Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) PUBLIC HEALTH DATA SYSTEMS TASK FORCE 2022 MEETING

August 24, 2022, 10:30 a.m. – 12:00 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
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	Member
Hans Buitendijk	Oracle Cerner	Member
Heather Cooks-Sinclair	Austin Public Health	Member
Charles Cross	Indian Health Service	Member
Steven Eichner	Texas Department of State Health Services	Member
Joe Gibson	CDC Foundation	Member
Rajesh Godavarthi	MCG Health, part of the Hearst Health network	Member
Erin Holt Coyne	Tennessee Department of Health, Office of Informatics and Analytics	Member
Jim Jirjis	HCA Healthcare	Member
John Kansky	Indiana Health Information Exchange	Member
Bryant Thomas Karras	Washington State Department of Health	Member
Steven Lane	Sutter Health	Member
Jennifer Layden	Centers for Disease Control and Prevention (CDC)	Member
Leslie Lenert	Medical University of South Carolina	Member
Hung S. Luu	Children's Health	Member
Mark Marostica	Conduent Government Health Solutions	Member
Aaron Miri	Baptist Health	Member
Alex Mugge	Centers for Medicare & Medicaid Service	Member
Stephen Murphy	Network for Public Health Law	Member
Eliel Oliveira	Dell Medical School, University of Texas at Austin	Member
Jamie Pina	Association of State and Territorial Health Officials (ASTHO)	Member

Name	Organization	Role
Abby Sears	OCHIN	Member
Vivian Singletary	Task Force for Global Health	Member
Fillipe Southerland	Yardi Systems, Inc.	Member
Sheryl Turney	Carelon Digital Platforms (an Elevance Health company)	Member
Avinash Shanbhag	Office of the National Coordinator for Health Information Technology	Executive Director of the Office of Technology
Dan Jernigan	Centers for Disease Control and Prevention	Deputy Director for Public Health Science and Surveillance
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Jeff Smith	Office of the National Coordinator for Health Information Technology	Presenter
Daniel Weber	Centers for Disease Control and Prevention	Presenter
Paula Braun	Centers for Disease Control and Prevention	Presenter

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

Michael Berry
And good morning, everyone, and thank you for joining the Public Health Data Systems Task Force. I am Mike Berry with ONC and serve as the designated federal officer of the HITAC and this Task Force. All Task Force meetings are open to the public, and your feedback is always welcomed, either in the Zoom chat or during the public comment period that is scheduled at about 11:50 Eastern Time this morning. We have a very large Task Force that consists of HITAC members, federal representatives of the HITAC, and we invited several other subject matter experts to participate, and so, we welcome all of you and sincerely appreciate everyone offering their time and input for this important work. I would like to begin roll call of our Task Force members, so when I call your name, please indicate that you are here, and I will start with our cochairs. Gillian Haney?

Gillian Haney
Here.

Michael Berry
Arien Malec? I do not think Arien has joined, but we are expecting him, of course. Rachelle Boulton?

Rachelle Boulton
Here.

Michael Berry
Hans Buitendijk? I think Hans will be joining us a little bit later. Heather Cooks-Sinclair? Erin Holt Coyne?

Erin Holt Coyne
Here.

Michael Berry
Charles Cross?

Charles Cross
Present.

Michael Berry
Steve Eichner?

Steven Eichner
Present, good morning.

Michael Berry
Joe Gibson? Raj Godavarthi? Jim Jirjis?

Jim Jirjis
Here.

Michael Berry
John Kansky?

John Kansky
Good morning.

Michael Berry
Bryant Thomas Karras is not able to be with us today, but should be here next week. Steven Lane?

Steven Lane
Good morning.

Michael Berry
Jennifer Layden?

Jennifer Layden
Here.

Michael Berry
Leslie Lenert?

Leslie Lenert
Good morning.

Michael Berry
Hung Luu? Mark Marostica?

Mark Marostica
Good morning.

Michael Berry
Aaron Miri? Alex Mugge?

Alex Mugge
Good morning.

Michael Berry
Stephen Murphy?

Stephen Murphy
Good morning.

Michael Berry
Eliel Oliveira? Jamie Pina?

Jamie Pina
Here, good morning.

Michael Berry
Abby Sears? Vivian Singletary?

Vivian Singletary
Here, good morning.

Michael Berry
Fil Southerland?

Fillipe Southerland
Good morning.

Michael Berry
And Sheryl Turney?

Sheryl Turney
I am here, thank you.

Opening Remarks - ONC/CDC (00:02:31)

Michael Berry
Thank you, everyone, and before I turn the meeting over to our cochairs, we have two special guests with us today to provide opening remarks. Please join me in welcoming Avinash Shanbhag, the Executive Director of ONC's Office of Technology, and Dan Jernigan, who is the Deputy Director for Public Health Science and Surveillance at CDC, and I will turn it over to Avinash.

Avinash Shanbhag
Thank you, Mike. Good morning, everyone. Hopefully you all can hear me well.

Michael Berry
Yes.

Avinash Shanbhag
Thank you, Mike. Thanks for that audio check. First of all, again, let me add to what Mike mentioned. Welcome, all of you, to this Task Force, and also thank you to the HITAC members, the public SMEs, and our federal colleagues for volunteering for this Task Force. This is a very important activity, and we really appreciate the service that you are doing to this nation by really lending your expertise to this very important activity. We sincerely hope that the work that you will do will build upon the previous HITAC activities that were done and really will support the tremendous modernization activity that CDC is embarking on, and at this point, again, I would be remiss if I did not personally thank our cochairs, Gillian Haney and Arien Malec, for agreeing to be cochairs of this Task Force.

I also wanted to thank our CDC colleagues for not only being great partners with ONC, but also lending their support to these Task Force activities, along with our ONC staff. So, again, we appreciate that this team will be doing, we look forward to hearing from you all, and it is such an important activity, and we are looking forward to hearing and getting output from this Task Force that will have significant impact to the modernization of public health data systems in the country. So, again, thank you very much, I look forward to your work. I looked at the task that you all had and that was put in your charge. It is a lot of activity in a very short period of time, so I want to again thank you and also ensure that as you all work through your activities, please do not hesitate to ask for any support from ONC team that we can provide to make sure that you are able to do your work. Thank you again, and with that, I am going to turn it over to my colleague Dan Jernigan, the Deputy Director for Public Health Science and Surveillance at CDC, to provide some opening remarks. Dan?

Dan Jernigan
Great, Avinash. Thanks a lot. Thanks for reconstituting and bringing this group back together. I think as many of you know, just in the last weeks, our director at CDC has demonstrated her commitment to public health data as a core capability. We know that there were a lot of issues that were revealed at the beginning of the COVID response. We have had discussions with this group and with others over the last year as a part of our executive order response, and then, also, in standing up the Data Modernization Initiative to help really address those issues at this time because it is such an important for the director.

The work you are doing is a really critical component of getting us to better, faster data for decision making at all levels of public health, and so, the work that you will be doing, I think, is part of a set of CDC- and ONC-identified priorities that we are doing jointly. I really appreciate the collaborative work that we have been doing with ONC and think that effort is really going to be an absolute necessary component for us moving forward. We have to deal with the technological issues, but also with the policy issues, and try and find all of those different levers that we can use in order to get to that better, faster data.

So, it is great to see all the folks that have been brought together for this group. Many of you have been contributing to the inputs that we have been getting as we have been working on the implementation for the Data Modernization Initiative, and we are really looking forward to hearing the outcomes of this and how it feeds into this overall approach that we are taking to get us to a better place. So, with that, let me hand it back to you, Avinash, and the group, and thanks for coming and being a part of this, and we really look forward to the outcomes from this.

Arien Malec
Thank you.

Avinash Shanbhag
Thank you, Dan. Do I turn it back to you, Mike?

Opening Remarks - Co-Chairs (00:07:42)

Michael Berry
Yeah, we are going to turn it over to our cochairs, Aaron and Gillian, for their opening remarks as well.

Gillian Haney

I will go ahead and get started, then. Good morning, everyone. It is a real privilege to be with all of you on this Task Force. A little bit about me: I have a background in infectious disease epidemiology and surveillance, and a more recent foray in recent years into informatics. I recently joined CSTE, just over a month ago, but prior to that, I spent over 20 years with the Massachusetts Department of Public Health overseeing infectious disease surveillance systems and data, including the commonwealth's integrated surveillance and case management system, electronic laboratory and case reporting efforts, syndromic surveillance, and data visualizations.

The charge before us is very complex, and while public health and healthcare have similar goals, namely, the wellbeing of people seeking healthcare and those who live in communities in our jurisdictions, our perspectives do differ, as do our needs and uses of data. I think it is important to recognize a lot of progress has been made since the enactment of HITAC. Data are electronically flowing, but as has been demonstrated during the pandemic and again with monkeypox, public health is still not receiving the data we need to stop disease spread.

Public health response is federated. Historically, our funding has been siloed, which has resulted in some unique legal requirements and an uneven distribution of resources across program entities. The F criteria or domains that we will be assessing over the next few weeks have different requirements, different problems, and different data uses, and it will be important for us to document and explore these differences in order to make recommendations for measured improvements. I believe we can all agree that adherence to data standards for syntax and context are critical steps to achieving quality data that supports public health action and will also enable increased automation for both providers and public health. I think this, in turn, should lead us to improved relationships and better outcomes for both clinical and public health. Thank you. Arien?

Arien Malec

Thank you very much. I think this is a very exciting moment, and the watchword that I have for this Task Force is the notion of "without special effort." We are all used to interoperability pervading our lives. This call that we are all on is enabled through implementations of multiple standards, a truly absurd number of standards that are implemented in technology, some of which is controlled by Zoom and some of which is just the internet, and it all works, and it all works without special effort on our part, except for my unique challenges this morning, to make the technology work.

The process that we have had over the last three years, as Gillian notes, has proven that we can make public health data flows work. We have not yet proven that we can make them work without special effort, and so, we have a unique opportunity right now to look at the certification criteria that were established for the EHR program and contemplate a revision to those certification criteria, and also contemplate what it would look like to establish certification criteria for mostly the receive side in public health, and our watchword really should be what would it look like to ensure that information flows to serve public health, to serve the public need without special effort?

There is a set of concerns, I think sometimes, on the EHR side or the EHR implementation or provider side, and sometimes on the public health side… I think as we walk through this effort, we should walk in with a certain set of assumptions. Assumption No. 1 is that these are voluntary certification criteria. Sometimes, "voluntary" means attached to programmatics or attached to funding, and it feels involuntary, but in making

recommendations on certification criteria, we are not forcing any particular organization to take any particular action. What we should be doing is thinking about reducing the total expense and spend of taxpayer dollars and of health system dollars in order to enable effective public health data flows.

No. 2 is that I think sometimes there is a concern on the STLT side that establishing certification criteria is going to establish a tax on public health or an obligation to public health to spend money. Let's walk in assuming that we are going to wrap this around programmatics that make sense with funding mechanisms that make sense. No. 3, sometimes local autonomy is historically very important for public health, and there is a concern that certification and standards will reduce the flexibility that public health authorities have to doing their job, and the watchword that I would recommend is the notion of raising the floor, and if you raise the floor the right way, that does not prevent you from raising the ceiling.

And then, finally, we have an historic moment here. We have a limited amount of time, as I think we will see when we walk through the timeline, and let's make sure that we do not make the perfect the enemy of the good and make sure that we are putting together some truly foundational recommendations to the national coordinator to pass on to CDC and other agencies has part of HHS that advance the nation's agenda. And with that, I will turn it back over to you, Gillian, to lead us through the introductions and the charge.

Task Force Introductions (00:14:05)

Gillian Haney
Thank you, Arien. Why don't we have our Task Force members go in alphabetical order? I believe there was a slide. There we go. So, Rachelle, beginning with you, if you could limit your introductions to just 20 seconds, though. Thank you.

Rachelle Boulton
Sure. My name is Rachelle Boulton. I am with the Utah Department of Health and Human Services. I have been here for about 16 years. I started as an epidemiologist in pandemic preparedness and response, communicable diseases outbreak and response, and I am now working in informatics. I have experience with electronic data exchange, surveillance system management, and data quality.

Gillian Haney
I was not sure if Hans joined.

Hans Buitendijk
I am on, if you can hear me. I am on the phone.

Gillian Haney
We can, welcome.

Hans Buitendijk
Okay, great. Good morning, and thank you very much for having the opportunity to join. My name is Hans Buitendijk. I am the Director for Interoperability Strategy with Oracle Cerner. I have been in the HIT/EHR space since the mid-'80s and have, as of late, focused on a variety of different interoperability topics on how to advance that and represent Cerner and the industry in a variety of areas. Specifically in this context,

I am currently chair of EHRA, a group of EHR vendors, and within that, I co-lead the public health Task Force, where we are focused on a variety of issues like the ones we are talking about here, and other than that, I am very active in HL7, Care Quality, CommonWell, a variety of HL7 accelerators, including the HELIOS accelerator, where I co-lead one of the tracks. So, with that perspective, I am hoping to be able to support and help move this capability forward. Thank you.

Gillian Haney
Heather Cooks-Sinclair?

Heather Cooks-Sinclair
Hi, I am Heather Cooks-Sinclair. I am with Austin Public Health here in Texas. I am the Epidemiology and Disease Surveillance Manager. I have been with Austin Public Health for 16 years, ranging from starting at the Office of Vital Records, who does our issuance of birth and death certificates, all the way through as an epidemiologist for about 10 years, doing all chronic vaccine preventables, preparedness, etc. Then, I spent the last five years doing surveillance, working with accepting our labs from all of our providers and all conditions with the exception of TB, and I have just recently taken on the management job within the last six months.

Gillian Haney
Okay. Erin Holt Coyne?

Erin Holt Coyne
Hi, I am Erin Holt Coyne. I am the Chief Public Health Informatics Officer with the Tennessee Department of Health. I serve as our data modernization director or director of our core informatics unit within our Office of Informatics and Analytics, and I have been with the department for about 17 years, and I started actually similarly, as an infectious disease epidemiologist and working in tuberculosis, HIV, hepatitis, outbreak response, and preparedness. I am an active member of HL7 and have been participating in the public health workgroup since 2011, and I have been serving as a cochair of that workgroup since 2015. I am also an active member of the Council of State and Territorial Epidemiologists, where I serve as a cochair of our data modernization workgroup.

Gillian Haney
Thanks, Erin. Charles Cross?

Charles Cross
Hello, I am Charles Cross. I am the Acting Director for the Division of Information Technology for the Indian Health Service. We are the division that develops our EHR, which is called RPMS.

Gillian Haney
Thank you. Steve Eichner?

Steven Eichner
Hi, I am Steve Eichner. I am the health IT lead for the Texas Department of State Health Services. I have been at DSHS for a little over 15 years, also serving as a HITAC member for the next couple of years,

which I am honored and privileged to serve on. I have engaged with HL7 in a variety of workgroups, and I am really happy to be here. Thank you much.

Gillian Haney
Joe Gibson?

Joe Gibson
Hi, I am Joe Gibson. I am currently at the CDC Foundation, but just as of a couple weeks ago. Most of my career was at the Marion County Public Health Department, serving Indianapolis as Director of Epidemiology, and while there, I did a lot of work with the Regenstrief Institute and Indiana Health Information Exchange on leveraging EHRs and HIEs for public health, a lot of work on national public health informatics projects, syndromic surveillance development, chaired NHO's informatics workgroup for a long time, and before I came to public health, I worked in pharma for about eight years, working on quality of life, working with healthcare plans around **[inaudible] [00:19:24]** so I have spent a lot of time with healthcare data.

Gillian Haney
Rajesh Godavarthi? Rajesh, are you there?

Arien Malec
I do not think he is here, Gillian.

Gillian Haney
Okay, thank you. Jim Jirjis?

Jim Jirjis
Hi, I am Jim Jirjis, an internist at CHIO at HCA, responsible for a variety of informatics things, but one of them is our public health reporting and our interoperability programs here at HCA. As you mentioned, Arien, about no special effort, I have a brief presentation outlining the incredible special effort it took us to be compliant with even the simple reporting, so this is such a key, important topic, and I am glad to be here. Thanks very much.

Gillian Haney
John Kansky?

John Kansky
Good morning. I am John Kansky with the Indiana Health Information Exchange, but I am also the former CIO at the Marion County Health Department, which is the most populous county in Indiana. Organizations like IHIE increasingly are working hard to support public health and enabling electronic public health transactions, including surveillance and reporting, so I am very interested in the work of this committee. Thank you.

Gillian Haney
Thank you. As noted, Bryant will be joining us later. Steven Lane? Steven? Okay. Jennifer Layden? Jen?

Jennifer Layden
Hey, everyone. Jen Layden. I serve as the Associate Deputy Director for Public Health Science and Surveillance at CDC. I am an infectious disease physician and epidemiologist. I joined CDC two years ago and, prior to that, was the State Epidemiologist and Chief Medical Officer for Illinois Department of Public Health, as well as served as the Deputy Commissioner for Chicago Department of Public Health. Good to meet you all.

Gillian Haney
I believe we have Steven Lane back.

Steven Lane
I have been here. Can you hear me?

Gillian Haney
Now we can, yes. Welcome.

Steven Lane
I have no idea why. Hi, I am a practicing family physician and clinical informaticist at Sutter Health in northern California, where I am Director for Privacy Security and Interoperability. At the national level, I have the opportunity to serve on the HITAC. I am on the board of Sequoia, the chair of the care quality steering committee, and also work with HL7 and Direct Trust. I had the opportunity to serve on the prior Public Health Data Systems Task Force in 2021, where we actually recommended another Task Force to look at the issue of public health data system certification, so I am really excited to be here. Also, with Arien, I have had the chance to cochair the Interoperability Standards Workgroup. So, I do have an MPH and a long-term commitment to public health and public health interoperability. I have had a chance to work with CDC and APHL on the Electronic Case Reporting Project over the last couple of years. I am really happy to be here and off mute.

Gillian Haney
Thank you. Les Lenert?

Leslie Lenert
Hi, I am Les Lenert. I am the Vice President for Data Science and Informatics at the Medical University of South Carolina. I am a physician and a researcher. I have about a 30-year career in informatics. I have done a lot of different things in that. I am currently on the HITAC, and I was previously on our Public Health Informatics Advisory Committee, but probably my strongest link was when I was the Center Director at CDC for Public Health Informatics when that was in place.

Gillian Haney
Hung Luu?

Michael Berry
I believe he was not able to make it today, Gillian.

Gillian Haney

Okay, thank you. Mark Marostica?

Mark Marostica
Yes, I am Director of Conduit Public Health Solutions. I have had the privilege for the past 20 years of supporting public health departments in the U.S. and internationally at the federal, state, county, and city level, working with them on their journey of modernization, and not only their disease reporting system, but syndromic surveillance systems, as well as connectivity to laboratories and EHRs. I am absolutely thrilled to be part of this and look forward to working with everybody. I see some familiar faces, and hopefully I can make a valuable contribution. Thank you for having me.

Gillian Haney
Thank you. Aaron Miri?

Aaron Miri
Good morning, Aaron Miri, Senior Vice President/Chief Digital Officer at Baptist Health in Jacksonville, Florida, also cochair of the HITAC. I also served on the board of CommonWell. I have also been part of a number of standards committees and so forth over the years. I have been very much attached to the drive for interoperability around public health, even in my prior role at UT Austin, partnering with Austin Public Health and others, as we drove a lot of the contact tracing across the city together with APH, so I got very familiar with the opportunities that present themselves to us and look forward to taking on those opportunities in this call to action and really coming out with some good results, so thanks for having me here.

Gillian Haney
Alex Mugge?

Alex Mugge
Hi. Alex Mugge, the Director of the Health Informatics and Interoperability Group at CMS, and also the Deputy Chief Health Informatics Officer, and we have worked with ONC over the years on implementing a number of different informatics and interoperability efforts, and look forward to putting some of this work towards the public health data systems and seeing how we can help and in what ways CMS can support this effort. So, thanks for including us.

Gillian Haney
Stephen Murphy?

Stephen Murphy
Hi, good morning. I am Stephen Murphy. I am an attorney licensed in Illinois and California. I am a Senior Public Health Attorney with the Network for Public Health Law. We are an organization that is dedicated to advancing public health through the use of law, and I focus on data privacy and public health law generally. Before the network, I was with the Chicago Department of Public Health as an attorney, focusing on mostly data privacy and public health authority, and I was the HIPAA Privacy Officer for the City of Chicago. Nice to meet you all.

Gillian Haney

Eliel Oliveira?

Michael Berry
I do not think Eliel was able to make it today, Gillian.

Gillian Haney
Okay. Jamie Pina?

Jamie Pina
Hi, good morning, everyone. I am Jamie Pina. I am the Vice President of Public Health Data Modernization and Informatics at the Association of State and Territorial Health Officials, or ASTHO. In that role, I work to support the state health officials across the country to help them understand the different aspects of data modernization and informatics that affect their work, and I have been working in the space of public health informatics for about 20 years, where I have worked in lots of different projects and with lots of different organization. I am also an Adjunct Professor at the Rollins School of Public Health at Emory, where I teach informatics, and I am thrilled to be on the panel. I know that our members have a lot of questions and insights about certification, and I am excited to bring those to the panel, and I look forward to working with and meeting you all. Thanks, Gillian.

Gillian Haney
Thanks, Jamie. Abby Sears? Abby? Maybe she is having technical difficulties. We will circle back. Vivian Singletary?

Vivian Singletary
Sure. Good morning, and thank you for inviting me to be a part of this wonderful, esteemed panel. My name is Vivian Singletary, and I am the Executive Director for the Public Health Informatics Institute. I have been with PHII for 11 years and, more broadly, working in the field of informatics and information systems for about 30 years, so I look forward to bringing very practical ideas and solutions that link together people, processes, and technologies, and look forward to working with you all. Thank you.

Gillian Haney
Fillipe Southerland?

Fillipe Southerland
Hi, good morning, everyone. Fil Southerland. I am Director of Healthcare Solutions at Yardi Systems. We are in electronic health records, servicing about a half million lives in the long-term, post-acute care space. Prior to joining Yardi, I ran a health-related startup, and I am a first-year HITAC member and honored to part of the group.

Gillian Haney
Thanks, Fil. Sheryl Turney?

Sheryl Turney
Good morning. Sheryl Turney. I am the Leader for Interoperability for Elevance Health. For those that are not aware, that is the new name that Anthem has taken on, and I work for the Carelon Digital Platforms for

Organization for Elevance Health. I also have participated in this workgroup in a prior year, and I am an active participant in Da Vinci as well as FAST, and am newly working on the Gravity Project, and I have been working with HITAC since its inception, and am very interested in moving this topic forward, so, thank you, and I am looking forward to our work.

Task Force Charge, Planning (00:29:35)

Gillian Haney
Thanks, Sheryl. Has any member joined who did not get a chance to introduce themselves? Okay, well, thank you, everybody. It is quite an illustrious group, and I am really looking forward to everything that you will be bringing to the conversations. I will just spend a few minutes going over what our charges are, if you will. As I mentioned, it is going to be quite a complex set of discussions coming forth. Next slide, please.

As indicated on these slides, we have been given quite a charge to really build upon the recommendations of the previous HITAC meetings and Task Forces and to continue the collaborative work with CDC on improving our data systems. All of this will be in support of CDC's data modernization efforts. Specifically, we are going to be looking at the different public health certification criteria, known as the F criteria, that have been outlined in ONC's IT certification program, and this is working to board certify the transmission of data to public health agency.

We will be looking at the different gaps in functionality and standards in those existing criteria, and specifically looking at gaps in functionality, implementation, implementation by developers. I think it is important to note that there will be different issues that will be brought up within each of these different domains. We will be looking to provide recommendations for advancing criteria, testing guidance, and/or standards to address these gaps.

Secondly, we will be looking at and assessing the specific functions, such as receipt of data, ingestion of data, analysis of these data, that are supported by public health data systems and those that would benefit from further standardization and potentially certification. Lastly, we are going to be recommending which data flows are aligned with existing criteria and those that should be prioritized for standardization of receipt of data. I would like to also mention that one of the things that is not outlined in the specific charge, but everything that we will be working for, is to drive quality data for public health action. Any comments on these charges?

Arien Malec
We will have a chance to do a discussion session at the end.

Gillian Haney
We can pause on that. So, we do have a panel of experts in our current state, and I will turn it over to Arien to introduce them.

Current State (00:32:15)

Arien Malec
All right. So, we wanted to make sure that we heard from public health practitioners, from the provider community, as well as from ONC, so I would like to turn over to give a perspective on the public health side

of the last three years of interoperability supporting public health to Erin. Erin, if you can lead us through. As a reminder, these are meaty topics. We are going to limit the presentations to no more than five minutes, so I will do a time check at some point, but let me turn it over to you to give us a state of the union in terms of public health interoperability from the public health perspective.

Erin Holt Coyne
Sure, thank you for the opportunity. So, as Gillian mentioned, the whole goal was for all this activity, this special effort, if you will, to provide data for public health action. We need to get the right information in the right hands at the right time. Manual data entry is burdensome for everybody involved, both sides of the coin, and resources are limited. We need more people practicing public health and doing less data entry. Regardless of our interfaces, success has been largely dependent upon completeness, accuracy, reliability, and timeliness of our data inputs, and regardless of interface, efficiency is impacted by the conformance of those data files received.

We routinely hear two main perspectives when it comes to challenges with public health electronic data exchange. One is there is too much variation across public health jurisdictions, and two, data received by public health is often incomplete and not standardized, so we are talking about variation across jurisdictions and problems with quality. When we talk about variability, there are really two flavors. Jurisdictional variability, certainly, what is reportable, where, how it is reported, deviations in variability and local technical specifications, and there is this constant balance between standardization and jurisdictional legal authority and reporting requirements that has to be met. We have to find that sweet spot.

In addition to jurisdictional variability, there is also programmatic variability. Many of our public health agencies operate a wide variety of public health programs, many of which are supplemented or completely supported by categorical federal funding, oftentimes leading us to situations where we have program-specific requirements and program-specific solutions, which can lead to potential redundancy and inefficiency in our leveraging of those resources.

There are two key things I wanted to point out that I think have demonstrated public health's willingness to help address that variation, and those specifically include electronic case reporting. I think it was back in the 2014 timeframe that the Council of State and Territorial Epidemiologists stood up an ECR Task Force to develop specific data requirements around case reporting, and it was our charge, and we made it a requirement that it had to support any reportable condition for any jurisdiction in leveraging the data expected to be supported in electronic health records.

Much of ECR today is handled through the AIMS platform, which has onboarded over 14,600 reporting facilities as of 8/22 into production for jurisdictions across the country, which is amazing. We are able to leverage ECR beyond COVID and notifiable conditions for other reportable conditions like, say, drug overdose or opioid overdose, to minimize a number of separate reporting mechanisms needed in standardized reporting.

The second area I would like to highlight is specifically in regards to the American Immunization Registry Association and their IIS measurement and improvement program. It started in 2015 with coordination with CDC, completely voluntary, and they have participation from almost all jurisdictions, I think maybe with the exception of one, and it is really focused on alignment with standards and providing guidance and support

for the improvement, and improvements in standardization across the IIS are broadly recognized within that community.

So, what are some specific challenges that we have? Jurisdictional public health spends a lot of time and resources in making special effort, if you will, to facilitate onboarding of our many partners and readying received data for use. Much of that time is spent validating file syntax and semantics, mapping vocabulary, validating and troubleshooting content with partners, translating files, serial debugging, pre- and post-production implementation, de-duplicating and updating patients and events. Onboarding and maintenance of these interfaces also prove challenging due to constant staff turnover for both partners, facilities being bought and sold, coordinating release schedules, and accommodating the evolving needs and evolving standards.

With that in mind, two additional challenges that we face are really centered around conformance or lack of conformance and issues with data quality and data completeness. When we talk about conformance, I will speak for myself and say we learned a lesson from EHR certification, and that is that you cannot always rely on the fact that an EHR certified is an indication of whether or not the interface is going to meet the expected conformance in implementation. You cannot necessarily just make that assumption.

There is a lot of optionality and ambiguity in the standards, which can lead to wide interpretation of those standards for implementation, and largely, a lot of our conformance has focused on syntax, but not as much on content and quality, and we really need to get to content and quality in order to be able to use this data for action, and this really results in processing burden leading to delay, and frankly, further variation. The other challenge that we have to be mindful of is in regards to data quality and completeness. Missing patient address is one that plagues public health small and large, across our entire spectrum, across all of our programs. When we receive information coming in as reports, one of the very first things that we do once we are able to actually use the data is assign public health jurisdiction, and that is to allow our public health staff to utilize their distributed resources across our state, across our jurisdiction, to carry out those investigation activities, transmission mitigation, and interventions. It is absolutely critical, and it causes delay when that information is missing.

Additionally, missing race and ethnicity has also been a challenge, and I invite you to reference the CSTE report titled “Addressing Gaps in Public Health Reporting of Race and Ethnicity for COVID” that was published in April ’22 for more detail, but we have problems with completeness, variation in coding, and value sets that are used, also variation in how folks support the handling of multiple races, and we see a lot of other and unknown values that really are just not usable, especially when you know that that information is known or available.

Arien Malec
Erin, quick time check.

Erin Holt Coyne
Sure. How much do I have left?

Arien Malec
You are a minute and a half over.

Erin Holt Coyne
Ah, okay. I will just finish by saying some considerations that I think are important are that we need to allow for evolution; we need to build systems that are scalable and extensible. FHIR is the new CDA, standards continue to evolve, we need to not necessarily be putting our eggs in a silver-bullet bucket, and we need to have some accountability for meeting interoperability standards on both sides of the coin, and we need to leverage lessons from existing certification programs, what worked and what did not.

Arien Malec
Thank you so much. Jim, over to you.

Jim Jirjis
Thank you. Hit the next slide, if you would. So, I represent HCA. We have about 190 hospitals in 22 states, so when we found ourselves in the midst of the pandemic, we were a little bit of a microcosm because of the number of states we are in. It gives us an interesting eagle eye on the variation. And so, what I wanted to walk you through a little bit is we talk about special effort, Arien mentioned we have proved we can do stuff, but we have not proved we can do it without special effort, so most of our efforts were special effort, and I just want to cover and give people a barometer of that.

So, just so you know, we have about 2,000 sites of care across the U.S. from Alaska, to New Hampshire, to Miami, to San Diego, and most places in between, 22 states, and we had a diverse experience, as you can imagine. This will not be new to many of you, but not only did we have to deal with federal reporting, but each state's public health department had different requirements and interfaces. Some of them did not even have an interface. But even beyond that, for example, in California, we had Santa Clara County that had a lot of public health data needs that were divergent or different than others, and so, for a provider in the middle, when you talk about special effort, every single one of these is an interface with different requirements, different implementations, different readiness, and need to test and troubleshoot. It becomes a very untenable many-to-many situation. There were differences in the frequency of reporting and the format type as well. Next slide.

This is a depiction of us, the provider in this game, and the public health departments are off to the right. The left is all the data sources. Now, mind you, before you look at this, we are just here focusing on COVID-19 test results as a single data element, Erin, to your point about things not being standardized or complete. And so, one of the things we found is when we were actually pursuing this, each of the sites that the laboratory companies that would do testing, and we now have tallied about 225 different lab testing companies that we received results from, zero of them actually report mapping to national standards like LOINC. We have to do that mapping ourselves.

The hospitals were rapidly changing methodologies. Here is an interesting one about completeness. If we get a patient admitted to the hospital, sometimes we do the testing, and it is in our EMR, and of course, we can send it, but sometimes they were tested somewhere else, they get sick, they are admitted to us, and we have to figure out how to get that result from the place it was tested and get it into our system so that we can then have it be part of the reports. That was a huge undertaking. We had to identify what we called a COVID czar, data czar, and in every single patient, we had to track this so that you had complete data, Erin, right? And we can see the variety here.

So, these are different-colored and different-sized arrows because there was a whole team focused on even identifying a new lab mnemonic from one of our hospitals that it represented a COVID test and what it meant. We had to map all that to value sets so that we could do the reporting, so that is Step 1. Step 2's special effort is if you have seen on public health interface or department, you have seen two, or you have seen a half. You have seen one. So, what we found is five states did not even have an interface yet because meaningful use had not really required it of either of us, but in all the other states, because the burden was on us to report, if the state did not have an interface, then we felt obligated to fax them, which they did not want, just so we could be compliant.

And so, what we found is these gray arrows were also whole teams that were having to babysit the different interpretations, different data needs, and test the interfaces and troubleshoot, an enormous amount of effort. You can see off to the right here a high variety with all of these point-to-point interfaces of the readiness of the recipient. There were we did not have a contract, there are months of contracting that have to be done, different data definitions, interfaces, etc. You get the trick here. Next slide. So, one of the main points is if you just focus on the EHR, and I know none of us probably are, you do not take into account the data edit source, then the intermediary has an enormous amount of special effort just to make sure we are complete, that we collate, we map, and then we transmit, and even the transmissions right now are many-to-many, point-to-point interfaces, just a totally unideal system.

So, I know we are running short on time, but here are some of the challenges. Redundancy: The opportunity there is coordination between state, federal, and local jurisdiction, enabling fewer point-to-point connections. We hope that we do not have a whole bunch of hospitals who have different capabilities having to interact with different public health departments that have all different capabilities and approaches. We would like to see a situation where it was a many-to-one and a one-to-many, like is there a trusted intermediary that is technically sophisticated so that all the providers could actually interface with one entity, and then, that entity is expert on interacting with all the public health departments, whether that is a QHIN, a report stream, or whatever.

There is a lot of process variation. It is not enough to say semantic and syntactic, but how people interpret and process is very different. Consistency in data collected would be an opportunity in its format, and embracing emerging technologies as well as the transport methods. I think we are all aware of resource constraints, and then, manual data collection. So, if you go to the last slide, here are what we consider some considerations for ideal use case, for example: Develop and ensure agreed-upon standards for both technology, process, and the data set data model. It has to be a lot more prescriptive, I think, more aligned with standard.

Really, addressing this problem of many-to-many. Each one of the arrows on this slide is special effort. Finding a better architecture that actually allows providers to interact with a single expert entity instead of interacting with 22 different variable entities. Same data, many purposes: One of the notions here was if providers could just know what the full sum of data reporting was, report that, and then the intermediary could be responsible for distributing that appropriately with permissible use. That is a model I know Report Stream is looking at.

And then, the main message here, too, is if the incentive and the certification is only on one player, like the provider, then it creates perverse incentives where, in fact, the provider is on the hook with all the special effort. If you do not include those who are generating the data, lab companies mapping everything to LOINC, for example, so that we all do not have to do the special effort, so lab companies are one, but if you look at the White House Task Force reporting, when we are looking at supplies, even EHR systems, none of those externalize the kind of information that we need, so our recommendation is if we are going to be successful, we have to look at all the different data sources and determine how to actually map the data early in the process and standardize the interfaces, etc. in a new model that gets away from the many-to-many. If you do not do that, no matter how you slice the pie, there is going to be a lot of special effort on the data's journey from its origination to Erin and the public health departments.

So, just some insights from those who are still living in the trenches, and just so you know, because curation has to happen, I still have a team member that has to do about an hour of work on Monday through Friday, but also, on Saturday and Sunday, has to spend about an hour and a half to do some of that special effort to get these reports out, and with that, I close.

Arien Malec
Thank you, Jim. I appreciate it. Jeff, over to you on the ONC perspective on the current state of the F criteria. And again, we are running a little bit behind, so, hopefully you can catch us up. Thank you.

Jeff Smith
Okay, sure thing. So, I am just going to spotlight a couple things. I know you have these slides, and obviously, we are going to be here for the duration of this program and the Task Force, so we are happy to come back and provide additional information, but I have a couple of things that I will harp on here. Our program does have 400 products, and it is used by numerous federal programs. I think that is important to note. We are not just promoting interoperability for CMS, but there are multiple federal programs that we support. Next slide, please.

Here, I think it is important to note that we do provide roughly 60 certification criteria spanning, of course, a suite of public health, F criteria, which, again, we will go into later, but I think it is also important to note that ONC adopts health IT standards on behalf of the HHS, and currently, we have about 50 or so standards spanning transport, vocabulary, and content exchange. And then, last, the third component of the certification program has to do with conditions and maintenance of certification requirements, which really do speak to the business and behavioral aspects of the equation of interoperability. Next slide, please.

So, it is important to note that our certification program is inextricably linked to the regulatory process and regulations, and it obviously has some pros and some cons. I think we all acknowledge that it takes a long time to work through the regulatory cycle, but once we have those requirements in place, they are binding, and I can tell you in talking with other certification programs, that is actually a really important piece of the puzzle. On the left side, you can see the regulatory process, which I will not belabor, but on the right side, you can see how the regulations get put into place. We run what is called a third-party conformity assessment scheme, and we have a lot of actors and processes that are underpinned by various ISO and IEC framework standards, and really, all this is to say that we do not just make this up, we follow widely adopted and broadly applied standards for product certification. Next slide.

Okay. So, here is the journey for interoperability if you are a health IT developer. I will not read this word for word, but what I will say is that it is important to note that we have authorized testing labs and authorized certification bodies, and these are the primary entities we work through in order to certify products. It is also important to note that we have nongovernmental alternatives that help developers demonstrate conformance to the certification requirement. We recently announced that Drummond and Aegis are an alternative testing method for the API criterion June 10. We have longstanding alternative test methods for e-prescribing, and also for immunization reporting through the AIRA HIMSS immunization integration program. So, what I would like to make sure you understand here is that we have the scaffolding and infrastructure to do things both inside as well as acknowledge activity that is outside of the federal government.

And then, I would also say here at the end, the last stop on the train here, under providers and hospitals, Erin, you did an excellent job in pointing out that programmatic requirements are an essential component of getting the certified technology used. We are a voluntary certification program, and so, there has to be some kind of programmatic hook or funding mechanism that would compel the use of certified technology, and I think that is a really important piece to understand. Okay, next slide, please.

Okay, so here are the F criteria in their full glory. I will point out a minor mistake here at the bottom. We say all criteria point to specific standards and implementation guides. That is untrue. For the F5 transition to public health agencies for electronic case reporting, there are currently no standards there. However, we do reference ECR NOW as an implementation specification that, if a developer used it, we would acknowledge it as working for certification. I would also note that these criteria are eligible for SVAP, and I think if you would like to have us come back and talk a little bit more about SVAP, we can spend more time on what that is, but it allows the industry to move forward on standards that have been previously adopted by the secretary, and I think this is going to be an important component for the organization for certification moving forward. Next slide.

Okay, the next to last thing here is it is important to acknowledge that we have test tools here for these things. The test tools really do mirror what the implementation guide requires, and so, if the certified technology does not do what you would like it to do and it does not test what you would like it to test, you have to look back at the implementation specifications and the standards upon which these rely, and I really cannot stress that enough. The implementation specifications are the bedrock, and then, the test tools are built to test the implementation specifications. So, again, there is currently no requirement, no test tool for F5, and certified EHR technology can be certified to F5 through what we call adaptation. Next slide.

All right, I think this is the last slide, so I am trying to get everybody back on track here. A couple high points of what the F criteria do. They do represent means by which certified technology is expected to generate a report and transmit a report, and so, I think it is important to think about it in terms of those two big buckets. The F criteria do require health IT modules to adhere to specific standards and implementation guides. We name these in regs, we can update them through regs, and we can use our SVAP process to provide a setter step when there are new standards out there, but that is a voluntary process.

Last but not least, they provide assurances that health IT modules, AKA the product, perform as intended, and I think these are all important to think about in comparison to what they do not do, which is cover all the functionalities that may be of interest, and I know that the IIP has a certification that tests a whole bunch

of other functionalities beyond what ONC requires. We do not, through certification, certify data quality, nor do we certify the entity or the organization using the technology, so these are all important things to keep in mind. And with that, I think we are almost back on schedule.

Arien Malec
I really appreciate keeping us back on track. Gillian, I think you have a proposal.

Gillian Haney
Yeah. I was going to provide a bit of an overview of public health informatics, but I think that given my earlier comment about the fact that each of these different criteria have such unique data needs, uses, and sources, I think it would be appropriate to actually table that and explore the state of informatics within each of those specific domains as each meeting goes forward, so I would like to propose, actually, that we table that and move on into some discussion points about what we just heard and where we are headed.

Arien Malec
Perfect. So, I am going to facilitate a Q&A or discussion table. I would like to ask folks to use the hand-raising feature, which you will find at the bottom of your toolbar, for the Zoom meeting. Oh, sorry. Daniel, would you want to give us a quick overview of current state from the CDC perspective? I apologize, I was working off of a slightly older version of the slide for the agenda. Daniel, I would appreciate if you could go through a rapid run.

Daniel Weber
Yeah, absolutely. So, I would like to skip ahead three slides, just in the interest of time, and I will try to go through this rather quickly. Next slide please. All right. So, through the Data Modernization Initiative assessment funded through the ELC CSELS coag, we are trying to support data modernization throughout the 64 funded ELC jurisdictions. We primarily support them in three different ways, as laid out on this slide. We can go to the next slide, please.

All right. So, the data being presented today is from the assessment responses from 64 recipients as of May 2nd, 2022. Assessments were completed by jurisdictions on a rolling basis between November 2001 and May 2002. We are primarily going to be focusing on the current state of activities and systems, including data exchanges, processes, and systems. Can we skip ahead to the next slide? Next slide, please. All right, so, we are going to start with the current state here. So, as you can see, the original question was “Has your jurisdiction conducted any of the following activities?” This section includes questions about the activities that assess health information systems and outcomes through the assessments. Actually, in the interests of time, can we skip down to the next steps so I can just provide a verbal update of all of these slides?

In general, the assessment was funded in order to help provide support to the jurisdictions to help them identify what they need, and then, in general, the next step from this assessment is going to be that we will analyze the qualitative responses and look at both quantitative and qualitative data by meaningful groupings, such as by geographic regions and size and type of jurisdiction. We are going to then evaluate the assessment instrument and process to see how well it served the needs of the jurisdictions, and then, we are also going to assess how CDC can use this information and other information from the jurisdictions to learn how we can better support their data modernization activities. There are some really great,

meaningful charts and graphs that I will make available to the attendees of this meeting post the meeting, but in the interests of time, I think we should move on. Thank you so much, and apologies.

Arien Malec
Paula, do you want to give a rapid tour through your content?

Overview of Public Health Informatics Projects (01:00:52)

Paula Braun
Yeah, I am happy to do that. I was asked to speak about some of the efforts that we have from the Data Modernization Initiative side at CDC to help address some of the comments that were raised. I think the most important point I want to get across here is that we do have opportunities in hand to help raise the bar, so that way, the kinds of innovations that we saw during COVID can be deployed more broadly without special effort, and so, some of the things that we are doing are obviously working side by side with CDC, ONC, and CMS to make sure that the signals we are sending to healthcare are strategic and aligned. There has been a lot of healthy discussion here today about that in ways that the Standards Version Advancement Process could be a benefit to everybody involved.

Similarly, we are working to put forward common data elements through the U.S. Core Data for Interoperability and the recently announced USCDI Plus, so that way, we can have a better sense of the totality of the information that is valuable to public health, and that is something that will continue to evolve over time, and we are working side by side with partners from across healthcare and the private sector through things like the HELIOS FHIR Accelerator for Public Health so we can have a better understanding of not only what exists today, but what has momentum and buy-in beyond public health so we can benefit from that.

Thirdly, we are looking at the networks that exist and that are emerging through the Trust Exchange Framework and Common Agreement and the QHINs that are being stood up under that structure, and so, through the formulation of public health use cases, hopefully we can begin to arrive at some workable solutions that shift the burden from each individual public health jurisdiction toward things that can be taken on more broadly by the market.

And last but not least, we are committed to making sure that the platforms and the services that we offer to our state health departments and other members of the STLT community are abiding by open architectures and open APIs, so that way, we can deliver the functionality that they need and the flexibility that they need in a way that helps overall to save time, money, and effort, and while most of the discussion here today rightfully is focused on the exchange of data between public health and healthcare, I think we also have a real opportunity here to think about how these standards can show the public the value of what happens when their data gets sent to public health, so I think thinking about it more broadly with that lens will help us move forward and help us make some tough calls about where we are today and what will help us get us to that future state. Thank you.

Discussion (01:03:48)

Arien Malec

Thank you so much. Now is a good time to transition to facilitated discussion. I think we heard through these presentations a really good reflection of life on the ground, which, as I noted up front, we have been able, through substantial effort, to address the mission of public health in a crisis. We have consistent issues where we have fallen down in terms of supporting data for contact tracing, supporting demographic race, ethnicity, and other data that facilitates looking at the equity of our public health response or getting a better view on disproportionate impact of disease burden and infection burden on populations. We have significant gaps in terms of programmatic variability, in terms of variance between deployed standard and implemented standard between deployed data or tested data and implemented data, and where intermediaries exist, particularly the AIMS platform and APHL, they have greatly facilitated the information exchange and overall burden for participation, and then we have emerging bright spots, things like ECR, where we are left out of certification.

And then, I think the important point that where there are gaps in certification, we need to go back to the implementation guidance and make sure the implementation guidance really addresses the semantic needs of public health, and then, as I noted, I think sometimes, we have used certification in a lab environment, but have not addressed real-world certification, and there is an urgent approach or need to ensure that we take an ecosystem approach and that we get data quality addressed at source. So, those are some of the high-level comments. Gillian, other comments that I missed in my broad summary of the testimony today?

Gillian Haney
No, I think that was perfect. The only thing I think I would add is that public health is receiving data from all of these different sources, and in addition to having complete information, it is important to note that the information comes to us at different points in time, and we are trying to synthesize this information and make sense of it in real time to be able to provision data to CDC. But, I am sensing some consensus, actually, already from the group about the need to have further standardization, the need to perhaps even tighten up some of the existing standards and repurpose from another criteria, as well as a drive towards data quality. I see hands are going up, Arien, so I will turn it over to you for facilitation.

Arien Malec
All right. Again, just a reminder to use the hand-raising feature if you are able to, and if you are not able to, we will go through the hands raised first and then do a call for folks who are not able to raise their hands. So, Les, you are first in the queue.

Leslie Lenert
That is interesting. I did not think I was that fast on the draw. I wonder whether longitudinal data needs to be in scope, both within an individual and a provider, over time, and also across providers. The reason I mention this is one of the things that ECR seems to be about from the architecture is delivering the best data possible at the point in time that the criteria for reporting are met, but the cases evolve over time, and our understanding of COVID really was limited by a lack of data in the longitudinal impacts, which seem to extend possibly over the lifetime of certain people, and that gets to those issues of if there needs to be more than one reporting event and if there needs to be the ability to link events across providers.

Arien Malec
Yeah, and as a comment to that, I think there are overlapping needs for public health in terms of public health response, and then, in terms of real-world evidence and research needs to address, for example,

things like the MMWR and ongoing case reports. I am going to let Gillian comment on this because I think one of our touchstones for this Task Force is that we should primarily serve the needs of the STLTs who are boots-on-the-ground addressing public health crises and ongoing public health needs. Anyway, I think our watchword here should be making sure that we are primarily serving the needs of boots-on-the-ground and then, secondarily, serving broader needs, but Jillian, I do not know if you have a comment there.

Gillian Haney
I do. I think Les makes an excellent point, and to my earlier statement about public health gathering information over time as new information becomes available and as circumstances on the ground change, it is really critical that we have complete core demographic information up front so that we can de-duplicate those reports as they come in and make sure that information is compiled within a single individual and within a single particular event. Public health spends an enormous amount of time trying to make sure that this person is actually indeed this person, and if we do not get full name, address, date of birth, sex, race, and ethnicity up front, it makes our jobs very difficult. And so, I will just pause there and say complete information up front is absolutely critical as information comes in over time.

Arien Malec
Fantastic. Again, in anything in healthcare, patient matching and patient linking are critical activities, and accurate demographic information is foundational for any of that. Jim?

Jim Jirjis
Yeah, I just have one question. I completely agree that we need to make sure all the standards are defined in there, etc., but one question I have, which may not be the scope of ONC, but at least of this Task Force, is one of the observations we have is a standard may be defined, but the incentive to use it may not be there, and let's go back to the lab testing company, for example. So, if you define that lab results need to be mapped to LOINC, but 225 labs do not do it, that is part of the challenge. So, is there going to be any recommendation around incentives for all the key players to adhere to a defined standard once we…?

Arien Malec
I have asked that same question. Let me answer in a nuanced way. It is not our charge and mission to define incentives for the programmatics that would go along with certification. It is primarily our charge in the Task Force to consider the sender and receiver, but you will note that there is sub-bullet 3, where we address data flows and the need for contemplating the data flows that are associated with public health, and so, I think in areas where there are important intermediaries or there are important originators for the data that are used in the data flow, we really should be contemplating recommendations for addressing data quality at source. So, hopefully not overly nuanced, but I just want to make sure that we are not in the business of making recommendations on programmatics or certification criteria, but I do think we are in the business of contemplating certification and implementation guidance associated with end-to-end data flows associated with public health.

Jim Jirjis
And so, if I hear what you are saying, it is not our job to define the incentives and recommend them, but it is to indicate that to be successful, they would need to participate, and then it is not our job to identify what those incentives are, just if it is not addressed, we have not really accomplished the "no special effort."

Arien Malec
That is right, and I think it also would be part of the charge to address certification criteria that are associated with the data flows. For example, if there are certification criteria associated with resulting authorities or agencies and those data flows are critical for public health, we could contemplate making recommendations in that area. Ike?

Steven Eichner
I have three points. No. 1, looking at the diversity of public health authorities or public health agencies across the country, many public health agencies have different spheres of practice or different scopes of practice, so there is not a universal model that fits all particular use cases, so we need to be cognizant of that as we are looking at information flow. Secondly, we did not hear it this morning very much, but looking at patient privacy, the more times patient data gets replicated unnecessarily, the greater the risk of that data being exposed and misused. That risk goes up.

Thirdly, in the same general vein, looking at routing of data to public health and ensuring that that routing makes sense for all parties is very useful. To Clem's point about looking at complete and updated data, if we are looking at entities in the middle, such as a laboratory passing on demographic information, the laboratory's interest is in the data to process the sample, go through the sample, and return test results to the appropriate authority, not necessarily in maintaining the extra information. So, from an incentive, value, routing, or certification perspective, that is something I think also needs to be addressed. Thank you.

Arien Malec
Thank you very much, and again, with your second point, again, a plea for thinking about this as a floor/ceiling problem. I think we acknowledge that STLTs have broad authority that is jurisdictional in nature, but if we can put our hats on and think about the common floor that addresses multiple needs, we will better serve the nation in terms of public health readiness. All right, Mark?

Steven Eichner
I just want to interject. Be careful about designing the floor because in some cases, you may set a floor that is higher than **[inaudible] [01:15:21]** capacity, so we need to be cognizant of that as well.

Arien Malec
Absolutely, thank you. Mark?

Mark Marostica
My question is along those lines, and you may have already addressed it in that conversation, but I was thinking about how to go about this and the transmission capability between the senders and the receivers. The question I had is should we think about this in developing standards which can be met today with the lowest-common-denominator system that the sender and the receiver have, or should we develop standards that we believe are most viable and expect the sender and receiver to improve their system to meet those standards, should that be necessary? What I think I just heard you say in that conversation is it is sort of a hybrid. We think about the current status and we try to build standards that a majority of these senders and receivers can satisfy, but still is modernized so as to build capacity in the future, and for those who cannot meet those standards, we hope that they would improve their system and modernize it to do so. Is that an accurate scope for this Task Force in thinking about how to set standards?

Arien Malec
I think if you look back at our charge, our charge is to improve standards and associated certification criteria, both for the EHR, the send side of this, as well as contemplate data flows for public health for the receive side. We clearly would not want to do that in a way that is impossible to achieve in practice. This is a personal opinion, but I think we also would not want to do this in a way that assumes that there is no funding for the system improvement that is associated with conforming to standards and certification criteria. So, yeah, I think our watchword should be to raise the floor such that the floor can be accomplished with as little special effort as possible to better serve the nationwide public health need for the past crises, as well as for future and emerging threats. Gillian, I am interested in your perspective there as well.

Gillian Haney
Yeah, I would agree with that. I think that a lot of things are working well, and I think we need to recognize that a lot of progress has been made, and it may be that it is time for us to tighten up some of the certification criteria in order to be able to enhance adoption of standards as well as improve the data quality.

Mark Marostica
Good point. The funding is an important element, but I am assuming that like incentivization, that is not part of our scope. It is just developing standards.

Arien Malec
That is right. I think we should be proceeding as if there will be sensible programmatics. I think it might be appropriate for us to comment where necessary that programmatics need to be carefully aligned or things of that nature, but we should assume that there are sensible programmatics and that there is appropriate funding to fund system upgrades associated with meeting certification criteria, but it is not our charge to contemplate what those programmatics should be, what the funding mechanisms should be, etc. Are there other folks who would like to put their hand in the queue, or are there folks who are not able to use the hand-raising feature of Zoom and who want to enter their comments in right now? All right, John, go ahead. Are you double muted, John?

John Kansky
No, I got it. Arien, I think this is within the constraints of the scope of the Task Force that you outlined. I hope this is not too ambitious. I hope we can have a discussion, maybe a recommendation, regarding with and without a data intermediary in the context of the whole set of transactions we are trying to **[inaudible] [01:19:55]** in the standard. So, say a standard, say a certified technology, but the data flows… What I am trying to avoid is… The ideal vision of much of the group on the Task Force is that with perfect implementation of these standards, intermediaries are not necessary. I would hate to be putting states or jurisdictions in a position of not being able to use an intermediary to implement these standards. Does that make sense?

Arien Malec
That makes absolute sense. Again, those parallel some comments that I have had about our charge, and I think the pathway to those recommendations is, as I noted, found in sub-bullet C of our charge that really contemplates the data flows associated with public health, and I think we can point to existing steps along the information flows or data flows. I think we have already noted lab data where the true public health data

flow starts at the order, includes the ordering provider and their electronic health information systems, but also includes the lab and the need to encode data at source, may include things like the AIMS platform, as well as STLT information technology systems and CDC, and I think sub-bullet C gives us the latitude to contemplate those data flows and areas where certification may be appropriate for those data flows.

Gillian Haney
I just want to add something about your comment about intermediaries. I think the AIMS platform has served as an example for aggregation, sending, and routing of lab data as well as our electronic case reporting efforts, and I think that while not perfect, there have been a lot of successes made through AIMS.

Arien Malec
Very good. I am seeing the Bat signal for the public comment period, so as a reminder, this is a Task Force of the HITAC, which is a federal advisory committee, and we run the Task Force according to the dictates of the Federal Advisory Committee Act, and public comment and public input are a vital part of our mission, so at this point, we are going to hand back over to run through the public comment.

Public Comment (01:23:12)

Michael Berry
All right, thank you, Arien and Gillian. We are going to open up our meeting to the public for any comments. 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. If you happen to be on the phone only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. So, let's pause for a moment to see if anyone raises their hand. And, I will just note while we are waiting that our next Task Force meeting is next Wednesday, same time, 10:30 a.m. Eastern Time. I am not seeing any hands raised at this time, so I will turn it back to Arien and Gillian. Thank you.

Next Steps (01:23:50)

Arien Malec
All right. This is a good time if folks who were not connected to the Zoom would like to get their voice in the queue, a good time to do that. Also, we are going to rigorously assign homework. I think we will send out an email that may have additional homework assignments, but I would encourage the Task Force members to review all of the content that was shared because there is a lot more than we were able to go through verbally, we had far more content than would fit in the time allotted, and then would also encourage Task Force members to carefully review the charge, and we are going to run through the Task Force following more or less the sub-part F certification criteria, so we are going to go system by system and look at associated certification criteria. I think we are still working out exactly the order that we are working in.

Annie asked a question, which is a fantastic one. The question is sub-part F is really about the send side and not about the receive side. In our charge, we have been asked to contemplate the full data flows, the receive as well as the send, so as we are going in that order, we are going to be taking a public-health-first perspective, not a transmission-first perspective. So, that is at least a subset of the homework assignment, and we may have more to send you after we have worked through the agenda for next week, and please recognize that we will continue to offer very ample opportunity for homework, and so, make sure that you

calendar time to do your Task Force homework for now until November, when we complete our report. Gillian?

Gillian Haney
Thanks, Arien. I think that this was a really terrific meeting in terms of level-setting where we are headed. I think that at the beginning of subsequent meetings, we will probably do another level-set again in terms of what is the specific challenge that we have within each of these criteria and what it is we are trying to solve for because as I have stated previously, while there are commonalities, there are very significant differences within each of the public health criteria laid for, so I think it will be important for us to be operating from a common set of understanding. It was a terrific conversation today, and I am really glad that we have so much expertise in this Task Force, so, thank you.

Arien Malec
Thanks to everybody, and here is a little reminder of our upcoming meeting schedule, but just recognize this time goes very quickly, and we will be in October and working through our final report material before we know it, so it will be fast and furious, so hold on to your horses. Thanks, everybody.

Adjourn (01:27:11)