ASTP | Health IT Advisory Committee

Health Information Technology Advisory Committee

HTI-2 Proposed Rule Task Force 2024 Virtual Meeting

Transcript | September 4, 2024, 11 AM – 12:30 PM ET

Attendance

Members

Bryant Thomas Karras, Washington State Department of Health, Co-Chair
Rochelle Prosser, Orchid Healthcare Solutions, Co-Chair
Mark Sendak, Duke Institute for Health Innovation, Co-Chair
Hans Buitendijk, Oracle Health
Sooner Davenport, Southern Plains Tribal Health Board
Derek De Young, Epic
Steven (Ike) Eichner, Texas Department of State Health Services
Rajesh Godavarthi, MCG Health, part of the Hearst Health network
Gillian Haney, Council of State and Territorial Epidemiologists (CSTE)
Joel Hartsell, Association of Public Health Laboratories (APHL)
Jim Jirjis, Centers for Disease Control and Prevention
Mary Beth Kurilo, American Immunization Registry Association (AIRA)
Katrina Miller Parrish, Patient.com
Kris Mork, Leidos
Alex Mugge, Centers for Medicare and Medicaid Services
Kikelomo Oshunkentan, Pegasystems
Randa Perkins, H. Lee Moffitt Cancer Center & Research Institute
Dan Riskin, Verantos
Zeynep Sumer-King, NewYork-Presbyterian
Naresh Sundar Rajan, CyncHealth
Rachel (Rae) Walker, Elaine Marieb College of Nursing, University of Massachusetts Amherst

Members Not in Attendance

Suresh Balu, Duke Institute for Health Innovation (DIHI)
Shila Blend, North Dakota Health Information Network
Lee Fleisher, University of Pennsylvania Perelman School of Medicine
Hannah Galvin, Cambridge Health Alliance
Steven Hester, Norton Healthcare
Erin Holt Coyne, Tennessee Department of Health, Office of Informatics and Analytics
Hung S. Luu, Children's Health
Dominic Mack, Morehouse School of Medicine
Meg Marshall, Department of Veterans Affairs
Anna McCollister, Individual
Shantanu Nundy, Accolade
Eliel Oliveira, Harvard Medical School & Harvard Pilgrim Health Care Institute
Fillipe Southerland, Yardi Systems, Inc.
Sheryl Turney, Elevance Health
Thomas Wilkinson, U.S. Department of Homeland Security

ASTP Staff

Seth Pazinski, Designated Federal Officer
Maggie Zeng, Staff Lead
Molly Prieto, Group 1 Co-Lead
Rachel Abbey, Group 1 Co-Lead
Sara McGhee, Overall Task Force Program Lead & Group 2 Lead
Ben Dixon, Group 3 Lead

Call to Order/Roll Call (00:00:00)

Seth Pazinski
Good morning, everyone, and welcome to the Health Data, Technology, and Interoperability: Patient Engagement, Information Sharing, and Public Health Interoperability (HTI-2) Proposed Rule Task Force meeting. I am Seth Pazinski with the United States Department of Health and Human Services (HHS) Assistant Secretary for Technology Policy and Office of the National Coordinator for Health Information Technology (ASTP), and I will be serving as your designated federal officer for today's call. As a reminder, this meeting is open to the public, and public feedback is welcome throughout the meeting. Comments can be made during the meeting through the Zoom chat feature, and there will also be time scheduled towards the end of our agenda for verbal public comments as well. I am going to begin with a roll call, so when I call your name, please indicate that you are present. I am going to start with our co-chairs. Bryant Thomas Karras?

Bryant Thomas Karras
Present.

Seth Pazinski
Rochelle Prosser?

Rochelle Prosser
Good morning, present.

Seth Pazinski
Mark Sendak?

Mark Sendak
Good morning, present.

Seth Pazinski
Good morning. Suresh Balu? Shila Blend? Hans Buitendijk?

Hans Buitendijk
Good morning.

Seth Pazinski
Good morning. Sooner Davenport? Derek De Young?

Derek De Young
Good morning.

Seth Pazinski
Good morning. Steve Eichner?

Steven Eichner
Good morning.

Seth Pazinski
Good morning. Lee Fleisher? I did get a message that Hannah Galvin will not be able to join us today. Raj Godavarthi? Gillian Haney?

Gillian Haney
Here, good morning.

Seth Pazinski
Good morning. Joel Hartsell?

Joel Hartsell
Present.

Seth Pazinski
Steven Hester? Erin Holt Coyne? Jim Jirjis?

Jim Jirjis
Present.

Seth Pazinski
Thank you. Mary Beth Kurilo?

Mary Beth Kurilo
Good morning.

Seth Pazinski
Good morning. I got a message that Hung Luu will not be able to join us today. Dominic Mack? Meg Marshall? Anna McCollister? Katrina Miller Parrish?

Katrina Miller Parrish
Good morning.

Seth Pazinski
Good morning. Kris Mork?

Kris Mork
I am here.

Seth Pazinski
Good morning. Alex Mugge? Shantanu Nundy? Eliel Oliveira? Kikelomo Oshunkentan?

Kikelomo Oshunkentan
Good morning. I am present.

Seth Pazinski

Good morning. Randa Perkins?

Randa Perkins
Present.

Seth Pazinski
Dan Riskin?

Dan Riskin
Good morning.

Seth Pazinski
Good morning. Fil Southerland? Zeynep Sumer-King? Naresh Sundar Rajan?

Naresh Sundar Rajan
Good morning.

Seth Pazinski
Good morning. Sheryl Turney? Rae Walker?

Rachel Walker
Good morning.

Seth Pazinski
Good morning. Thomas Wilkinson? I see Raj Godavarthi has joined us as well. Are there other members that I missed or who just joined that would like to indicate that they are present?

Rochelle Prosser
Seth, Bryant and I received an email last night that Shila Blend will not be able to attend today.

Seth Pazinski
Okay, thank you, Rochelle.

Bryant Thomas Karras
Erin said she would be joining late, so, watch for her to come in.

Seth Pazinski
All right. Well, I am going to turn it over to our co-chairs for open remarks and to get us into our agenda.

Opening Remarks (00:04:12)

Bryant Thomas Karras
My main opening remarks are wow, my co-chairs did such an amazing job yesterday. I feel incredibly nervous at how much we have to get through and whether or not Workgroup 1 will be able to follow that act, but I am looking forward to today. I hope we can have some good discussions and get to the consensus of what we can get to, and if we have to table some things or assign continued homework as a Task Force or as a Health Information Technology Advisory Committee (HITAC), then maybe that is what we will have to do. Rochelle or Mark?

Mark Sendak

I am confident in Bryant and that we will have a wonderful meeting today. Thank you for everybody's time, and I appreciate the collaboration.

Rochelle Prosser
Yes. Hello, I am offsite today, and I just wanted to thank everyone for their hard work. We really got through a lot of the HTI-2 rule yesterday and came to consensus with some robust discussion and a few recommendations for ONC, and so, today, as we move into Dr. Bryant's area for health policy, I really look forward to seeing how we can come together and help to codify some of these rules, as well as complete the work that his section of the team did. So, thank you very much for your work. Back to you, Seth.

Task Force Recommendation Worksheet (00:06:03)

Seth Pazinski
So, we are going to start by revisiting two items briefly in Groups 2 and 3, and then we will move into the bulk of our conversation today, focused on the Group 1 draft recommendations. I am going to ask Sara McGhee to start sharing the screen on the Google doc, and we are going to start with Group 2 in revisiting one of the recommendations that we had there. So, I am going to turn it over to Mark to take us through this item.

Mark Sendak
Thank you, Seth, and thank you, Sara. So, the change we want to make here is in Column K. We want to clarify the language in Column J where you see the parentheses, health information exchange (HIE) Trusted Exchange Framework and Common Agreement (TEFCA). Are there any comments about making that change, or does that look good? If there are no comments, I will go ahead and make it.

Rochelle Prosser
So, we are just adding in the other specified CommonWell and any other network, just to make it clearer?

Mark Sendak
Yes.

Rochelle Prosser
Okay.

Mark Sendak
I will copy that over. If we want to go to the next, I think Rochelle had one to review. Is that right?

Seth Pazinski
Yes, this is Seth. We want to flip over to Group 3, and Rochelle, take us through revisiting the one item from yesterday.

Rochelle Prosser
Yes, thank you, Seth. So, under the TEFCA manner request, we received notification from the higher group from HITAC to add language into our recommendations that we recommend ONC guidance on the potential of Qualified Health Information Network (QHIN) lack of adoption for Fast Healthcare Interoperability Resources (FHIR) after standardization occurs for QHINs that do not fully implement FHIR complete interoperability, and we thank HITAC for that because that was one of the areas I was looking for to add and could not find that language in there, and how this is being discussed is we were given three choices: Whether to adopt QHIN with FHIR, whether to let QHIN stand alone and let FHIR expire, or to adopt full FHIR, and as that was the standardization to go, or the fourth choice, to come up with something else.

And so, as a group, we had chosen the original one to go with both because certain application programming interface (API) builds do not take FHIR into consideration as the higher standard, and in order to allow full interoperability of all QHINs and as the intermediary between facilities and patients for access of records, we felt it was still necessary to keep both sides. So, we are okay to add this language in the recommendation to say that we will choose Line Item 1 going forward with both. If there is anyone else that has questions on the explanation as to why we are adopting this recommendation, I am happy to discuss it at this time if you want to raise your hand.

Steven Eichner
This is Steve Eichner, really fast, just to reemphasize and support that for public health entities, we are not necessarily in a position to jump immediately to FHIR or across the board either, so we intend to support v2 for some time.

Rochelle Prosser
Excellent. Thank you, Steve. Katrina?

Katrina Miller Parrish
I may not be hearing this correctly, but what I recall was there was sort of a requirement for FHIR to be the standard for QHINs or the requirements for QHINs plus participants and sub-participants, so what I was trying to aim for was the QHIN as the main focus to start. I know we talked about how the participants and sub-participants will feed in, and that is part of the challenge, which is why I think this has been widened out to QHIN plus participant plus sub-participants, but I do want to make sure that I am understanding what our recommendation is. It is really to establish that standard for the QHIN and participant and sub-participant before the requirement language is removed. I am not sure I am looking at the right thing to explain that correctly.

Rochelle Prosser
Yes. So, in the presentation that ONC did for us, which I think was done by Rachel, there were four choices that we were to choose from, as you mentioned: Have it adopted with both, have it adopted where QHINs would stand alone, have it adopted where FHIR would stand alone after the QHINs expired, or come up with something else, which would allow those sub-categories and sub-groups to be able to find the interoperability. We had a heavy and robust discussion because if a QHIN were to expire, often, they have the ability to hold patient data, and as such, we wanted to ensure that there was still going to be a path for transfer of the data that that QHIN would have held, should they have failed or expired. So, I think having the recommendation on guidance on the potential lack of adoption was the outcome, instead of just choosing Choice 1, having both.

Katrina Miller Parrish
Okay. So, again, focusing on the QHIN itself, really focusing on if they are not standardizing with FHIR, that is really our main focus for the recommendation, as opposed to the other choices.

Rochelle Prosser
Correct.

Katrina Miller Parrish
Okay, got it, thanks.

Rochelle Prosser
Yes, thank you. Go ahead, Hans.

Hans Buitendijk

I am looking for a little bit more clarification as well. So, if I understand correctly, our intent is to say that if a QHIN ceases to be a QHIN, what happens to the data that they may hold? Not all of them hold data, some do, or they hold it as an organization, but not as a QHIN. So, for those QHINs that actually hold data, we are looking for guidance on what to do there. That is one part that I am hearing. The other part is that QHINs may not fully adopt FHIR. To me, that is where I am challenged a little bit more, that while in the beginning, ramping up to FHIR, maybe not everybody is moving as quickly as a QHIN, whatever the participants and sub-participants do, but at some point in time, because of the agreement that they are part of TEFCA, they have to support QHIN or FHIR at that point in time, unless there are some optional things in there that can do, which frequently are the participants and sub-participants.

So, I am still trying to figure out the phrasing that is here that starts with "We recommend to complete interoperability." I am not sure which one of the two and if both are fully captured. I am not sure whether we captured our thought completely on wanting to address QHINs that cease to be QHINs and what happens with the data, as there needs to be continuity, and non-support for FHIR, which can be there in the beginning, but less so over time, that we need to be able to continue that regardless of whether they are in the network or not. So, that is the part I am not clear about. What are we trying to say here?

Rochelle Prosser
So, that is why we were saying we recommend ONC guidance, because, as you said, there are two issues outstanding. What we came to a consensus on as a committee was to say that we would adopt both, having the QHIN and the FHIR still continue on after the version of this rule, because, just as you are saying, it is going to take time for some smaller QHINs to adopt FHIR and some facilities to say, "Okay, we need to get with the program on this." But we do not want to say one over the other, where FHIR is a little bit slower and more challenging than the QHIN, and also, where there is both, the ability, and if the QHIN fails, though God forbid it does, but they do a lot, we want to have direction on how we can ensure the transfer of that information left over, and for the abundance of time for Bryant's program, if this language is not where you would like it to be, and I will give it to Ike as soon as I am done, we can put it as a takeaway and revisit it if we have time.

Hans Buitendijk
I am going to try to put some **[inaudible – crosstalk] [00:16:31]**.

Rochelle Prosser
Yes, Katrina, we are doing that. Go ahead, Steve.

Steven Eichner
Just for clarity's sake, I think the purpose is saying QHINs should not migrate to exclusively use FHIR, but there needs to be ongoing support for other modalities, like v2, for transmission. Is that a fair summary? Does that help address your concerns, Hans?

Rochelle Prosser
I am good with what you just said, and I think that Derek is also happy to help us craft this a little bit more clearly, so I propose this. Oh, Hans is writing here. He has lost his ability for the mic. Go ahead, Hans.

Hans Buitendijk
Sorry, I was double muted. To Ike's question, part of why I am getting up, and it might just be me, is that in the conversation, FHIR and QHIN are used as relatively equivalent concepts, and that is where I get stuck. In my mind, they are two different things. FHIR can be deployed inside or outside TEFCA. It is a method of interoperability. A QHIN is a way of getting a group together on a defined set of use cases that may or may not be FHIR-based. That is why I am trying to keep them in my mind as two different things and what we are trying to

achieve with one versus what we are trying to achieve with FHIR adoption, and that might help clarify, at least in my mind, and maybe for others too. So, what I have put in the chat is perhaps what we are trying to say, that we have a QHIN challenge with what happens if they terminate, we need to hold onto the data, and we need to have a transition for that, and what happens with FHIR adoption, and for TEFCA, that would mean how we get all the QHINs and everybody within that to adopt FHIR at a reasonable pace, completely and consistently. Is that what we are really trying to say?

Rochelle Prosser
Yes. Let's put a pause in this to allow Bryant to continue on, and we can revisit it later at the end. Derek, Hans, Ike, Norm, and I can sit and work together to refocus this one statement. Okay, thank you.

Bryant Thomas Karras
All right. Let's go to the Group 1 tab. Scroll up to the top. Our hope is to change things to green, and we will start a timer on each of these so that we keep our pace, and hopefully we can get through everything. If we cannot get to a consensus and turn things green, then we can potentially push them again or stay silent on different criteria. Overall, I think that this is something that we heard discussed a little bit in the other groups as well: Naming conventions between different actors, especially in bidirectional transmissions or certification criteria, can become really problematic. We ran into this in a lot of different activities, so we are hoping that there can be consistency throughout the document, making sure that people know who the sender and the receiver are, and not commingling healthcare providers with laboratories, electronic health records (EHRs), or ordering physicians. That gets quite messy. I know the notice of proposed rulemaking in the *Federal Register* cannot have diagrams, but perhaps we can make sure that things are made clear and consistent in supportive documents.

Are there any objections to turning the red text here, which does not really go into the final rule, but is just guidance for staff to try to add consistency throughout? I will wait three seconds, and if there is no objection, let's turn it green. If Hans's mic is not working, that could be really beneficial in us getting through this efficiently.

Hans Buitendijk
Are you concerned?

Bryant Thomas Karras
Sorry, I was joking, Hans. No objections? Thank you. Mary Beth, do you want to lead us through this next one?

Mary Beth Kurilo
Sure, I would be happy to, Bryant. Thank you. So, the first one was already green, so this is really just focusing F1 criteria on the 2018 update 2.5.1 implementation guide, as the guide under development is still in the works and likely will not be published until late 2025/early 2026, so I am assuming we are good with that. Hearing no objections, I will keep moving.

Bryant Thomas Karras
Keep that green, okay.

Mary Beth Kurilo
The next one is really around the terminology you were just referencing, the bidirectional term and the actors. So, if you look down to the fourth line, A27, this was our group's effort to revise the language. So, A27, MBK's revised version for review, says, "We recommend the term 'bidirectional' be replaced and that the actors in each use case, e.g. EHRs and immunization information systems, be better identified in each individual requirement." I will let folks read through the rest of that. We also just asked that this section be renamed to "Immunization information system

submission and/or query" to address the dynamic nature of the data flow, but get rid of the term "bidirectional," which I think was problematic.

Bryant Thomas Karras
We were really talking about different things, not bidirectionality.

Mary Beth Kurilo
Right, exactly.

Bryant Thomas Karras
Who is driving today? Is it Maggie?

Sara McGhee
It is Sara. Hello.

Bryant Thomas Karras
Sara, can you turn Line 4, the paragraph "We recommend…"

Sara McGhee
Oh, I need to do it right up here.

Bryant Thomas Karras
Oh, right. Could we turn the second "We recommend" to the word "systems" green? And then, we will wait for people to see that. Have people given that a review? Any objections?

Rochelle Prosser
I was looking at the one above, where you are removing "bidirectional" to put it as "add the item." I think the spirit of what the policy was looking at was to make sure the transfer of that information can go both ways, either from the patient to add and upload information or the actual provider or exchange to push it down to the patient. If I am seeing it incorrectly, please let me know.

Bryant Thomas Karras
Yes, patients are not allowed information to the registry, only providers.

Rochelle Prosser
So then, a provider can add it, and it gets facilitated to wherever it is going, and to wherever it is going, it can be reciprocated?

Bryant Thomas Karras
It can be shared, yes.

Rochelle Prosser
It can be shared, but not edited.

Bryant Thomas Karras
Right, so that is how the bidirectionality part was misleading. There are actually two different transactions. There is a transaction for submission, and then there is a separate transaction for query and response.

Rochelle Prosser

All right, then in that case, I would agree.

Bryant Thomas Karras
Mary Beth, am I correct in my assessment?

Mary Beth Kurilo
I think you were.

Bryant Thomas Karras
Patients cannot just upload or enter in vaccines that they have gotten elsewhere. They have to do that through a provider **[inaudible – crosstalk] [00:26:19]**.

Mary Beth Kurilo
Right, and I think that is true of immunization information systems, but also, since this one is focused on F1, also true of EHRs, that they would need to tell their provider, and their provider would enter it.

Rochelle Prosser
Hans, you had a question.

Hans Buitendijk
Yes. A question that I have is trying to figure out which one of the paragraphs we are really looking at because there are a couple of parallel ones.

Bryant Thomas Karras
We are going to keep marching through. Right now, we are just looking at the second half of the second paragraph, which was just turned green. It is repeating itself. There is a Version 1, and then Version 2 for review.

Hans Buitendijk
Yes, and then there is a Version 3 below that. That is why I was confused.

Mary Beth Kurilo
Yes, but I think that is a separate topic. I tried to group them by paragraphs, so that next paragraph that is still black, red, and blue, is a separate topic to discuss.

Rochelle Prosser
Okay. So, in the green section, you still have bidirectional exchange before immunization registries in the second line, and with immunization information systems. So, if you are proposing to replace the term “bidirectional,” would it not be removed here as well?

Mary Beth Kurilo
It would. So, we are recommending removing “bidirectional” altogether.

Bryant Thomas Karras
They had to reference the title “bidirectional” to say that we do not like that title and want to change it.

Mary Beth Kurilo
Right. So, we propose replacing the title of “immunization registries bidirectional exchange” with “immunization system submission and/or query.”

Rochelle Prosser
For ONC, is that going to be a difficulty in actually changing the rule? My understanding is that when the rule is written, it is written in, and so, changing the title might be problematic. Could we have clarification or flexibility in adjusting that? That is specifically a question to ONC.

Sara McGhee
This is Sara. That is a fine recommendation on changing the title.

Bryant Thomas Karras
Thank you.

Rochelle Prosser
Okay, thank you.

Bryant Thomas Karras
All right.

Mary Beth Kurilo
Should we keep moving, Bryant?

Bryant Thomas Karras
Go on to the next paragraph, "We recommend that ASTP." Oh, wait, that is actually…

Mary Beth Kurilo
Yes, we are going to move you down to the sixth line there, where it says, "8/27 MBK's revised version for review." Oh, do not scroll down so far. Go back up. Sorry.

Bryant Thomas Karras
A little bit more.

Mary Beth Kurilo
A little bit more. Perfect, okay. I think this was, again, a group effort across Group 1. "We recommend that the ability for a provider to respond to an immunization query be supported by G10 and G20 using a common FHIR-based approach rather than requiring implementation of a Health Level 7 (HL7) v2-based query." So, again, this is from the perspective of the EHR. We are recommending that the rule does not require EHRs to implement HL7-Version-2-based query, but rather that they focus on FHIR-based query called out in G10 and G20, since this seems like a better, longer-term investment. And then, if the group accepts that, there is some language as well that can be deleted that addresses this need for EHRs to build in a v2 query that we recommend would be removed. And Hans, please jump in if you have more clarification there about why we are making this recommendation.

Hans Buitendijk
I am happy to provide that if there are any questions around that, but it is primarily that we want to make sure that we have, as EHRs, to implement v2-based queries, which is what query, view, and print (QVP), etc., would do, that would require an infrastructure that is much more complex to maintain for many others to query. It is one thing to do it with 50 or 60 Immunization Information Systems (IIS), but another to do it with thousands of EHRs. So, using the FHIR-based queries for immunization data seems to be a better way, that if somebody needs to query a provide for that, they use the G10/G20 for that using FHIR to query, not the v2-based querying mechanism.

Bryant Thomas Karras
Right. We need to keep moving, so if there is no discontent with that, let's turn the second half of that paragraph green from after the blue "review" to "respond." Ooh, not too far. Mary Beth, is this a separate paragraph?

Mary Beth Kurilo
This is really just a language cleanup, that the rule refers to both patient-specific queries and immunization-specific queries, and what the implementation guide refers to is patient-specific queries that include the immunization record. So, we are just cleaning up the language there.

Bryant Thomas Karras
All right, can we do both lines? The next was the cleanup of the date, right? You found a date discrepancy.

Mary Beth Kurilo
Yes, exactly.

Bryant Thomas Karras
I think that is just a typo.

Mary Beth Kurilo
Perfect, thank you. Okay, the next very lengthy paragraph ties in with a conversation we had yesterday about the guidance around SMART Health Cards, SMART Health Links, and SMART Health Cards Vaccination and Testing Implementation Guides. I think we covered a lot of this conversation yesterday, and if I am correct, this is the preferred language going forward. Hans, I am going to hand it over to you because you made some additional changes in this language as well.

Bryant Thomas Karras
Hans, is the paragraph that you started a replacement for all of the above, or just additional text to add to what is above?

Hans Buitendijk
Can you highlight where exactly you are looking? I am jumping around, and it is hard to keep track.

Bryant Thomas Karras
After the blue "revision for review," I think we highlighted "we support," but then, you have a paragraph down below that says, "we support patients accessing," I think. It is a replacement, so that is the one we should be highlighting.

Hans Buitendijk
Correct. I just want to make sure.

Bryant Thomas Karras
So, could you turn the red text after Hans, Mary Beth, and Steve's 8/29 "we support patients" green, going all the way to the end of "record"?

Hans Buitendijk
Keep them going for a couple more.

Bryant Thomas Karras
Could you scroll a little bit?

Hans Buitendijk
Scroll a little bit further. Just keep on going.

Bryant Thomas Karras
I think you turned too much green.

Hans Buitendijk
No, I do not think so.

Bryant Thomas Karras
It should just be after “Hans MBK…”

Sara McGhee
Sorry, it is difficult to see it in the box at the top. My apologies that it is taking me a while.

Bryant Thomas Karras
Oh. Now it looks okay. Great, I just had a little bit of a lag. All right.

Hans Buitendijk
I thought we were further down. I am now confused. So, it is now 8/27. There you go.

Bryant Thomas Karras
Wait, it reverted.

Sara McGhee
Sorry. Okay.

Hans Buitendijk
So, where it says, “Hans/MBK/Steve…”

Bryant Thomas Karras
That is the start.

Hans Buitendijk
And you go through the red bullet that is as complete as possible, if it turns black and is not yet green, then I think we have it, right? That is what we are looking at.

Sara McGhee
Sorry, it keeps jumping up on me.

Hans Buitendijk
If you double-click right on the text, you can select it in the box.

Sara McGhee
Right. You want this text green now?

Bryant Thomas Karras
Yes, but the first half of that paragraph should not be green.

Sara McGhee
This part. Got it.

Bryant Thomas Karras
Do you see the bold “Hans”? There you go.

Sara McGhee
Thank you for your patience. It is difficult to do this in the Google sheet.

Bryant Thomas Karras
There is a lot in this cell. Am I right, Hans and Mary Beth, that what we just turned black is redundant?

Mary Beth Kurilo
Yes.

Bryant Thomas Karras
Okay, good. I think we are ready to move on to the last three bits on this. We are way behind. Do these need to be included as well? Oh, there is a Hans suggestion.

Mary Beth Kurilo
I think we can get rid of that middle section because we already agreed to it up above because we talked about focusing on G20 and G21.

Bryant Thomas Karras
It was already addressed.

Mary Beth Kurilo
Yes. The comment above that, the references to what functionality sunsets and what functionality persists for EHR exchange, I think that is a comment we want to make, to make sure that the wording is clarified to ensure that both submission and query persist as expectations beyond January 1st, 2027. And then, again, this is just a wording cleanup, recommending ASTP clarify whether ‘query’ and ‘request’ mean the same thing, and if so, select one of those terms and be consistent throughout the document. Again, those are just clarifications.

Bryant Thomas Karras
So, turn that last sentence green, turn the references green, but do we ignore the one in between?

Mary Beth Kurilo
I think we can, because we already made the recommendation up above green, so I think we are good with deleting that.

Bryant Thomas Karras
Okay, so we will move ahead with everything that is green. Any objections? Let’s move on. Thank you, all right. Steve and Gillian? Oh, Hans has some new edits here.

Gillian Haney
Take that pulled language, actually.

Bryant Thomas Karras
So, are we sticking just with the green, then?

Gillian Haney
I believe so.

Bryant Thomas Karras
All right. I will give people a second to read this. Is this syndromic surveillance?

Gillian Haney
I think the first sentence is incomplete. I am not quite sure what happened to the language, and I do not remember what we had there. Steve, do you recall?

Bryant Thomas Karras
There is "sched."

Gillian Haney
Schedules?

Bryant Thomas Karras
Steve, can you unmute?

Steven Eichner
I am zooming in.

Sara McGhee
Bryant, if it helps, we save copies of these documents every day.

Bryant Thomas Karras
Yes, so we can figure out what the last bit of that… I cannot believe we turned something green that was truncated like that. Just for clarity, Hans, I think one of the reasons I would like us to stop referring to syndromic surveillance HL7 v2 messages as Admit / Discharge / Transfer (ADT) is because they are ADT-like, but they are not ADTs. They are ADTs and Observational Result (ORUs). In the format, it could be misleading for implementers to think, "Oh, we just do it as an ADT," but it is not. It is a specific syndromic surveillance implementation guide (IG). Shall we move on? Sara, if you and the team could figure out what that last conclusion of the first sentence is, that would be awesome.

Steven Eichner
Just to clarify for the group, the rest of the text is focused on looking at other scheduled reporting with the idea of making sure that the adoption date for a new standard was aligned with programmatic activities, so we were not changing standards in the middle of reporting windows and potentially disrupting ADT.

Bryant Thomas Karras
Oh, with the Centers for Disease Control and Prevention (CDC) week system?

Steven Eichner
Correct.

Bryant Thomas Karras
Moving on to the 1st of the year versus the 31st of December.

Steven Eichner
Right, and any other reporting that was similar in nature.

Bryant Thomas Karras
Right, and we get to some of that in the next bit. All right, let's move down to the next section, electronic lab reporting. This is our bread and butter. This one should be easy, right?

Gillian Haney
Yes, we updated Erin's original language in red below.

Bryant Thomas Karras
All right, and is that a replacement or an additional sentence?

Gillian Haney
It is an additional sentence.

Bryant Thomas Karras
Okay, so, after Erin 8/26, that "recommend" to the end of the screen?

Gillian Haney
Yes.

Bryant Thomas Karras
Thank you. All right, cool. Has Erin been able to join us? She is still late, okay. All right, next section. Hans and Steve? We had a homework assignment for Jim Jirjis. Dr. Jirjis, were you able to confirm?

Jim Jirjis
Did you guys receive my email response to that one as well, or is that the one outstanding? I think I had sent follow-ups to you, Bryant, from our last call. There were four, I think, and if we do not have that, I will have to… Let me look for it.

Bryant Thomas Karras
Rachel or other ASTP staff?

Rachel Abbey
No, we did not receive any feedback on cancer. We just received feedback on Antimicrobial Use and Antimicrobial Resistance (AUAR).

Jim Jirjis
I sent you the other two we discussed. Let me look back and see if I got anything. We reached out, but let me see if I got anything back from cancer. If not, I will ping them again.

Bryant Thomas Karras
I may not have gotten those, Jim. I apologize. There were some issues with my email server. Something was administratively filtered. So, Hans and Ike, what do we suggest doing here? Should we come back to it?

Jim Jirjis
Let me see if I can find the email I sent you. Go ahead and continue.

Bryant Thomas Karras
Yes, let's go on and come back to this. Okay, next. Joel?

Joel Hartsell
Yes, I can jump in.

Bryant Thomas Karras
Most of these are green already. Can you talk us through the last ones that we need to convert?

Joel Hartsell
Yes. In the first one, I updated the Reportability Response (RR) IG language. That was in the green section. So, we updated the language in four, and Erin, I know there is an outstanding comment from you, so, jump in if you have any considerations here, but we are really just trying to clarify that certification for this should be transitioned from just self-attestation to demonstration and show the capabilities for electronic case reporting around completeness and data quality thresholds. That first sentence is really the piece that was changed. Gillian, I know you had some thoughts on this as well.

Bryant Thomas Karras
Are you talking about No. 1?

Joel Hartsell
No. 4.

Bryant Thomas Karras
No. 4, okay. So, let's turn No. 4 green. Erin is not on, Joel, just so you know.

Joel Hartsell
Oh, she is not on yet? Gillian, do you have any residual thoughts on this?

Gillian Haney
I am just trying to find my email.

Joel Hartsell
I think Erin's comments were around a consensus-driven process. I guess I can let others chime in. Maybe the process does not need to be called out here, similar to what you and I talked about on Friday, Gillian. Do we want to call?

Gillian Haney
I think we should not. I think we should leave it out for right now.

Bryant Thomas Karras
So then, in No. 5, we called out that there are more federal organizations that should be specifically listed or engaged with, and then, let's go on to No. 6.

Joel Hartsell
So, the language is updated. I think everybody was comfortable with the language in the black when last we talked, but we updated the language, based on the group's recommendation, to persist the choice of the FHIR electronic case reporting (eCR) IG or CBA.

Bryant Thomas Karras
So, are we keeping any of the red text?

Joel Hartsell
The red was new. I think we were keeping all of the comment.

Bryant Thomas Karras
Okay, so we turned the whole comment green?

Gillian Haney
Yes.

Joel Hartsell
Yes, sorry. Good. You can delete the blue language, obviously.

Bryant Thomas Karras
We will come back and delete that later, but with everything green, is there any objection to those moving forward? Great, let's move on to National Healthcare Safety Network (NHSN). I think we had some more Jim Jirjis homework here. I will check my inbox, Jim.

Jim Jirjis
I put some of it in the chat here, syndromic and cancer. We did send you the NHSN one. I am looking for it now. I think Abby Viall had sent that to you, but let me find it.

Rachel Abbey
Yes, Abby sent that.

Jim Jirjis
I am looking for it right now.

Bryant Thomas Karras
We saw the Abby message, okay. So, we have the STU 1.0.1 for cancer. Should we scroll back up to the cancer one before we do the NHSN one?

Hans Buitendijk
Bryant, I think there are effectively three recommendations there, and Erin's comment was still an open question there.

Bryant Thomas Karras
The FHIR adoption? The IG might be out, but the adoption may be problematic.

Hans Buitendijk
Yes. So, the intent of the first one was to say that "Do not require it" can still be used, but there is a lot of adoption going on in Clinical Document Architecture (CDA), and if we already shift over to FHIR only, that would take away some of the efforts there that probably are very valuable, but allow for FHIR, so it is an option, not an "instead of," to do a "not require" or not allow for FHIR. I think the second one from Ike is to mention clarification because they are separate transactions, and the third is a name change. Erin had a question/clarification about whether they were addressed in a reasonable way yet. I think there are three recommendations in here. Ike, did I get that right from your perspective as well?

Steven Eichner
Yes, sir. Great job.

Bryant Thomas Karras
All right, let's turn that first "recommend." Ike, are your comments inclusive of each other? Should they all be turned green?

Steven Eichner
Yes.

Bryant Thomas Karras
Okay, delete the word "Ike" in front of each of them, unless, Steve, you want to become part of the *Federal Register*.

Steven Eichner
No, thank you. I am happy to contribute; I do not need to be recognized.

Bryant Thomas Karras
So, we will go in and delete "Ike:" from each of those, but I am still a little bit confused on Erin's reference here.

Hans Buitendijk
I think it is because the recommendations are focused on the cancer registry, and some of the wording there indicates to stay with CDA. As long as you are reporting a separate one, and only as a FHIR report, it might come across that we are suggesting not to do cancer pathology reporting, which is not what we said. We only focused the first three on the cancer registry reporting part, but we did not make a comment about the cancer pathology report. So, I think what she is trying to say here is to make a comment in the positive about cancer pathology because we do not want to give the impression that we are suggesting that, with the above, cancer pathology would disappear. That was not the intent.

Steven Eichner
And that pathology needs to continue its proper format, and the data in CDA is not necessarily sufficient for cancer pathology reports.

Bryant Thomas Karras
Is the change in the name sufficient to make that distinction?

Steven Eichner
I think clarifying in the name and clarifying language that they are two separate reporting activities is the goal.

Bryant Thomas Karras
In your comment, Ike, changing the name to "cancer registry reporting transmission to public health agencies," I do not see the insertion or inclusion of pathology report.

Steven Eichner
Right. The first comment looks at creating the distinction between the two.

Bryant Thomas Karras
But do you suggest that we need to change the name to being both registry reporting and pathology?

Seth Pazinski
We are at time.

Hans Buitendijk
Maybe one suggestion is that we could suggest to separate the two criteria, one for cancer registry and the other one for cancer pathology. That helps to avoid any confusion between the two.

Bryant Thomas Karras
And commingling of the standards when they are not the same.

Hans Buitendijk
Correct, and then, you can still say one is required and one is optional.

Bryant Thomas Karras
We are out of F numbers. What do we put it at? Well, we will let ONC figure that out, but we may want to say that it should be distinct and modular.

Steven Eichner
That would be FX1/FX2, right? Or F3A/F3B, whatever it is.

Bryant Thomas Karras
I think it is four, but we will just move on. So, let's leave Erin's in red, but the green can stand. Can we make a note to ONC staff that we are worried that the inclusion of both the pathology reporting as FHIR and the registry reporting as CDA in the same criteria could be a bit confusing for implementers? They should probably be separated. All right, let's move back to NHSN. We may have gone too far. There we go. Or is it right above? Right there, okay, that was it.

Jim Jirjis
Yes, you got the email.

Bryant Thomas Karras
Okay, scroll down a little bit. So, for this one… I am still not seeing that email.

Jim Jirjis
You should have the one from Abby.

Bryant Thomas Karras
So, she is saying R4/D3. Am I in the right one?

Jim Jirjis
What was the date and time on that, Bryant, so I can find it too?

Bryant Thomas Karras
It is August 29th, and it also went to Molly and Rachel. All right, so, we need to just double-check.

Rachel Abbey
I think the issue is that R4 is not balloted yet, so that is an issue.

Gillian Haney
Even if it was not balloted yet, didn't we wonder if we could make a statement about utilizing the most current version because it was expected to go through?

Unknown Speaker
Good morning, everyone. I never introduced myself, do not ask me why not, but this is Theresa Cabral, and welcome, everyone.

Bryant Thomas Karras
Hello?

Gillian Haney
The problem is that we will not be aligned with international partners, and this is really critical.

Bryant Thomas Karras
All right. CDC does not gain anything by moving AU to R4/D3. "We do not need to be aligned. We are fine with remaining an R1." If they do not need to be aligned… All right, I am still a bit confused, but I am happy to take suggestions from other committee members. Do we stick with this and let the federal agencies work out when and how they can reference the newer versions?

Hans Buitendijk
I think if we can have the basic comment that says that there is alignment between what CDC is trying to do and what ONC is putting in certification, that it is using the same process as what Centers for Medicare & Medicaid Services (CMS) and ONC have started to do, where the latest one in the rule is the latest one that is published, and that Standards Version Advancement Process (SVAP) is being used to get the latest one that is actually going to be required, so that you can keep certification at the correct level. Getting into that mode would be very helpful and is very predictable. Right now, on the NHSN side with this, it is a little bit harder to maintain that awareness of where we are adding, what number is being used, and how we get there, so consistency and alignment, at least from our perspective, was the main objective, and then we would let the versions fall out where they fall out. This would be a way to get there.

Bryant Thomas Karras
And, as you have it, the sentence indicates that. Let's go with the green and move on, not making a specific reference to the… Okay, next section. So, this is the National Healthcare Survey one, and again, let me check my email from Jim. That is the same.

Gillian Haney
This is more of the same issue.

Bryant Thomas Karras
We need to go back in time and have all of these IGs invested in earlier so they can be properly referenced and advanced.

Hans Buitendijk
What happened initially is that we had to certify to whatever was in the rule, but then we had to report going to whatever the requesting party wanted it to get, so that created some confusion. Again, if we can align and have a predictable cadence, that is the key, so we do not have to certify against one thing, and then we effectively have to report against something else. That is the underlying concern, however it is being resolved.

Bryant Thomas Karras
I am not seeing an email on this one, Jim. Did things need to stay silent? Wait, here we go. It is in this one. It looks like most of the emails are about the antibiotic resistance issue, not about the survey issue.

Rochelle Prosser
Jim had to leave for a call conflict.

Bryant Thomas Karras
Great. Did he put it in the chat?

Mary Beth Kurilo
No, he did not, but we can follow up with him, Bryant.

Bryant Thomas Karras
All right. I am not seeing a resolution to that. For now, I think we can adopt just the green. We still need to wait to resolve the CDC program area reference. It sounds like they are unlikely to be able to get it released in time for this publication. All right, next section. This is the birth reporting FHIR IG. Frankly, this one is making me nervous in that I have not heard a large adoption of this or a large number of states that have piloted it successfully, but I do not think that this is a voluntary advancement. Hans and Ike, do you feel comfortable with moving this forward and seeing if it moves the needle?

Hans Buitendijk
I am.

Bryant Thomas Karras
All right. So, do you suggest we turn that recommendation from red to green? It says, “More utilization curve before inclusion.” So, your text suggests that we do not include it for certification programs.

Hans Buitendijk
Not at this point in time, yes.

Bryant Thomas Karras
Okay. All right, I think I am okay with that. Any discussion amongst broader Task Force members?

Steven Eichner
This is Steve. I agree. This kind of goes to the heart of the ongoing disconnect between United States Core Data for Interoperability (USCDI) and USCDI+. I am not sure if we would want to take advantage of the opportunity to make a comment in that space. My personal perspective is that there needs to be greater alignment, coordination, and understanding about what USCDI+ actually is with respect to certification criteria and what content providers must actually retain and report.

Bryant Thomas Karras
All right. What about the last sentence there? I do not think we need to include G10/G20 in this.

Hans Buitendijk
Agreed.

Bryant Thomas Karras
What about that last red sentence?

Hans Buitendijk
It may need a little tweaking, but the intent there was that as we are including birth data specifically in USCDI and up in G10 and G20, at that point in time, certain health information technology (HIT), including specialty EHRs, may not have the ability or do not need the ability to support that very specific birth data. So, here, it is trying to address that question. As we put things from the vital records birth and fetal death reporting implementation guide into USCDI, we should be very careful that certain HIT cannot do it, so we should enable certification to what you manage, not that you have to build extra that you do not need.

Bryant Thomas Karras
It is that modular certification.

Hans Buitendijk
Effectively.

Bryant Thomas Karras
So, with the typos, if you can change “dara” to “data” and “lava” to “have…”

Steven Eichner
Hans, this is Steve. As we are looking at the G20 or other API criteria, wouldn’t the potential disconnect between USCDI and USCDI+ be a concern? You may or may not get a successful return in looking at an API request for data in USCDI+, not USCDI, so that is another relevant issue.

Hans Buitendijk
Possibly. It depends on how they are being translated into implementation guides, because ultimately, from a certification perspective, we are really not looking at USCDI or USCDI+. We are looking at the implementation guide that is relevant for the use case at hand, whether it is a G10 general query or a specific other thing. We want to make sure that USCDI and USCDI+ data are properly represented in those guides, and that where there is HIT that is not managing certain data, they need not expand their capabilities for data that they otherwise do not need. It need not yield that confusion.

Bryant Thomas Karras
Hans, I am going to cut this a little bit short, as we need to move on. Is the red text modifying the G10/G20 discussion, not just the birth reporting?

Hans Buitendijk
It relates to both because **[inaudible] [01:18:29]** so it is asking in this criteria the question about being included into USCDI, so that is why it is listed here but it does **[inaudible]** G10 and G20.

Bryant Thomas Karras
Okay. So, you propose moving the red text to green and putting it after “would have to support”?

Hans Buitendijk
Yes, and I can work on a slight tweak, just to make it clearer to understand.

Bryant Thomas Karras
Okay, so we are turning it green. We will let you tweak it offline while we move on to the next one. All right, F9. Naresh, do you want to lead this one?

Naresh Sundar Rajan
Sure. So, this is with regards to the conversation we had on Prescription Drug Monitoring Programs (PDMP), specifically bidirectional query. I believe I have had discussions again with Kevin Borcher, the PDMP team, and PMX, the national standard exchange committees. So, what I have put together is basically the recommendation here. Could you go to the right?

Sara McGhee
I hid a bunch of cells.

Naresh Sundar Rajan
Oh, okay. I think this is fine. I just added a different color here. I wanted to make sure my comments were in here, so I added a recommendation. It should be in one of these cells.

Sara McGhee
Is it in this one, maybe?

Bryant Thomas Karras
It looks like you have not hit save.

Naresh Sundar Rajan
No, it is Google Drive, but anyway…

Bryant Thomas Karras
What column is it in? We may have hidden it.

Naresh Sundar Rajan
Let me just check that. So, it should be Cell J11, I guess.

Bryant Thomas Karras
Okay, so it should be there.

Naresh Sundar Rajan
Right there, the colored one.

Bryant Thomas Karras
Maybe we need to make that cell larger. Can we stretch it down and see if it is below? Ah, the new red text?

Naresh Sundar Rajan
Yes, the red text, right there.

Sara McGhee
My apologies. My mouse did something. Hold on just a moment. Okay, right here. Is that correct?

Naresh Sundar Rajan
Yes, that is correct. If we could just go over the red text specifically, the idea here is the PMX standard is widely adopted across 54…

Bryant Thomas Karras
But it is not an open standard, and it is not a healthcare standard. It is a law enforcement standard.

Naresh Sundar Rajan
Right. So, if you see what I have actually added there, there needs to be a parser mediated through PMX to FHIR, and that alone opens up the proprietary nature of that. There is always a challenge between as soon as possible (ASAP), which is, again, proprietary, versus the FHIR that needs to be mapped. The solution that I had from my side is that if the PDMP community needs to specifically open up from their side on the mapping between parsers, which is mediated through vendors right now, which is, again, proprietary, there needs to be some sort of standard adoption on both sides, definitely coming through ASTP on that.

Bryant Thomas Karras
Any other discussions? Although there is an adoption of National Council for Prescription Drug Programs (NCPDP) 2017071, I am not seeing that supported here in your recommendation, Naresh.

Naresh Sundar Rajan
If we specifically talk about payments and interstate exchange, which is pretty much…

Bryant Thomas Karras
But I do not think this is interstate exchange. Yes, I agree with you about PMX for interstate exchange, but this is the certification criteria for the EHR interacting with the state registry.

Naresh Sundar Rajan
Understood. I think we can definitely incorporate NCPDP in here as appropriate.

Bryant Thomas Karras
Okay. It looks like my edits may have disappeared. I put the 2017071 and the new 2022 standard after NCPDP SCRIPT in Erin's line.

Naresh Sundar Rajan
I am not seeing that. Did you add it today?

Bryant Thomas Karras
Yes, I added it today, and it looks like it got written over. Has Erin joined us yet? Why don't we table this one for now and come back to it at the end if Erin is able to join or pick it up first thing tomorrow? Naresh, maybe you and I can have some discussions, because I think this is similar to cancer, where it is trying to do both the registry reporting and the pathology reporting. This may be looking at multistate query as well as reporting into the registry, which are different things.

Naresh Sundar Rajan
Predominantly, it is **[inaudible] [01:15:12]** only, and there are some states, like Nebraska, where you would have all prescriptions, in which case you would have facilitation for something like a patient portal or provider portal, which are needs that are beyond. Right now, the exchange is more along the lines of Hypertext Markup Language (HTML) on discrete, so that alone is probably not sufficient.

Bryant Thomas Karras
No, that is probably not something that ONC is going to want to push. Specifically, there is a new e-prescribing NCPDP on FHIR IG that should be totally open and hopefully something we can move to, but let's table this and come back to it, unless any of the Task Force members wants to make a recommendation that we stay silent on it completely. I am trying to do another day's worth of quick work. Let's scroll down to F10.

Seth Pazinski
This is Seth. I just want to flag that we are at public comment time, so I suggest we move to that. I am not sure how much time we have scheduled for the next item, but if we have time, we can go back to the Google doc.

Bryant Thomas Karras
All right.

Public Comment (01:16:44)

Seth Pazinski
All right, so we are going to open up for public comment at this time. If you are on Zoom and would like to make a comment, please use the hand raise function, which is located on the Zoom toolbar at the bottom of your screen, and if you are participating by phone only today, you can press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. As we give folks an opportunity to raise their hands, I just want to give a reminder that our last HTI-2 Proposed Rule Task Force meeting is scheduled for tomorrow, Thursday, September 5th, from 11:00 a.m. to 12:30 p.m. Eastern Time, and a reminder also that all HITAC meeting materials can be found on HealthIT.gov. I am not seeing any folks on the line, nor any hands raised in the Zoom, so I will turn it back to you, Bryant, to see if we have time to get through one more item, and then we will move to next steps and adjourn.

Next Steps (01:17:51)

Bryant Thomas Karras
All right, let's go back to the Google sheet, please. Erin is still not on, but Hans, do you want to talk to us about limit of reporting (LOR)/ Laboratory Results Interface (LRI)?

Hans Buitendijk
Yes. I am trying to see how to best summarize it, but the basic intent behind this is that within the computerized physician order entry (CPOE), orders for lab are communicated to different labs, and depending on what the lab is, there is more or less public-health-specific data that is needed to enable the lab to report it if they have a reporting requirement. Therefore, requiring all LOI for all communications seems to be more than is needed because not all of them need that extra public health data, particularly what is addressed in the LOI guide. Plus, there is a wide set of implementations that uses v2 2.3.1, 2.4, and 2.5. Making this kind of a big shift would be challenging if everything had to be changed accordingly, so supporting all of LOI might end up hitting us with LRI that we are implementing at once. The intent there is to tailor and use components of LOI and LRI as well, and that is the essence of what this is trying to do. These are components so you can plug it into existing v2 messages, not that you have to also go to LOI or LRI.

Bryant Thomas Karras
I thought that, in recent years, there has been a successful push to 2.5.1, and we are less and less with 2.3.

Hans Buitendijk
No, there is a lot out there.

Bryant Thomas Karras
Oh, okay. Scroll down a little bit to the results section of this.

Gillian Haney

Can I ask a question on that? Is that first bullet, which says “laboratories external to the healthcare provider organization, e.g. commercial laboratories or public health laboratories,” supposed to be the header for the following two statements?

Bryant Thomas Karras
Can we back up a little bit?

Gillian Haney
There is a little bullet under “orders.”

Bryant Thomas Karras
I think the orders are different for internal labs in a hospital versus external labs and national reference labs versus public health labs.

Gillian Haney
But I am not sure what that line is stating, “laboratories external to the healthcare provider’s organization.”

Hans Buitendijk
So, if you have a clinic and they do not have their own lab, the labs are external to them.

Gillian Haney
No, I understand that, but what is that proposing?

Bryant Thomas Karras
It is all going back to the poll, back to “recommend addressing different contexts for each of the following situations.”

Hans Buitendijk
Yes, the double dash.

Gillian Haney
Oh, okay.

Hans Buitendijk
Given the direction of where Electronic Test Orders and Results (ETOR) is going, that is here full LOR and LRI are in play.

Gillian Haney
No, I got it. I was confused. Okay, I understand. Thank you.

Bryant Thomas Karras
For the format of the transmittal, it will probably have to be a full sentence of each of these, because it will be too hard to reference back to the lead-in paragraph colon. Hans, we have five minutes left. Do you think we can turn this green?

Hans Buitendijk
I do, but…

Bryant Thomas Karras

Do any other committee members have concerns?

Rochelle Prosser
I have no concerns. I am good with green.

Bryant Thomas Karras
Gillian, if we could figure out a way to make it clearer what the dashes versus the double dashes are, would you be comfortable with that?

Gillian Haney
Yes, that is fine.

Hans Buitendijk
Unfortunately, the double bulleting does not work inside spreadsheets.

Rochelle Prosser
Is there a colon after “needs to have”?

Bryant Thomas Karras
Yes, there is a “needs to have,” then a colon.

Rochelle Prosser
Maybe we could just number it or something, like one, two, three.

Bryant Thomas Karras
That is a good idea. We will go through and number them. Hans, are the single dashes numbers and the double dashes sub-letters within that number?

Hans Buitendijk
Yes, but if you want to see it and you are not, I can just do that right now.

Bryant Thomas Karras
Let’s do 1, 2, 2A, 2B, and 2C.

Hans Buitendijk
Yes. I will change it right now.

Bryant Thomas Karras
Although, orders between two labs seems like it could be No. 3.

Hans Buitendijk
Possibly, but we could do that and split it out. They are external. I could have it inside a hospital to my hospital lab, but in turn, that lab is going to go to an external lab.

Bryant Thomas Karras
The lab-to-lab may not be using an EHR. That may be two LIMS systems that would be certified. At any rate, I will leave it to you. Yes, that looks much better. Gillian, are you okay with that?

Gillian Haney

Yes.

Bryant Thomas Karras
I am sad that we are referencing 2.3.1 in a proposed rule in 2024, but…

Gillian Haney
[Inaudible] [01:25:07]

Bryant Thomas Karras
We need to have an association like the Immunization Registry that pushes for advancement and adoption of new standards consistently across the Electronic Laboratory Reporting (ELR) community. That will be our goal for this year. All right, let's turn all of this red text green and wrap it up for today. I think there was one comment from Erin at the bottom that would not be green. Is that right? We can scroll down… Erin is not on to defend this, so should we…

Gillian Haney
It looks like she was proposing adding this.

Bryant Thomas Karras
Is that a replacement for the language up above?

Gillian Haney
Yes.

Bryant Thomas Karras
It was the 2.3.1.

Gillian Haney
And it was this issue around the specimen stuff that was particularly important that she wanted in there, which I do not have a problem with.

Bryant Thomas Karras
Let's turn it green, then, after "Erin 8/26." And then, can you guys move that to No. 4 under "for orders"?

Gillian Haney
I think it is more of a general statement around public health.

Bryant Thomas Karras
It might actually be a replacement text for 2.2.

Gillian Haney
That is how I read it.

Bryant Thomas Karras
Okay. So, we can swap that in as a replacement for 2.2.

Seth Pazinski
We are going to have to wrap up, Bryant.

Bryant Thomas Karras
Okay, we will call it.

Seth Pazinski
Is there agreement on that last point?

Gillian Haney
I concur.

Bryant Thomas Karras
Hans?

Hans Buitendijk
Yes.

Bryant Thomas Karras
Okay. So, that last bit that we did from Erin is a replacement for 2.2. Thank you.

Seth Pazinski
So, for next steps, we are going to have our final meeting tomorrow, as I mentioned, so where we land with approved recommendations for the Task Force at the conclusion of the meeting tomorrow will be what the co-chairs will present for consideration at the full HITAC meeting on September 12th, so I look forward to everyone's participation tomorrow, and we will adjourn for today. Thanks, everyone.

Adjourn (01:28:19)

Questions and Comments Received Via Zoom Webinar Chat

Katrina Miller Parrish: 8/8 slide 16 - is this what we are discussing? Option 1: We could sunset the API FHIR limitation once all QHINs can support brokered FHIR.

Option 2: We could sunset the API FHIR limitation if all QHINs, Participants and Subparticipants support facilitated FHIR exchange.

Option 3: We could maintain the exception as is, regardless of FHIR API adoption among TEFCA entities.

Hans Buitendijk: Perhaps state that ONC provide guidance on what happens with data that a QHIN manages when the terminate being a QHIN, as well has how to advance FHIR consistently and completely across TEFCA.

Steven Eichner: I am happy to work offline with Hans, Derek, and others to improve the language.

Noam Arzt: I thought that QHINS (as QHINs) can't hold onto data, just transport it from point A to point B (or multiple points)?

Noam Arzt: Maybe I got that wrong...

Rochelle Prosser: Under HIPPA a QHIN can choose hold patient information and data. We did confirm this under the HIPPA act.

Hans Buitendijk: The purpose of QHINs is to enable exchange of data (and would have to hold data on patients and their record locations within the QHIN in some way). But the organization being the QHIN can also hold data, e.g., as an HIE. But I don't they are holding that data as a QHIN, rather as an HIE.

Steven Eichner: Noam, documents such as the Public Health Standard Operating Procedures outline at least one scenario where data may be retained. Please also note that retention may not be permitted by state or other laws, which take precedence over the TEFCA agreement.

Noam Arzt: I get that an HIO can hold data, but as Hans says, that isn't in their capacity as a QHIN, right?

Noam Arzt: I thought the PH SOP specifically says that a QHIN can't hold data...

Noam Arzt: I guess I have to look back.

Hans Buitendijk: There are QHINs (most I believe) that explicitly will not hold data beyond the necessary indexing/directory type data, but not the actual data.

Hans Buitendijk: To be clear, SynSurv uses HL7 v2 ADT messages, even though SynSurv are not ADT specific messages, as the data originally aligned with the HL7 v2 ADT message data set. That is why we are recommending that SynSurv switch sooner rather than later to FHIR to have more flexibility to address clinical content and not be communicated as HL7 v2 ADT messages and not be confused with ADT messages. So akin to eCR, but not part of eCR. Happy to discuss separately.

Jim Jirjis: Sandy Jones verified the cancer registry IGs are correct as referenced:

Pathology Laboratory Reporting:

• HL7 FHIR Cancer Pathology Data Sharing IG: https://hl7.org/fhir/us/cancer-reporting/STU1.0.1/

Ambulatory Physician EHR Reporting:

• HL7 FHIR Central Cancer Registry Reporting IG: https://hl7.org/fhir/us/central-cancer-registry-reporting/STU1/

• HL7 CDA Release 2 Implementation guide: HL7 CDA© Release 2 Implementation Guide: Reporting to Public Health Cancer Registries from Ambulatory Healthcare Providers, Release 1; DSTU Release 1.1 (US Realm), Volume 2 - Templates and Supporting Material, April 2015

Jim Jirjis: for the syndromic question: Karl verified the syndromic IG was correct as referenced:

> HL7 Version 2.5.1 Implementation Guide:
>
> Syndromic Surveillance,
>
> Release 1 - US Realm
>
> Standard for Trial Use
>
> July 2019

Noam Arzt: Back on QHINs, I guess I was remembering Section 5.4.a in the PH SOP: "Information transacted under the Public Health Exchange Purpose MUST NOT be persisted or Used by any Node along the transaction

chain that is not the addressed recipient, unless agreed to by the data source or recipient through a specific written agreement or as needed for a required audit as specified in the QTF." But I guess the "unless" give the escape clause I didn't quite remember.

Noam Arzt: I have red-green colorblindness. This spreadsheet is challenging to view for me. :)

Rochelle Prosser: Sorry to hear this Naom and apologize for adding difficulty to you review. We can address this internally to help our ADA members and general Public going forward.

Jim Jirjis: have to leave call for conflict.

Rochelle Prosser: Thank you for your contributions to this discussion jim

Katrina Miller Parrish: Might be good to do this level of editing on a document with tracked changes in the future, linking it in the spreadsheet.

Rochelle Prosser: welcomed suggestion Katrina

Katrina Miller Parrish: Strong work teams!!!

Questions and Comments Received Via Email

No comments were received via email.

Resources

HTI-2 Proposed Rule Task Force 2024
HTI-2 Proposed Rule Task Force 2024 - September 4, 2024, Meeting Webpage

Transcript approved by Seth Pazinski, HITAC DFO, on 9/30/24.