not cascaded to cancer registries and emphasized the need for funding.
  - Arien commented that money for public health has been focused on pandemic responses but considerations for rebalancing spending should be made.
- The co-chairs thanked the presenters for their time and all commenters for sharing during the discussion.

Topic: Task Force Topics Worksheet

Arien thanked all who members who updated the PHDS TF 2022 Topics Worksheet. He described updates to the document, including a color-coding system (green = consolidated to recommendations text, yellow = in-progress, red = potential duplicate). He 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:

- Ike asked PHDS TF members to comment on the TF's charge with regard to items related to certification. He stated that several comments in the topics tracker document might be out-of-scope (e.g., recommendations for ONC).
  - Arien reviewed Parts 1, 2, and 3 of the TF's charge and noted that looking at potential certification for intermediaries is within scope for Part 3. The TF could recommend that ONC work to develop IGs for areas that are not required for certification, and then focus on testing before certification. The TF's main focus should be on the existing (f) Criteria, then incremental expansion beyond the (f) Criteria could come next (focusing on EHRs, public health data systems, and associated data flows).
  - Ike emphasized the need to look at data quality issues, even where data is flowing bidirectionally. This will help them avoid creating extra work or inaccurate decision making. Gillian and Arien agreed that content and data quality are important.
- Hans spoke to the comments he entered regarding the (f)(3) Reportable Lab Tests & Value/Results. He stated that the IG for the lab reporting interface (LRI) has not been published yet and described how to balance the TF's recommendations.

- Arien responded that the TF should make general policy mechanisms and recommendations (not down to the level of the specific IG). If there are specific things being used in ELR flows that would be better served by an eICR approach, the TF could make recommendations.
- Erin commented that not certifying senders and receivers for LRI on the same standard would create issues. She asked if making recommendations about certification for lab and EHR partners would be in scope and suggested level setting across the board.
- Arien stated that Part 3 of the TF's charter could be used to allow the TF to make recommendations across potential uses and certifications in the larger ecosystem. The TF should not focus on only one leg of the reporting and should look at public health data flows from order/origination to reporting to address data issues. However, it would be out-of-scope for the TF to make specific recommendations around how physicians order labs or how laboratory information system (LIS) vendors generally structure their information. Gillian and Erin agreed.

- Hans described the observations and recommendations he shared in the tracker document on the (f)(2) Syndromic Surveillance criteria.
  - Arien suggested that the syndromic surveillance guide should be cross mapped to the latest version of the USCDI. Hans agreed but noted that more should be done.
  - Arien summarized the comments, noting the need for a revision to the IG for syndromic surveillance. The recommendations should consider regional variations and the latest version of the USCDI.
  - TF members shared feedback, including the suggestion to look at admission-discharge-transfer (ADT) feeds. Arien commented that the ADT can carry a lot of information and agreed with the need to include the sending side of the process, as well as the IG.
  - Hans, Arien, and Gillian discussed the recommendation that ONC work with jurisdictions to align with patient coding, ensuring that the full data set is recorded, and how to augment anonymized syndromic surveillance data with more specific data from eICR and ELR to optimize the flow. Gillian commented on the different ways public health uses syndromic surveillance data vs. ELR and eICR data sets.
  - Bryant commented that the IG for updates to syndromic cases using de-identified identifiers. The suggestion is possible using ADT-based customize syndromic surveillance reporting feeds (different than case reporting). Arien agreed and added that there is an opportunity to use the updated IG in more settings.
  - The TF suggested to raise the floor and ensure that there is a common floor for all to use.
  - Bryant questioned the recommendation that ONC explore alignment between syndromic surveillance and other public health reporting streams to optimize data flows and build on data sharing policies. There should not be a convergence to a single data stream. Arien suggested a recommendation to create alignment of data flows and mapping public health data flows rather than alignment of content. Gillian commented on the timing of syndromic surveillance vs. when and how public health receives and uses other data (lab, etc.), and she suggested that there are opportunities to complete case reports. However, syndromic surveillance is a distinct flow and use of data.
  - Ike and Hans discussed the benefits of optimizing and/or aligning data flows, even when they are still in the deidentified space. There are opportunities to look at ways to enhance data flows from providers to public health, even when they are used for very different purposes.

Next Steps

Homework for October 5, 2022, Meeting – due by Tuesday, October 4:

- Please read and familiarize yourself with (f)(6) Transmission to public health agencies – antimicrobial use and resistance reporting (https://www.healthit.gov/test-method/transmission-public-health-agencies-antimicrobial-use-and-resistance-reporting
- 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. Please contact Accel Solutions if you cannot access this document.

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

Public Comment

Seth Pazinski opened the meeting for public comments:

QUESTIONS AND COMMENTS RECEIVED VERBALLY

There were no public comments received verbally.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT

Steven (Ike) Eichner: Good morning! I'm sorry for being a moment late.

Arien Malec: Thanks Ike!

Steven Lane: Welcome Dr. Yu and thank you for your years of innovative work in cancer data interoperability, including the many years during which I had the pleasure of working and learning with you at the Sutter Palo Alto Medical Foundation.

Arien Malec: I so far have yet to see mention of the existing CDA IG.

Steven Lane: Does NAACCR also work with registries in Mexico and/or the Caribbean?

Bryant T. Karras: Certified Tumor Registrar

Arien Malec: Thank you Bryant!

Stephanie Hill: Yes, NAACCR does a lot of work with CARPHA and the IARC Caribbean Cancer Registry Hub

Mark Marostica: With the PH Depts we support there is a renewed focus on having a patient's cancer history linked to their communicable disease case history as cancer can put a patient at higher risk for diseases given their Immunocompromised status (e.g COVID-19). Is such a linking already prevalent in the PH community or is this something we need to include in our recommendations?

Arien Malec: Again no mention of the existing CDA guide…

Stephanie Hill: I would say linking with CD varies across states. Many link with HIV and Hepatitis, but there are still many barriers to data sharing even within different programs of a health department

Steven Lane: Also, very little mention of the future benefits of exchanging Cancer Data via FHIR-based push and/or query.

Arien Malec: eICR mentioned, mCODE-based transitional data model, OMOP FHIR transitional data model...

Arien Malec: Here we go -- no longer being certified for the f(5) criteria…

Arien Malec: f(4) I think -- f(5) is eCR.

Bryant T. Karras: yes modular certification was a huge hit to Public Health... they only had to do a few not all f(s)

Arien Malec: The issue with using the general query and eICR mechanisms is that cancer informatics models are very specific b/c oncology is very much not like general medicine….

John Kansky: Given all these challenges and gaps in data, I am wondering if there are examples of State cancer registries approaching and working with an HIE to (a) fill in entirely missing reports and/or (b) filling in gaps in data in incomplete reports.

Steven Lane: The eCR approach would seem to turn cancer reporting around so that automated triggers could lead to the sending of an eICR to a central hub or registry which would then respond with a FHIR query for the precise (standardized) data needed to understand the case as well as ongoing queries to understand the treatment and clinical course.

Steven Lane: https://omoponfhir.org/

Steven Lane: https://build.fhir.org/ig/HL7/fhir-mCODE-ig/

Stephanie Hill: NAACCR has formed a Minimal Data Set Task Force to address this very issue

Steven (Ike) Eichner: Another challenge is the connection between how information is being stored within an EHR and how messages are generated/sent. If there are changes in field structure during deployment, those changes can iinterfere *[sic]* with forwarding data.

Sandy Jones: Reporting from Ambulatory: The MedMorph HL7 FHIR Cancer Registry Reporting IG is using the USCDI, PH Library, and mCODE profiles. Link to FHIR IGs at:

Arien Malec: To misquote Doug Fridsma, one of the issues here is that data models are like toothbrushes -- everyone wants one but nobody wants yours.

Jim Jirjis: great quote

Bryant T. Karras: Yes @Sandy I encourage all to watch the MedMorph cancer reporting demo UW and Washington did at HIMSS

Sandy Jones: Forgot to include the link: https://build.fhir.org/ig/HL7/cancer-reporting/

Sandy Jones: Cancer community has also developed HL7 FHIR IGs for laboratory reporting of cancer pathology data to EHR systems and central cancer registries. Links provided here: HL7 Fast Healthcare Interoperability Resources (FHIR) Implementation Guides:
Cancer Pathology Data Sharing Implementation Guide: http://build.fhir.org/ig/HL7/cancer-reporting/

Integrating the Healthcare Enterprise (IHE) Structured Data Capture (SDC) on FHIR:
http://build.fhir.org/ig/HL7/ihe-sdc-ecc-on-fhir/

Abby Sears: I love Steven's comments about leveraging the eCR process for cancer data.

Hans Buitendijk: While eCR provides an approach to addressing registry reporting (cancer being one of them), but with a perhaps larger set of variation of data requirements unique to specific registries.

Abby Sears: + 1 Arien Malec's quote

Arien Malec: eICR is going to get dx info, and contextual health information, but is going to be missing detailed staging, path, and tx cycle information.

Sandy Jones: Yes. That is true. We also are using the (MedMorph) eiCR for cancer pathology reporting as well.

Arien Malec: leveraging the trigger basis for eICR is fantastic....

Sandy Jones: RCKMS already has the cancer triggers for EHR reporting, but haven't been implemented yet.

Sandy Jones: I can't talk, so that is why I'm just commented in chat. 😀

Hans Buitendijk: Would it be eICR or need for registry specific data sets, including data unique to that registry? I.e., common infrastructure, but not necessarily eICR for all?

Arien Malec: Onc/heme/radonc/surgonc are definitely capturing the information they need.

Arien Malec: It's a staging/transitional data model issue, not data availability....

Sandy Jones: We have done a comparison between eiCR and cancer content IGs.

Steven Lane: The current cancer reporting model places the burden of reporting on the providers, similar to the historic approach to case reporting generally, and yields a similarly unsatisfying, variable and expensive result. It will only be by automating these processes are we likely to see the progress we seek.

Sandy Jones: Cancer Registries has adopted the mCODE Profile for their Cancer Reporting IG.

Bryant T. Karras: https://www.himss.org/resources/reporting-work-cancer-care-continuum

Erin Holt: in addition to MedMorph, it might also be looking at Clinical Registry Extraction and Data Submission (CREDS) IG. From the project scope statement: "The purpose of this Implementation Guide is to simplify the efforts of healthcare provider organizations to collect the data needed to submit to registries, by making it easier for registries to supply healthcare providers with the information that providers need to prepare a registry submission. This guide profiles how a registry says what needs to be sent, and how a healthcare provider organization can use that to automate the collection and formatting the data into a submission, conforming to registry or FHIR implementation guide defined profiles and protocols." "

Erin Holt: CREDS is currently in development with HL7

Steven Lane: http://build.fhir.org/ig/HL7/fhir-registry-protocols-ig/StructureDefinition-CREDSStructureDefinition-mappings.html

Bryant T. Karras: WA State DOH/Univ of WA Pt was enrolled in a clinical trial by her oncologist. A copy of the case report – the same bundle that was sent to the state cancer registry earlier – is sent to the WA DOH for a WA Department of Health/UW collaborative research project on melanomas. The data are managed by the state and shared in de-identified form with UW researchers. This approach takes advantage of the MedMorph infrastructure and uses the same standardized case reporting methods to provide rapid reporting of path results.

Sandy Jones: @Erin I have talked with Keith Boone about CREDS and how cancer could use this.

Erin Holt: @ Ike, there is also some solutioning happening in the comments, and its worth noting where solutions may already exist and should be tried before certification.

Erin Holt: @Sandy, thank you!

Chandrika Rao: Thank you for giving us this opportunity to share our registry's experiences.

Stephanie Hill: Thank you for inviting us!

Arien Malec: thank you!

Nigar Salahuddin: Thank you!

Sandy Jones: Thank you so much for inviting cancer registries to present our experience.

Erin Holt: syndromic isn't defined by conditions, where eCR requires (unless manually initiated) an identified condition.

Erin Holt: the purpose or intention and usage in the overall surveillance continuum are different

Steven Lane: Here is the link to the Sequoia Project Data Usability IG mentioned above by Steve Eichner: https://sequoiaproject.org/wp-content/uploads/2022/08/2022-08-29-Sequoia-DUWG-IG-Version-0.1-for-Public-Comment-FINAL46.pdf

Bryant T. Karras: @Ike the eliments *[sic]* are listed in the PHIN IG as optional

Bryant T. Karras: so WA is not "custom"

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

There were no public comments received via email.

Resources

PHDS TF 2022 Webpage
PHDS TF – September 28, 2022 Meeting Webpage
PHDS TF – September 28, 2022 Meeting Agenda
PHDS TF – September 28, 2022 Meeting Slides
HITAC Calendar Webpage

Meeting Schedule and Adjournment

Arien and Gillian thanked everyone for their participation and the cancer registry panel presenters for sharing their expertise. 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. Arien explained that the TF is looking at holding a public health data systems developer panel during a future meeting to better understand certification. He described how the recommendations in the spreadsheet would be turned into a recommendations report. 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 October 5, 2022. The meeting was adjourned at 11:59 a.m. E.T.