Health Information Technology Advisory Committee

Public Health Data Systems Task Force 2022 Meeting

Meeting Note | October 19, 2022, 10:30 AM – 12 PM 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 receive presentations on the HL7 Public Health Work Group projects and the Network for Public Health Law. 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, but there was a robust discussion held via the chat feature in Zoom Webinar.

Agenda

10:30 AM	Call to Order/Roll Call
10:35 AM	HL7 Public Health Work Group Projects
10:40 AM.	Network for Public Health Law
10:45 AM	Discussion
11:00 AM	Task Force Topics Worksheet
11:50 AM	Public Comment
11:55 AM	Next Steps
12:00 PM	Adjourn

Roll Call

Seth Pazinski, Acting Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the October 19, 2022, meeting to order at 10:30 AM.

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
Joe Gibson, CDC Foundation
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, Health Gorilla
Leslie (Les) Lenert, Medical University of South Carolina
Hung S. Luu, Children's Health
Mark Marostica, Conduent Government Solutions
Alex Mugge, CMS
Stephen Murphy, The Network for Public Health Law
Eliel Oliveira, Dell Medical School, University of Texas at Austin
Abby Sears, OCHIN
Jamie Pina, Association of State and Territorial Health Officials (ASTHO)
Vivian Singletary, Public Health Informatics Institute
Fillipe (Fil) Southerland, Yardi Systems, Inc.

MEMBERS NOT IN ATTENDANCE

Heather Cooks-Sinclair, Austin Public Health
Jennifer Layden, CDC
Aaron Miri, Baptist Health
Sheryl Turney, Carelon Digital Platforms (an Elevance Health company)

ONC STAFF

Seth Pazinski, Acting Designated Federal Officer
Brenda Akinnagbe, Program Staff
Liz Turi, Program Staff

PRESENTERS

Craig Newman, Altarum
Stephen Murphy, Network for Public Health Law

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 the TF would receive two presentations from subject matter experts (SMEs). Gillian commented that the HL7 Public Heath Work Group is the entity that facilities the HL7 standards for public health.

Topic: HL7 Public Health Work Group Projects

The co-chairs welcomed a SME to share perspectives on health care surveys with the PHDS TF 2022.

Craig Newman, Altarum, presented perspectives from the HL7 Public Health Work Group. He described the structure of the HL7 Public Health Work Group, noting that it is composed of volunteer members who sponsor and guide projects for those who want to create, ballot, and publish an HL7 guide. He provided an overview of the HL7 core specifications and other areas of standards and implementation guides (IGs), which were detailed in the presentation slides. He shared outcomes of what has worked best for HL7 in relation to public health and shared examples of how they continue to raise the bar, noting that the examples were listed in the presentation. He explained that though they have had many achievements, there is a lot of work yet to be done and described HL7's learnings that will continue to guide their future work. He commented that, historically, Meaningful Use, Promoting Interoperability, and other funding programs have not focused on all

stakeholders and partners. He invited attendees to reach out with comments and to join the HL7 Public Health Work Group calls, which are held regularly on Thursdays from 4 to 5 PM ET.

Stephen Murphy, Network for Public Health Law, Mid-States Region, presented an update from the Network for Public Health Law. He explained that they focus on data, data privacy, data sharing, and general public health public health authority work. He discussed their origins and explained that they were created to promote and support the use of law to support public health problems. He explained how the law governs every aspect of data, including its collection, use, disclosure, and protection and shared examples of each relevant to public health. He described the decentralized data reporting system and reporting requirements according to state law, which were detailed in the presentation slides. He provided an overview of the example of the CDC's Immunization Information Systems (IIS) consent. He discussed the concept of the Minimum Necessary HIPAA Privacy Rule standard and described how some public health jurisdictions have encountered problems and deal with trigger codes for reportable diseases. He highlighted how the Reportable Conditions Knowledge Management System (RCKMS), which is hosted on the AIMS Platform, is used to determine the reportability of the initial case report and to which jurisdiction the case report must be reported. He shared recommendations for how ONC would resolve issues related to Minimum Necessary. He briefly described the Information Blocking Rule and suggested that ONC provide additional guidance on how this rule applies to the transmission of data for public health. ONC could also work with the Office for Civil Rights (OCR) to provide guidance on the transmission of data to public health.

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

Discussion:

- Gillian thanked the presenters and noted the importance of Craig's comments around not overlooking version two in the Clinical Document Architecture (CDA) and to need to consider the vast differences in resources and capabilities across public health. She commented that not everybody will be able to migrate to using Fast Healthcare Interoperability Resources (FHIR) at this time.
- Gillian asked Stephen to comment on the Minimum Necessary applies to those not covered by HIPAA privacy laws or hybrid entities.
    - Stephen explained that a hybrid entity is a covered entity where parts of the entity are subject to HIPAA (if they were a separate entity), while other parts of the organization are not. This often includes public health departments, and he explained that many hybrid entities parse out the parts that are subject to HIPAA from those that are not. Minimum Necessary applies to covered entities and business associates and does not apply to non-healthcare components in a hybrid entity. He described the nuance of having a covered entity on the sending and/or receiving end.
    - Gillian shared issues she encountered in a former role in Massachusetts overseeing surveillance for infectious diseases, including determining how to parse electronic case reporting (eCR) to respect patients' privacy. They tried to use only the minimal necessary amount of data necessary to investigate the case.
    - Stephen commented that there are other privacy laws beyond HIPAA, which is just the floor, and described relevant state and federal confidentiality provisions (e.g., around mental health, HIV/AIDS). He encouraged the TF to think beyond HIPAA.
    - Arien commented that issues arise when a covered entity wants to provide data to a public health authority, including the entire Consolidation Clinical Document Architecture (C-CDA), but that the public health authority and HHS/OCR have not provided inform guidance. He asked for recommendations about how to better promote the issuance of uniform guidance from OCR or others on the format and content of data released by EHRs to public health according to Minimum Necessary. He noted that National Public Health Laboratory (NPHL) did provide a uniform guidance statement and language for states/localities to adopt.
    - Stephen shared a disclaimer that his presentation was informational, not intended as legal

guidance, and he encouraged everyone to talk to their own legal counsel. He described how he has distributed guidance in the form of letters to those who were resisting reporting information. He explained that the privacy rule states that a covered entity may rely on the representation of a health department or a public health authority as to what is the minimum necessary. In response to Arien's suggestion that OCR and ONC could issue guidances, he noted that this is a grey area but could be done.

- Stephen and Arien discussed the work previously completed by the Chicago Public Health Department. Arien asked if OCR could issue a guidance that if a public health authority requests data in a certain format according to information that is mapped back to national standards, it would constitute the minimum necessary.
- Gillian commented that the Versions 1 through 3 of the United States Core Data for Interoperability (USCDI) are not sufficient to address the needs of public health. Erin questioned whether any one version of the USCDI (or USCDI+) would support minimum necessary for public health.
- Bryant commented that his public health department worked with Washington State and local jurisdictions to determine the minimum necessary. It would be difficult to create one guidance and set of data elements that apply broadly across the entire country. He stated that public health and providers must be partners in the healthcare team response. Stephen responded that Minimum Necessary is meant to be a flexible standard and commented that the provision within HIPAA that prevents a protected entity from disclosing protected information to a public health authority is broad.
- Hans commented that data classes included in Version 1 of the USCDI are sometimes too much and other times not enough. He suggested that they use case reporting and knowledge management tools to capture guidance at the trigger of an event and across jurisdictions in a consistent, non-English, structured, and computable way for clarity. The USCDI is useful for general scoping but should not be used to determine Minimum Necessary.
- Gillian highlighted Erin's comments in the chat via Zoom.

- Ike shared several comments, including:
  - He echoed Bryant's comments about getting the correct authority to weigh in on differences in state and local regulations.
  - The purpose for the collection of data should be connected to what is determined to be the minimum necessary (must account for extraneous data in terms of cost, storage, and risk of release of private data).
  - The USCDI is likely not the right data set to define the minimum necessary. Public health has different data needs across authorities and needs more flexibility to choose and populate data fields.
- Steven highlighted information he shared in the public chat regarding his experiences with Carequality during the early part of the COVID-19 pandemic. He suggested that the progression towards FHIR addresses problems with queries from public health to providers (specified query can be made) to meet minimum necessary requirements.
  - Gillian responded that some public health authorities are under resourced and cannot support FHIR, so they have to build in flexibility to meet all public health needs.
  - Steven asked if a public health jurisdiction could state that a C-CDA request is minimum necessary for their purposes. Stephen responded that a covered entity could rely on representation of a public health department as long as it is reasonable. Bryant responded that the Washington State Assistant Attorney General consulted with the NPHL in crafting the position and letter from their state health officer to allow for the query. However, Washington still struggles with the variety of responses returned (e.g., customized implementations put data elements in different places), so utilizing the information can become challenging. He suggested a potential recommendation to the HITAC to provide technical assistance to

smaller or less well-funded public health authorities.
    - Stephen asked if the local health department determines the minimum necessary and if this is codified somewhere. Bryant responded that Washington is a home rule state, so the public health authority is a county or multicounty consortium authority; the state public health agency works under their behalf to gather information.
- Arien shared the following comments:
    - If a state or local public health authority provides legal guidance, that clearly constitutes minimum necessary.
    - The USCDI constrains the boundaries of what is readily producible by EHRs, so it provides a boundary envelope for the floor.
    - There is a need to determine if FHIR is the correct tool and how/whether to move forward or if maintaining the status quo is most helpful to public health.
    - OCR could provide uniform, higher level guidance independent of public health authorities. OCR also administers HIPAA and HIPAA penalties.
    - He invited TF members to share feedback on his comments. Stephen stated that, ultimately, OCR will determine if entities are following the rules, and OCR has done regular enforcement actions for more egregious HIPAA violation situations.
- John described how his state changed state law in order to allow public health information authorities to leverage the health information exchange (HIE) in his state as an aggregator of data. He described issues that occurred after the start of the COVID-19 pandemic that led to the governor's issuance of an executive order and a change to state law. He asked if others have experienced this policy barrier, too.
    - Stephen responded that the public health authorities that are granted to local health departments vs. to the state vs. other situations (e.g., centralized, decentralized, home rule states) vary. It depends on the situation and the specific public health authorities.
- 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 = locked in spreadsheet and moved text to transmittal document, yellow = in-progress, red = potential duplicate, yellow = discussion in progress, grey = yet to be reviewed by the TF). 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.

Arien described how the PHDS TF 2022 will create and submit the draft transmittal to the National Coordinator for Health IT. The TF will use its working spreadsheet document to create a recommendations document and transmittal letter, and Liz explained that the ONC team has begin to transfer the "green" topics the TF agreed to finalize into the draft PHDS TF 2022 transmittal document. The TF is under no obligation to make recommendations to the CDC or other stakeholders but has often made recommendations during other task forces that ONC coordinate with other stakeholders.

The co-chairs shared the draft transmittal document and explained that TF members were invited to share information via the tracked comment feature (document will be locked). Liz added that TF members would receive a link to the TF's disposition tracking document in the link with their homework for the week. They reviewed these topics, including observations, gaps, and recommendations, and the co-chairs facilitated a discussion. Arien encouraged TF members and public attendees to share feedback via the public chat feature in Zoom.

Discussion:

- Gillian commented that any place in the document that referred to stakeholders or authorities should be updated to refer to them as state, tribal, local, or territorial (STLT) Public Health Authorities and their partner organizations. The TF's transmittal will reflect this change.
- John voiced his support for the row 5 recommendation. He discussed small and large state-level policy barriers and suggested that they should be acknowledged. He recommended that ONC offer guidance on this topic and related barriers.
    - Arien suggested that the CDC could offer advice to STLTs on the policies they should use, though it is unlikely that this suggestion is adopted. He noted that public health authority is broad and jurisdictional but there are some ways to use the public health authority that are more useful than others. He asked for feedback on how to help public health authorities achieve their goals while reducing process-level friction.
    - Gillian recommended general acknowledgement that public health authorities exist at the state and local level, but public health should come together to develop consensus to speak with a unified voice, wherever possible.
    - Arien suggested a potential overarching recommendation that ONC convene, and John suggested allowing public health authorities to leverage intermediaries, wherever it is logical. Gillian and Arien spoke to his comments in the public chat about multitenant and single tenant intermediaries. Arien defined different types of intermediaries and described potential future changes and needs. Ike expressed his concern over who has access to data when it moves through an intermediary to public health and for what purpose/what retention rights apply. Bryant noted that Arien may have oversimplified his definitions of these intermediaries and described issues they encountered in Washington that were unforeseen. Arien explained the recommendation the TF could make to the HITAC only covers the certification criteria and its use (must be flexible to public health authorities to allow them to achieve the public health mission including multimodalities of use). He invited TF members to review the language he drafted.
    - The co-chairs will work on turning this into a recommendation to the HITAC.
- Gillian reviewed her overarching comment recommending that ONC identify use cases that reflect real-world testing, and public health should develop a consensus driven set of use cases.
    - Arien agreed with the recommendation and that it should be moved into the transmittal.
    - Hans asked if a statement should be added to address the variations because certification is currently a singular set across all jurisdictions. He asked for clarifications. Arien responded that the recommendation should ensure that the floor level of interoperability meets the floor level of public health (currently does not). The data that currently flows through public health interfaces is misrepresented because it was not what was created to flow through them originally. Gillian suggested that the minimum standard should assess what is missing. Ike commented that issues arise when the data are translated from within the EHR to the outgoing message, rather than what data are sent. Arien shared use cases of variance and non-conformance.
- Joe described the two overarching recommendations he made around the interfaces between healthcare and public health and other partners. He recommended that the systems have functionality to transmit subsets of the data to public health authorities. The second recommendation shared use cases.
    - Arien noted that, while he agreed with the comments, the recommendations might be verging on being out of scope/extra to the TF's charter. Joe commented that the recommendations are related to the meaningful use of the data.
- Gillian reviewed the overarching recommendation she made that ONC promote the development of new testing tools. No TF members objected to its inclusion.
- TF members discussed whether overarching recommendations around supporting modular certification were overlapping or should stand alone.
    - Arien shared examples, and Bryant noted that there is no financial incentive for the

modifications (sustainability problems). Arien stated that, when the TF recommends including certification, they also include the funding associated with achieving that certification.
    - The TF agreed to move the recommendation to the transmittal and to ensure that there is no duplication.
- Fil described an overarching recommendation that ONC coordinate with CMS and other federal partners on defining and incentivizing certified health IT.
    - Arien commented that this is out of scope unless the recommendation indicates that health IT that is in use by organizations that are not covered by Meaningful Use or Promoting Interoperability also be certified to the public health standards. He shared examples. Fil agreed and stated that the recommendation should be limited to the appropriate (f) Criteria.
- Erin described a series of recommendations she shared regarding Laboratory Tests and Orders/Results (receivers, including IGs and the standard). She stated that she tried to set a baseline of certification criteria while also including the option of advanced criteria for entities that are ready to adopt new or additional criteria.
    - Arien asked for clarification around what should be included and suggested that the TF recommend that public health data systems be certified to the (f) Criteria. The TF could also make recommendations that ONC work to update appropriate IGs to the latest supported versions consistent with public health funding and technology. He suggested that the TF use a broad level policy framework, while giving ONC flexibility to do the assignment.
    - Bryant commented that the TF is tasked with making recommendations that ONC needs to get to a more detailed level of specificity. Eventually, the TF will have to reconvene as new versions are released. Hans described the most recently published versions of the standard and IG listed, noting that the TF should push for greater specificity.

Next Steps

Homework for October 26, 2022, Meeting – due by Tuesday, October 25:

- 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.
- Begin commenting and reviewing the Draft Disposition Working Document. Please comment and edit in suggesting mode. This document is available via Google Docs.

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

Public Comment

Seth 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

Jim Jirjis: i know there is talk about modifying HIPAA by relaxing the Minimal necessary requirement. Any insights into that?

Erin Holt: Could you speak briefly on how minimum necessary applies to the uncovered portions of a hybrid entity?

Arien Malec: Rather than relaxing minimum necessary, it would be better to release guidance that covers USCDI as deemed minimum necessary for relevant purposes.

Jim Jirjis: good point

Vivian Singletary: Yes, agreed

Erin Holt: All versions of USCDI?

Vivian Singletary: I like the idea presented about ONC working with OCR to issue guidance around the interpretation of minimum necessary information

Erin Holt: +1 VS

Arien Malec: When the PHA provides guidance that USCDI is minimum necessary, there's zero issue.

Hans Buitendijk: As USCDI grows, it also would grow beyond minimum necessary.

Jim Jirjis: Arien. is that what is being proposed

Steven Lane: https://carequality.org/wp-content/uploads/2022/05/Carequality-Policy-on-Public-Health-Queries-During-COVID-19-Emergency-Amended-5-5-2022.pdf

Steven Lane: Carequality Policy on Public Health Queries During COVID-19 Emergency (Amended May 2022) The Carequality Steering Committee recognizes that access to clinical information for public health agencies, and that the ability for public health agencies to leverage Carequality connectivity would be highly beneficial. This document addresses the existing barriers and outlines the temporary waivers to address these barriers in this policy.

Steven Lane: This policy was utilized by WA State early on. I am checking to determine if any other jurisdictions did so.

Steven Lane: The promise of FHIR connectivity between PH and providers is that jurisdictions could attest that their queries can be relied upon to represent the Minimum Necessary data for the purpose that the request is being made. While we are limited to IHE/CDA queries and responses we need a policy structure like that we developed at Carequality to support PH queries for CCDs or other specified documents.

Erin Holt: Fungal Men outbreak of 2012 is a good example of what Bryant described.

Bryant Karras: yes thanks @Steve L we did that early in 2020, BUT unfortunately most providers ignored the PH query to Careequality… the use cases were never fully implemented. maybe now in 2022 it would work better

Gillian Haney: 2 steves! @STeve Lane you are next!

Hans Buitendijk: +1 to Ike on the varity *[sic]* by purpose/trigger as well.

Arien Malec: We are driving ourselves towards FHIR-based queries — but again, I'd note the parameters of what is queriable *[sic]* is going to be defined by USCDI.

Craig Newman: The Helios FHIR accelerator is exploring the impact of moving to a FHIR based query approach for some PH use cases. Everyone is welcome (and encouraged) to join those discussions. Please reach out to me (craig.newman@altarum.org) if you'd like more information.

Hans Buitendijk: It will be a balance of push and pull, not just queries. And using FHIR is not just to support queries. It can be used for push as well. Having FHIR based ecpression *[sic]* using CQL provides a potential means to document the varied needs across jurisdictions and pruposes. *[sic]*

Erin Holt: I don't think queries will be the one size fits all solution for PH

Noam Arzt: If we are heading towards FHIR-based queries, I am concerned that if we rely on USCDI to define our data requirements we will find ourselves trying to reproduce detailed, reporting specifications in USCDI. That does not seem to me like a good direction.

Hans Buitendijk: To Gillian's point, expressing knowledge in FHIR and allowing submissions in different formats can help meet everybody where they are and evolving to a common approach.

Erin Holt: +1 to Hans. I think it will be the most practical way.

Jim Jirjis: USCDI content is poor. We have analyzed 100 source documents and found tremendous variation. For exam ple *[sic]* some institutions send only 30 days worth of USCDI information, others 6 months and yet others like the VA 3 years. Completeness of the information is an big issue

Erin Holt: in some places, legally enforceable guidance might also suggest more local/state legislation is needed to address needs

Hans Buitendijk: USCDI is helpful to have overall scope on availability of standards, but the standards and certification can drive when what interactions are to use those standards for the relevant subset of USCDI

Arien Malec: The general point is that if you don't like USCDI, you really won't like nothing.

Steven (Ike) Eichner: A Texas group has developed a model CCDA "requirements" document to provide guidance to users about what content should be populated to support coordination of care between hospitials. *[sic]* The material is sharable.

Arien Malec: The point here may be a recommendation to have public health engage in the definition of USCDI because, and I stress again, that's the boundary of what an EHR is going to produce.

Hans Buitendijk: I like USCDI to scope data for which standards have been agreed to and enable a roadmap, but for specifying what is needed when and which HIT needs to support what, it is just too "blunt" to carve those variances.

Steven (Ike) Eichner: Public health has been engaged in USCDI development, submitting a number of elements in different iterations.

Gillian Haney: thanks to Steven and Craig!

Craig Newman: +1 for Steve E., PH has been engaged in USCDI, but I'm not sure we've seen much progress in getting data elements elevated. I'm not sure why that is.

Craig Newman: Thank you for the opportunity to speak. Please let me know if you have follow up questions.

Hans Buitendijk: @Ike: what would be examples of such intermediaries? HIE's mostly, or other types of organizations as well?

Erin Holt: Should/could/would we consider things like EDI engines or an ESB or similar as an 'intermediary' internal to an org that may facilitate meeting a cert criteria (in scope for modular cert)?

Hans Buitendijk: +1 to Ike on that aspect.

Liz Turi: Would this be separate from the SVAP process?

Hans Buitendijk: As update, LRI R4 is published now.

Joe Gibson: Early on, we had a few recommendations about specific updates. We've had a mix.

Gillian Haney: I concur with having specificity

Erin Holt: Thank you Hans!

Gillian Haney: +1 Hans comment just now

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

There were no public comments received via email.

Resources

PHDS TF 2022 Webpage
PHDS TF – October 19, 2022 Meeting Webpage
PHDS TF – October 19, 2022 Meeting Agenda
PHDS TF – October 19, 2022 Meeting Slides
HITAC Calendar Webpage

Meeting Schedule and Adjournment

Arien and Gillian thanked everyone for their participation and summarized key achievements from the current meeting. The co-chairs shared a list of upcoming PHDS TF 2022 meetings, including dates the TF will present to the HITAC. Arien noted that public health systems developers will present to the TF at its next meeting.

The next meeting of the TF will be held on October 26, 2022, from 10 AM to 12:30 PM (extended). The meeting was adjourned at 12:01 PM E.T.