ONC | HealthIT ADVISORY COMMITTEE

Transcript

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

September 16, 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

Name	Organization	Role
Eliel Oliveira	Dell Medical School, University of Texas at Austin	Member
Jamie Pina	Association of State and Territorial Health Officials (ASTHO)	Member
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
Lauren Richie	Office of the National Coordinator for Health Information Technology	Acting Designated Federal Officer
David DiCesare	NYS Department of Public Health	Presenter
Riki Merrick	APHL	Presenter
Justin Nucci	CO Public Laboratory	Presenter
Carmen Pugh	LabCorp	Presenter
Prashant Gupta	LabCorp	Presenter

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

Lauren Richie
Okay. Good morning, everyone. Hi. I am Lauren Richie with ONC. I am filling in for Mike Berry today. Want to thank you for joining the Public Health Data Systems Task Force. We have a few guest presenters with us today, so I would like to welcome them and thank them for their time in presenting today. Just as a reminder, all task force meetings are open to the public. Your feedback is welcome either in the Zoom chat or during the formal public comment period which is scheduled for about 11:50 East Coast time. With that we will get started with roll call.

Gillian Haney
Good Morning, present.

Lauren Richie
Arien Malec?

Arien Malec
Good morning.

Lauren Richie
Rachelle Boulton?

Rachelle Boulton
Good morning.

Lauren Richie
Hans Buitendijk?

Hans Buitendijk
Good morning.

Lauren Richie
Heather Cooks-Sinclair? No Heather yet, OK, Erin Holt? Charles Cross? Steve Eichner?

Erin Holt Coyne
Good morning.

Lauren Richie
Charles Cross? Not yet. Steve Eichner?

Steven Eichner
Good morning.

Lauren Richie
Joe Gibson?

Joe Gibson
Good morning.

Lauren Richie
Raj Godavarthi? Not yet. Jim Jirjis? John Kansky?

Jim Jirjis
I'm here.

Lauren Richie
John Kansky?

John Kansky
Good morning.

Lauren Richie
Bryant Karras?

Bryant Thomas Karras
Hello all.

Lauren Richie
Steven Lane?

Steven Lane
Good Morning.

Lauren Richie
Good Morning. Jennifer Layden? Les Lenert? Hung Luu?

Hung Luu
Good Morning.

Lauren Richie
Mark Marostica? Sorry if I misspronouced that. OK, Aaron Miri? Alex Mugge?

Alex Mugge
Good morning.

Lauren Richie
Steven Murphy?

Steven Murphy
Good morning.

Lauren Richie
Eliel Oliveira?

Eliel Oliveira
Good Morning

Lauren Richie
Jamie Pina?

Jamie Pina
Present, good morning.

Lauren Richie
Abby Sears?

Abby Sears
Here, thank you.

Lauren Richie
Vivian Singletary?

Vivian Singletary
Here, good morning.

Lauren Richie
Fil Southerland?

Fillipe Southerland
Good morning.

Lauren Richie
And Sheryl Turney?

Sheryl Turney
Good morning.

Lauren Richie
Good morning, everyone. Is there anyone I missed that joined while I was doing role call? Okay. If not, I will turn it over to the cochairs to get us started.

Gillian Haney
Okay. Good morning, everyone. Welcome to our fourth meeting, and today we are going to be reviewing the F criteria of number three, electronic laboratory reporting to public health agencies. I expect we will have quite a robust discussion, but we will have presenters from experts in the field representing public health, APHL, and the Colorado Public Health Laboratory as well as the private sector with Labcorp

representatives. I am very excited to hear from them. Public health has been in the field of electronic laboratory reporting for many, many years. I know in Massachusetts we started our efforts to move from fax and paper back in the early 2000's. It really took a while for ELR to get off the ground, and then it really sped up over recent years as we received funding from CDC to support those efforts. Further, during the COVID pandemic we saw a massive increase in the volume that we needed to manage and some centralization of some of those electronic feeds. By the end of the pandemic, I believe that all public health seemed to look local public health agencies could actually receive the standard HL7 2.5.1. message. There was significant progress that was made although it took quite a bit of time. Unlike efforts within electronic case reporting, electronic laboratory reporting has been quite a bit federated within each jurisdiction. We do have our representatives here from one of the large group national laboratories, but within our states we work very closely with our clinical laboratories in the hospitals. Most of those feats would be going straight directly to local health departments. I think there are opportunities for us to discuss meaningful certification options to try to reduce variability and improve data quality. I think one of the things that we've heard quite a bit is that because laboratory reports are often the first notification that goes to the health department, missing whole demographic information such as complete address information really stymies our ability to move forward quickly and act on that initial report. That is in part because that information is not collected in the laboratory information system. There may be opportunities to look at potential certification within what information is sent on the test order into the limbs and then directly to public health. With that I will turn it over to my cochair, Arien to introduce our panelists and walk us through discussions.

Arien Malec
Thank you. Yeah. No, this is an exciting panel both because Gillian, as you know, this is an area that we have been able to do nationwide. We have got great existence proofs for the utility and feasibility of ELR. Then we have also got a tremendous amount of lessons learned on the ground, particularly not so much related to the test itself, but as you know the demographics and surrounding information around the test as well as responding to rapid changes in diagnostic methodology. Let us go on to the panel overview. All right. We have a pretty impressive panel. We really wanted to make sure that we had representation from public health. We have got representation from the public health labs as well as APHL. Then really pleased to be able to get representation from one of the large national labs themselves. We are also going to be soliciting, in a panel discussion, feedback from hospital and health system members on the experience on the send side, or at least the portion of the send side. This is a complex area as everybody knows because lab data takes multiple hops prior to getting to public health. With that I am going to turn it over to David to give us the perspective from the public health side of this equation. David, over to you. David, are you on mute? Do we have David? All right. Why don't we go on to our next panel?

(f)(3) Transmission to Public Health Agencies – Reportable Laboratory Tests and Value/Results (00:07:47)

David DiCesare
Hello?

Arien Malec
Oh, hey David. There you are. Perfect. Awesome. Go for it.

David DiCesare
Okay. Okay, can you hear me good now? Something was wrong with my phone apparently.

Arien Malec
No problem. We got you.

David DiCesare
Okay. That is good. Okay, you have got my slides. Perfect. Okay. Just talk a little bit from the New York State side as far as how we process what is going on with our intake of the data and some of the things that, from my perspective, I see as a possible improvement. A lot of the issues that we have with inbound data from the labs mainly go along with standardization issues. We do have issues where even though the current national standard for HL7 is 2.5.1., we are still receiving from many hospitals and smaller commercial labs and the like older versions of HL7, and we are also receiving flat files. Our New York standard flat file that we had for 20 something years, and along with various types of CSV files that have been developed due to COVID over the past two years. With HL7 I will start with that, especially with the national standard, the 2.5.1. Even though 2.5.1. is a standard, there is a lot of interpretation of that as far as what labs send, how they send it, how states want to receive it for their own purposes. Here within New York our HL7 parser is very flexible to the various HL7 that comes in. I do know that there are, from conversations and from working with other states, that some states want specific fields or the formatting to be done in a specific way for them. I have heard from labs on the national calls that it causes some issues as far as, hey we got to do this for New York. We got to do this for Tennessee. We got to do this for Washington, and issues within standardization. I am being vague with how I am talking about it, so if there is specific questions afterwards, feel free to ask. I will try to get into it with my next slide as well. The flat files, especially over the past year or two with COVID has thrown everyone off because every state has their own CSV file that they have created as well as the national flat file that was created a year or so ago. Alongside of that there is the standardization of coding schemes. Most facilities that are using HL7 use LOINC and SNOMED, also use local codes. There are some out there that have not caught on to the LOINC code yet, and typically, I am only talking from New York State perspective, send us just local codes because they are smaller sites, and their lab systems cannot handle the intake of LOINC codes and/or SNOMED for that matter. Even with that the sites that do use LOINC codes, there are so many codes out there these days between ones that have been deprecated over the years and new ones that have come out because of new testing that it is very, very hard for labs and states to keep up with them all. I know we have PHIN VADS which is a great tool. These days I am not sure how often PHIN VADS is truly updated to meet all these codes. Having better standardization among those codes that the labs are told to follow to send would be a big help in getting things taken care of as far as how states operate. Lab systems, EMR, vendor changes, or the state health departments have been an ongoing issue mostly from the hospital labs, not necessarily the large commercial labs, but hospital labs every couple of years tend to change their lab systems going from soft or Meditech to Cerner or Suncrest or Epic. Among all the other things that are going on with the world with COVID and everything, here in at the states we have to deal with these transitions, and that kind of goes in with the standardization. I am not really sure anymore. I know a lot of these EMR and lab vendors five years ago had to go through the whole meaningful use process. I'm not sure where that whole process stands as far as meeting the standards that they had to go through to make sure that their systems are meaningful use capable. Sometimes cooperation with those lab vendors as far as requests that the states have one-offs and the like get met with some resistance because they are trying to create one interface that meets everybody's goals. As we all know that is not something that really happens. And my fourth issue that we have on the inbound is completeness of information being reported primarily on patient demographic which everyone complains about and have complained about for years. There are issues as our health code has expanded in New York State and our partners down in New York

City. As far as wanting provider NPI, facility NPI to be sent a lot of times that is incomplete because ordering facilities can have multiple NPIs, and it is hard for labs to know which NPI to send or even maintain them within their systems to send them. That over the years it has become a new hurdle for us as far as completeness. We here at New York have compliance reports that we send out to labs not only for infectious diseases, the standards, but also for HIG and lead, and cancer pathology reporting all broken down by programs. Each program sends out their own compliance reports out. Within some of our programs they ask for corrective action plans from the labs as far as how they're going to try and rectify the either incomplete data or invalid data that is sent over. That is one of the ways that we are trying to work with and get as much complete data as we can with this. In brief, I know I only have a few minutes for this, that is the basic issues that we are facing. If you want to go on the next slide. Possible solutions for some of these issues: A lot of this from my point of view, and this has been my point of view for many, many years is we need to get some acceptance or some, I'm trying to think of the right word here, delegation of standards and what needs to be done more from the national CDC level. We have an HL7 standard that was issued and validated, and as I mentioned it changes. It morphs for each state. I can speak to this as states are working with interstate reporting through the AIMS platform. We have discovered that each state wants something different in how we, New York State, sends to them. If there were something to say, "Here is the standard. You need to abide by the standard." If it says that a value type for an OBX segment can be anyone of these five value types, you should be able to take and absorb any one of those value types. It helps both the states. It helps both the labs as far as how to take in the data properly.

Arien Malec
Hey, David. Sorry to interrupt, I am going to do just a time check because got a couple more of panelists.

David DiCesare
Yep.

Arien Malec
I think we can absorb the information on this slide. Thank you so much, and just hold on because we going to go to panel discussion at the end.

David DiCesare
Okay.

Arien Malec
If we can go on to our next panel which is Riki and Justin. Riki representing both the national perspective for public health labs as well as the important work that APHL does with the AIMS platform, and then Justin representing the work on the ground as an operating public health lab. Riki, over to you.

Riki Merrick
Thank you, Arien. Next slide. I just wanted to briefly mention the current state, and I'm not really going to talk too much. I have a lot of words on the slide, so people can read this later, but as David pointed out, there is a national profile. Each state has variations as he points out. There is **[inaudible] [00:19:36]** link to a certification which highly encourage people to use. There are test cases that people need to go through that try to look at the different possibilities of how labs can send certain data for certain conditions, but older versions of ELR are definitely still in use as David mentioned. The currently most implemented standard is

the ELR R1 standard though some public health agencies may have updated to later versions or the public health component in LRI which is the latest version and a new version that includes covering the HHS component for COVID reporting. It's going to be published here any minute. It's evolving. The one problem that the labs are having, and David pointed out, there is not enough demographic information in some of the lab results. Epi uses that to assess health disparities among other things as well as matching patient matching so that... The labs don't necessarily get that information, so I think there is a little bit of dataflow problem going on here. Next slide. What are the gaps? The certifications applied only to the EHR systems. LIS systems that are standalone that are not modules and EHRs do not need to be certified. The public health systems on the side, on the receiver end also do not need to be certified at the moment, so that's a problem. The RCMTs, which I think you mentioned, I think that's published as those. Has a list of all the codes associated with reportable conditions, but they don't consider the combinations of the LOINC for the test and the SNOMED for the results to trigger, and it doesn't include any state specific rules. There is RCKMS, reportable conditions knowledge management system that has trigger codes and allows jurisdictions to author their specific roles, but the current focus there is eCR. We could hopefully expand or have the jurisdictions utilized, their capabilities of clarifying and reporting roles in RCKMS for the lab specifically. Then what would be my recommendations: Expending certifications to LIMS systems and public health surveillance systems. At the moment we are only certifying the systems, but really I think what we need to certify is the actual implementation at each side of a certified system. We should consider updating to the latest version, the public health component in LRI because as the standards evolve, we have incorporated better features. For example, including the test, the device identifier so that you can actually really know which specific test was done bx LOINC from a method perspective looks at it as a broader picture, and in some cases that may make a difference for the result interpretation. Then support expansion of use of eCR for the data use to assess health disparities because those kind of demographic datas usually reside in the EHR, and the lab doesn't really need them for the result processing. Next slide. Do I have another one? I just pulled together some more **[inaudible] [00:23:34]** related items, so it would be nice to have both systems on either end of the exchange adhere to the standard and be able to use the proper value sets. David mentioned it is hard to keep up with the LOINC code that are applicable to each of the tests. I wanted to mention for SARS-CoV-2 CDC publishes a LIVD file which provides you the LOINC code at the test level for each of the specific tests as well as the related SNOMED codes for the specimen type and the result values if they are codified. SHIELD is hoping to create a resource like that, a laboratory interoperability data repository that people can access to help them make that LOINC and SNOMED codification a little easier. It would be nice to have a master patient index so that patient matching would be easier. The rest is words on the slide people can read later. I have another slide, or is over to Justin? Okay. The other question was: What recommended data flows align with the criteria and the ELR for results which is, as David pointed out, is usually the first indication to public health that there is something going on. It is timely and unadulterated, but demographic and social determines of health I think should flow through eCR and additional clinical information about comorbidities and other things that might help the EPIs and researchers find correlations between things also should flow from the EHR. You mentioned AIMS real briefly. One of the things AIMS does is help folks that have to connect to more than one health department to only have one connection and AIMs provides the routing kind of like a post office. I will turn it over to Justin on that.

Arien Malec
Yeah, thank you. Justin.

Justin Nucci

Okay. Next slide I guess. Okay. Hi everybody. Justin Nucci, data systems manager for the Colorado Department of Public Health State Laboratory. Just a quick background, I mean we support HL7 2.5.1. reporting for to our ELR team as well as directly to CDC for things like FLIP and ALRN and LRNB. We also support HL7 messaging to our local health information exchanges, and then in the cases we do have direct integrations, we support that going back to hospitals. I guess first thing is we support a lot of different flavors of HL7, which can be a difficulty itself, but moving on from there one of the biggest challenges that we have particular between us and our ELR reporting team is the fact that we are not the primary provider of data coming from demographic data coming around patients. We still get a lot of sample submissions on paper although we are working moving towards web portal and direct integrations when possible. However, a lot of the times we will get just patient name and date of birth. Which really limits the ability for, as the consistent theme here is to be able to do patient matching and follow-up particularly if there is no other report going directly to the ELR team for that person. The other piece to this I think that is more of a challenge for the ELR team then for us is that when we send the messages, they also send messages to our ELR team. We are not the original sender. We usually identify that, but it is not identified in the same fields as it would be if it was directly coming from the hospital or the provider. I think that information is often not very complete as well. Once again, we can only provide what has been provided to us, and that is limited in most cases. The other thing that comes down I think is another consistent theme that we are hearing is that we support not only your standard reportable disease diagnostic information but as well as some of the more advanced public health surveillance things like COVID whole-genome sequencing which I think the list of SNOMED codes is now over a thousand. Salmonella serotyping and enteric disease of WGS for things like PulseNet ID which is just really nonstandard information. We do use a lot of local coding in nonstandard fields. I think when reporting some of this information to our ELR team, and that is something that we are constantly having to work directly with them to come up with, for lack of a better term, a workaround to support some of this information particularly around the PulseNet info, so enteric disease, sequencing typing. Yeah, there is a lot of challenges, but I think the best thing we can do is continue to support electronic ordering at the state laboratory which gives us some more control around collecting the demographic fields and supporting our ELR team on the downstream side to make sure we have complete information.

Arien Malec

Thank you so much. That is fantastic. This completes our super high-level and rapid run through the public health lab side of this. Then now we are going to go to the commercial and community lab view, really looking at the national commercial lab just as a representative proxy for all labs, so if can go onto the next section. Carmen and Prashant are going to talk about Labcorp's perspective on the last three years. As a national lab they have got a unique perspective on being exposed to all of the variation state-by-state as well as being intermediaries in a complex flow Carman and Prashant, over to you.

Carmen Pugh

Quick introduction. My name is Carmen Pugh. I am responsible for Labcorp's corporate state reporting program. Labcorp is unique in that we have a centralized mainframe where the majority of our laboratories actually feed into the one main LIS. That allows us to have one corporate state reporting office and the ability to create one file for each state instead of multiple files or reports from each individual state. I have been with Labcorp for state reporting for about the past 16 years, so I've actually seen our program grow from the very beginning with very few states receiving electronic reports, mostly paper, to basically every

state getting an electronic file. Prashant, do you want introduce yourself, and then I can go ahead and go through the bullet points?

Prashant Gupta
Sounds great. Yeah. Full name is Prashant Gupta, Vice President Architecture and Informatics responsible for all of our data and analytics platforms here to support Carmen.

Carmen Pugh
All right, I will also clarify that I am a med tech, a clinical laboratory scientist. I am not IT, so Prashant is here to certainly help me fill in any gaps of my knowledge. I apologize that we do not have any slides. Just to quickly kind of go through the bullet points that were given to address and talk about on this call, a clear view of our current state reporting for Labcorp: We currently have about 14 different programs or processes in place that allow us to accommodate all of the different state reporting requirements for all of the different states. We have approximately eight programs that will create HL7 files, and this goes across for infectious diseases, COVID, HPVs, cancers, HIV genotypes. We have four programs that have the capability of creating fax files for the states that still want faxes. We have a program that creates a non-HL7 piped limited file, primarily for blood leads because a lot of states cannot take their blood leads in HL7 format. We still have a program that creates paper reports that get printed, and we have to step into an envelope and mail a couple of times a week. We can report anywhere between 200 to 400 HL7 ELR files on a daily basis, that just depends on what program is running at what particular time. We report to every state. We report separately to some cities and counties, and we report to most US territories. Our HL7 format is 2.3.1. I acknowledge we are behind. There are some states that do require duplicate reporting, so a couple of states will require that we report, for example, STDs in a fax, but also included in our HL7 file. We even have one state that requires that we report HL7, non-HL7 electronic file, and non-HL-7, and also fax for one particular disease. Everybody hear me okay? Okay. There was a beep, sorry. We do include LOINC and SNOMED in our reports. We work very hard to make sure that every state reportable disease test and result is assigned to LOINC and/or SNOMED before we go live with that test. We have different ways of transmitting our files. We use Fitamess SFDP **[inaudible] [00:34:15]** transmitter. Then some states actually have their own tools that we have to house internally within our firewall to allow us to transmit our ELR files to them. Lastly, we have been reporting to the CDC through the BioSense or National Syndromic Surveillance Program de-identified reports on all potential state reportable tests. We have been doing that, I would say since the mid-2000's all of that just to reemphasize that it is de-identified patient information. Some of the gaps that we are seeing with the implementation of ELR is primarily Labcorp, and most of the lab work that we get, we are not seeing the patient. What we are getting our blood collections or specimen collections from a medical facility, hospital, and medical provider. They are collecting that information. They are the ones face-to-face with the patient. They are collecting the information, and they are placing the order and sending it to Labcorp. We are not face-to-face with the patient, and yet there is this push now for laboratories to collect a lot of information that can only be obtained from that patient. What is the patient's race? What language do they speak? What is their sexual orientation or their gender identity? We do not have that information as a laboratory. We are not for the most part face-to-face with that patient. I think one of the issues is that there is just a lack of regulatory standards for a state that says a lab has to report this, but there is no regulatory standard that says that healthcare provider, that medical facility has to collect that information and put it in the lab order. The lab has to collect it and basically what we are being told is, "If you do not get it, you should not do the test". That is not in the best interest of the patient or public health for us to refuse to do that test. Another gap or another issue that we encounter as a national lab with the

reporting is that all the different reportable diseases and tests can differ from state to state. I pulled different regulations for three diseases: chlamydia, Lyme and tuberculosis. Chlamydia ranged across six or seven different states reporting times of one day, 48 hours, five days, seven working days and one week. Lyme was pretty much the same. Then for TB, some of the requirements were immediately, one working day, seven days, or only phone the next business day. There is not even an option for an ELR reporting for that particular state. Because of the test and the results that differ from state to state, it is a lot more difficult for national laboratories to keep up with what each state needs. We have certain states that are now starting to require all results. A couple of states say we do not care if it's negative, we want every hepatitis. We want every HIV. This increases the burden because for five states, you are reporting all hepatitis, but for other states you are having to report just the positives and what they want in terms of the tests to be reported. They might say Hepatitis B, but some states will list which Hepatitis B test they want, and other states just say, “acute,” or, “chronic,” or, “both,” with no guidance. We are left with working those specifics out with that particular state health department to determine what exactly do you mean by acute because what you mean by acute differs from what another state means by acute hepatitis. Some of the recommendations that we have for advancing the criteria or standards, just like the previous two or three presenters said, there has to be one HL7 implementation guide. There cannot be state flavors or state variations. One of the main reasons why Labcorp has not yet been able to come up with the 2.5.1. or a newer version of HL7 is we do not have the capability of meeting every single state’s individual requirements. What will work for one state will not work for another, and it is just not feasible to create 50 or 60 different HL7 versions. Everybody right now takes our 2.3.1., so we are staying with 2.3.1. for now. We will work on it, but that is one of the reasons we have not advanced at this point. I do think that there needs to be one standardized set of patient demographics and no variations from state to state. You have got 25 of the states that want race and ethnicity. You have got 50% of the states that just want race. You have got some that want pregnancy status. There needs to be across the board. This is the basic amount of patient demographic information that a laboratory needs. I think it needs to be dropped the requirement for labs to collect and store patient demographics that we do not need. We do not need pregnancy status. We really do not need race. We do not need ethnicity, except for a handful of tests that actually require that for the testing algorithm and the calculation of the results. Most of that information that is needed, we do not even need address, but we recognize that patient addresses needed for public health reporting. I think that is something that a lot of laboratories should work to achieve. I think that we need to have standardization across all states. There needs to be some standardization amongst the vendors and the EMRs, primarily if you look at a lot of the problems with health reporting especially with laboratories you have to kind of do a root cause analysis. The first improvement has to begin with the very first encounter, that patient encounter. When you have got healthcare provider who is sitting face-to-face with their patient, that is the root cause analysis. That is the primary time when all of the information that is needed is available, so that healthcare provider can collect all of that demographic information. They need to be able to store it into their system, their EMR vendor systems, whatever. That means that all of the vendors and all of the EMR's have to have a minimum standard of data that they have to be able to store. Currently you could have a medical facility that uses an EMR system, and it doesn't store patient address. That is an extra fee. That is an extra package that that medical facility has to pay for. Oh, you want to have the patient's address stored? That is going to cost you another $25,000 to be able to do that so that you can send the address to the laboratory. There has to be some type of minimum standard of data across the board for vendors and EMR's that they have to have this base set of information, and they have to be able to transfer that information to other medical facilities, to other laboratories. I think that the last point I wanted to make is that case reporting, it has to be beefed-up, it has to be improved because those healthcare providers are the ones that are face-to-face with those

patients. They are the ones that have the very first idea that we have got a potential reportable disease. They should have to do their reporting daily. There needs to be an electronic way for them to do it, and they should be doing it for suspected and confirmed reportable diseases so that the first notification actually comes from the person who says, "I think you have COVID. I think it might have chlamydia. I need to go in and report you as a suspect case," so that when the laboratory reports a positive result that information can be married up with the public health department system and everybody has got all the information they need for surveillance. That is all I had. Prashant, did you have anything you wanted to add?

Arien Malec
Okay. Perfect. Yeah, I just want to do a time check. Prashant, if you have got something quick, otherwise I want to get to panel discussion. Prashant?

Prashant Gupta
Oh, sorry. Yeah, I said, "Let's move on." I think this is…

Discussion (00:42:40)

Arien Malec
Okay. Perfect. Thank you so much. Super, super helpful. I do want to point out I dropped in the chat, and we will include it in our spreadsheet, but Steven Lane and I put together, as part of our ISP task force with many of the task force members that are part of this task force, put together a ridiculously deep dive report on orders and labs encompassing LOI, Livd, LRI, made some of the recommendations that were dropping in the chat in terms of as we get to broader penetration of eCR, relying on eCR more for the clinical context, and then thinking about an ecosystem-based approach for certification to make sure that we pick up all of the actors in the chain. I would just encourage task force members who were not part of that previous task force to go back and look at that deep dive and look at some of the recommendations that we put there. With that, I am going to go to discussion, so ask folks to use the raise hand feature and ask questions of our panelists. I am going to take coordinator's privilege and ask both Labcorp and probably Carmen, Prashant, and Riki, if you can you give us a view on what are the state-by-state variations that are not accommodated in the LRI flavor of the ELR spec? Let us assume we move to the latest LRI spec and heard the public health genomic sequencing issues loud and clear. Outside of that, were are there state variations that are not currently accommodated in the latest LRI spec?

Riki Merrick
That is a good question. The reason we have been evolving LRI, the public-health component of LRI is to accommodate variations that come up over time when we learn of it, we being HL7 in this case.

Arien Malec
Mm-hmm.

Riki Merrick
One I could think about was for COVID, the requirement to report the school information. That is sort of doable with a NK1 segment in ELR, or one as well as LRI right now. That was one state variation that I can come up with at the top of my head whereas demographic information more than lab related information. I think the lab related information, we have pretty much covered with the latest LRI. Okay.

Arien Malec
Got it. Super feasible. Perfect. If only we moved to the latest LRI spec on a nationwide basis, and if only we were getting complete order information inclusive of standard demographic elements and minimum patient contact information, we would be accounting for sounds like almost all of the state-based variation.

Riki Merrick
From a standards perspective of be able to communicate them between systems, yes. I think the other big problem that Carmen was mentioning is making sure that everybody knows of the variations, and those are easily accessible.

Arien Malec
Got it.

Riki Merrick
That is the other aspect, I think.

Arien Malec
Perfect. Bryant has his hand up. Bryant, go ahead.

Bryant Karras
Unless you asked a question too.

Arien Malec
Oh, yeah. Carmen or Prashant, any additions to Riki's comments?

Carmen Pugh
I would say that we're continually receiving, and I don't want to name states or point any particular entity out, but we do receive requests to play certain data elements in HL7 fields that are not designated for that use. We would have a state, just for us can you put this value in OBR-13 or something like that, and from a national perspective, it makes it difficult for us because what we do for one state ends up applying to every state.

Arien Malec
Yep.

Carmen Pugh
So now we have to find a way to either remove from every other state or just tell every other state, "Ignore the information in the field." I would say there is probably three or four different states that have sent me their flavor of the newest HL7 implementation guide. They are like, "As soon as you can do this, send it. Send us a test file and we will work with you." Then we go through it and we can discover where it differs from the national.

Arien Malec
Got it. In all of those cases, that data is available in the LRI spec, it is just that states are requesting variation off the spec for data that is available in the spec.

Carmen Pugh
Or they want information that only that state has put into a demographic piece of information that may not have a spot in HL7, so they are finding a spot that they would like to receive it in.

Arien Malec
Got it. That sort of that we have a little background chat comment on eCR should be the origination of record versus the ELR. Okay, Bryant, back over to you.

Bryant Karras
Mute button was stuck. Carmen, I apologize, and feel free to turf this to Mr. Gupta. I am really struck, and I am trying to get curious here. I am not understanding the stance that you cannot go to 2.5.1. because some states are asking for a complete implementation of the LRI, and some states only want a partial implementation. It seems like you should do a full implementation of 2.5.1., and in the states that do not want those demographic fields can ignore them.

Carmen Pugh
Right. I agree, and I am sorry if I said that we could not. Let me backpedal a little bit and me say that we have been working every year to start the conversion over to a 2.5.1., and for the last three years, we have had pandemics thrown our way, and we have had to put that off. I did not feel that the last couple of years was a time for me to start going to a state that is taking our 2.3.1. file, has no issues with our 2.3.1. file and saying, “Here, test this.” What I am hearing from a vast majority of states is they are being bombarded with local hospitals and smaller laboratories that are not even getting ELR reporting, and they are trying to onboard them, so why should I take up their time? Then when we are starting to do the 2.5.1., looking at the changes that we need to create that format, we see that, we follow the national guide and then we find that another state wants to piece a different information here. Ultimately what we are going to do is proceed with the National Guide. And then we will have to work state-by-state and say, “Here is our file. Take it or leave it. If you cannot accept our newest format, then we will keep you on a 2.3.1.” That is what we going to have to do. We will follow the national standard; we will not follow the state flavors.

Bryant Karras
I just want to make sure that characterization of state flavors, there are optional element within that implementation guide, those are not optional for you to determine which you implement and not. Those flavor choices are for states to determine. I just want to make sure, so we make the choice for that superset, you are being inclusive of what states require by law in most cases.

Arien Malec
Yeah. Thanks for answering.

Bryant Karras
I hope you have a multistate working group for that process. Looking forward to working with you.

Arien Malec
Yep. Perfect. Erin, let's go over to you.

Erin Coyne

Yeah. Hi. Thank you for this opportunity. I will just say that a few other things that we tend to see specifically in ELR, and I think we will see variation both public health, but also, we will see it on both sender and receiver side of the interface is in regards to the implementation of parent-child relationships. That I think causes quite a bit of problem and work and special effort if you will with the consumption and interpretation of that information. That is pretty huge particularly in the lab results that we are dealing with in public health. The other thing that I would mention is the adoption and usage of SNOMED CT whether it is for the coded result but also for the specimen details. That is also a pretty big challenge. Then you might see public health agencies that are very kind of draconian. We have to have LOINC. We have to have SNOMED, if we do not, we are not going to onboard you. We get pushback on that, or you might have public health jurisdictions that say, "Okay, we really want LOINC and SNOMED, but you do not already have it coded so we are going to take your local flavors and we will do the mapping." That is where, I think, at least a slim part of variation might also come into play where public health jurisdictions who might be in the situation where beggars cannot be choosers are going to try to take whatever they can get, try to create documentation based on that variation, and now we start to see the proliferation of that variegation.

Arien Malec

Thank you for that. Hans, let's go over to you.

Hans Buitendijk

Me on mute. Sorry. I was responding to a chat there. I am not going to repeat some of the comments made in the chat. I really appreciate the discussion and the updates, the perspectives. They echo a lot of the discussions that has happened to **[inaudible] [00:54:24]** indicate in the IPS in prior public health **[inaudible] [00:54:28]**. At that core of it, it seems to be that we have an align and optimize between data streams issued. Yes, we have completeness as well, quality as well. I am not debating that. That is ongoing thing, but a part of it is this aligning and balancing when to use what flows. Particularly as we have seen over the last couple of years, two years during the pandemic, that as an emergency comes about new data requirements come up fast and furious differently in different areas, different parts. Having a resilient approach that can easily add that to in a flow of that extra data is critical because we do not know what it is going to be tomorrow. One could say, "Well, we can always create it for the extra part." Well, where would we query? We go back to the trusted source as the primary place to get the data. That means is that we want to rely on the trusted source to get the best context to public health and not flow that through two or three different steps through and add a part that in itself does not have a need for it. I think that there is this alignment and optimization that is really critical. I am purposely using the name of one of the Helios Tregs there as a line and optimize that we need to look at that. I think that is really coming through the feedback, the update that the panel is providing that is critical. Then the related question is, it always comes back there as well is patient matching. How do we do that? We do not have a unique identifier, so we need to have a reasonable minimum set. Agreed, completely agreed that the transactions must have that, so that when it comes back together again in public health, it can be pulled together with an agreed to data set at agreed to level of confidence that it is the right patient in the absence of a unique identifier. One of the comments in an discussion debate going back and forth a little bit is that how can we use other methods for that as well? I think we would strongly want to look at the opportunities of the variety of networks particularly at the national level to pull it together. What can we take advantage of that is happening there to arrive at that singular or at least linked set of patient records that public health can take advantage of as well where appropriate and authorized to do that? That means is that the networks have an important

responsibility to ensure is that they are able to understand not just for public health but for treatment that is critical as well, a core element of it, where the patient's data, and how do we do that in the best way so that we have a comprehensive understanding of where they are. Then we could take advantage of that. I think part of the discussion needs to not only be on the individual standards that handle lab reporting, but how does it fit with the other data flows? Where is the data best done? From patient matching perspective, how can we take advantage of efforts already in place? That in itself also require a good linking of records i.e., the national networking efforts, TEF in particular right now, a lot of attention. How can we take advantage of that to fulfil that promise of comprehensive location of patient records?

Arien Malec
Yep. Again, just to editorialize, you cannot use the facility if you do not have at least the demographic basics that come in on the order. If your order only contains an accession number and an opaque local identifier and maybe a first name and last name, you cannot use any of the facilities. All of that rests on at least getting the basic minimum demographic information in the order to the lab. I would really encourage task force members who were not part of that task force to read the report that we wrote on lab because I am obviously biased because Steven and I and the task force members spent a lot of work putting those recommendations together. It does occur to me that if we just did all of those things, we would be in a much, much better position. Hung, let us get you in the conversation.

Hung Luu
Oh, I just want to echo what you said, but also, I do think that we need to also concentrate on the infrastructure because you can have the best standard in the world, but if the hardware or the software to carry out the messages does not include the functionality to support those data elements, then you are stuck. The fact that there are some laboratories out there having to foot the bill to add additional functionality to a LIS system or EHR that they have already purchased in order to accommodate demographic information I think is a travesty. It should not be an unfunded mandate like that. If it is something that is important enough that it is mandated for public health reporting, it needs to be accommodated for without additional expense. I fully support the work of developing the appropriate standards, but I think we also should press that the existing infrastructure needs to be fixed and the functionality needs to be elevated to accommodate what it is that we want to achieve.

Arien Malec
Yeah, maybe just a little bit of context for everybody who is not aware of the super detailed weeds that we are wading through here. Generally certified systems need to have transparency of purchase, and FTC has the big famously put out some high-profile lawsuits really in the False Claims Act to divergences between what people think they purchased and the need to purchase additional capabilities for certified requirements. The problem here is that we took out the LRI. We took out the meaningful use incentive for electronic lab results out of a belief that it was topped out, that is most provider organizations could receive electronic results through nonstandard means. Then we had a policy of taking out the certification criteria associated with topped out requirements because EHR vendors did not want to go through the issues of certifying to things that were not required by the programmatics on the CMS side, and so there are no certification criteria for lab results attached to the existing EHR program. We have never had certification criteria attached the orders. We do not have certification criteria that apply to LIS vendors because we do not have either an incentive program or a requirements under clear or other for the lab side of the equation.

Weirdly it is completely permissible for people to nickel and dime organizations for interfaces in this space because it is not in fact a certified requirement of a certified program. Whether it is right or not, it does not violate, I am not a lawyer, but where the FTC has gotten involved in the False Claims Act, it has been related to purchase of a certified technology, and then the need to purchase additional capabilities on top of that where the technology was warranted as being certified. It all goes back to, we took out a lot of these requirements from the certification program. We are…

Gillian Haney
I think that's the next segue into the tracking sheet actually.

Arien Malec
Yeah. Exactly. Yeah, yeah, yeah. I realize I am monologuing an area that I am passionate about. Gillian, I would like to turn it back over to you to go through the tracking sheet.

Topics Worksheet (01:03:27)

Gillian Haney
Can we please pull up the tracking sheet? I did notice that quite a few people had had an opportunity to provide some comments, and we will start with I think the sessions that we have already had around immunizations, and then look at ECR and go from there. If we could start with immunizations, please. I just want to add that I for CST have not had an opportunity be providing comments yet. That needs to go through a process obviously but be assured we will be actively engaged in providing our own commentary here. Can you make that a little bit bigger please? We only have about 10, 12 minutes for discussions. I know Arien, you ran through some of the comments earlier. Thank you so much on our last call. We do seem to be getting some agreements that are coming through within the text here beginning first one in the round. The key importance of supporting standards and certifying systems to help public health authorities to achieve ourself more efficiently, we should have ONC coordinate more with public health and system developers and organizations to define and certify standards for vital statistics, so including that in with immunization registries for a situational awareness. I think that would be helpful. I know certain states already have actually begun doing efforts to populate those registries from vitals. They have already been making those connections there, and so that work has already started in making sure with we put some recommendations in place I think would be a good place to start for a broader adoption and more standardized message. Certification criteria for reporting and query treating in cluses of transport. We seem to be getting some agreement there as well. Is that Abby Sears? I just want to make sure. Please, if people could also just use their full names to make sure that we are getting everybody correctly. Anybody else want to say anything about that particular recommendation?

Arien Malec
Hey Gillian, just to want to let the invited panel know they are welcome to stay for this section.

Gillian Haney
Oh, sorry.

Arien Malec
We finished grilling them, so if they want to go do other things with their lives, they are free to go, but just really thank the panel, apologize, thank the panel for their time. It was fantastic, informative and obviously spurring a ton of conversation, so thank you all.

Gillian Haney
A big thank you from me too, especially for Labcorp who came on at late, late, late notice. Much obliged. If people want to raise their hands if they have additional commentary or things, please, please do so. I am trying to keep my eyes open for that. Okay, moving onto the next recommendation also from Arien. Looking to create a more expansive race, ethnicity coding system I think is huge. I have heard that CDC is convening a group to do so. That looks like that effort is moving forward, and hopefully we can take advantage of that, and perhaps make a recommendation to look to that standard for implementation. Next, falling on test... Sorry, my screen just keeps moving there.

Bryant Karras
Gillian. Gillian, can I really want…

Gillian Haney
Please.

Bryant Karras
This to be a discussion.

Gillian Haney
Yes, please.

Bryant Karras
On the last point, I think this is kind of a process question maybe to what is the scope of the recommendations that we can make here? If there is a vocabulary standard that is not yet published by CDC, can we make a recommendation towards an anticipated release?

Arien Malec
Sure.

Bryant Karras
And/or do we just simply need to encourage that that process keep proceeding and review it once it is published?

Gillian Haney
I think we can do both.

Bryant Karras
Yeah.

Gillian Haney
I think it is in the charge to look at both existing criteria and seeing where opportunity is to tighten them as well as to recommend that new ones be established.

Arien Malec

Yeah, and if we know of the existence of a larger than ONB but smaller than full CDC then that is race, ethnicity subset, we certainly could encourage that ONC coordinate with CDC to publish and certify to that standard.

Bryant Karras
And then the timeline of that certification process versus standards, interoperability, advisory, or voluntary adoption of those advanced, more inclusive processes. Do need we to wait?

Arien Malec
We don't need… Yeah.

Bryant Karras
For the full rulemaking process type, for them to drop into certification because we cannot wait that long to get some…

Arien Malec
Yeah.

Bryant Karras
Of these things in to respond to the disparities **[inaudible] [01:09:32]**.

Arien Malec
Yeah, so Bryant in our last workgroup we were in the middle of a particular process, in that case the ISA publication process, and so there were specific rules that we were operating against the ISA process. Here we have a little more free reign to make recommendations. It is going to be to ONC to figure out how to get those recommendations through…

Bryant Karras
All right.

Arien Malec
The existing processes.

Bryant Karras
I just don't want to recommend the impossible.

Arien Malec
Yeah, yeah, yeah.

Gillian Haney
Okay, very specific online for here, very specific recommendation that we use the HIMSS IIP test method used for certification, and Deborah picked the current one.

Arien Malec

Hans, I think that is the same recommendation, or somebody else made the same recommendation. I point that out a couple places where there is some duplication. Hans, from a EHRA perspective, is that consistent with where most EHRs are certifying? Is that consistent with the test method that most EHRs are certifying to?

Hans Buitendijk
Is a mix. It is a perfectly appropriate comment and recommendation to make. It is actually already developed from organizations to do it, not everybody. Others go directly to the ONC test to that capability.

Arien Malec
Thank you.

Hans Buitendijk
It is an alternative. If we believe they are testing for more, than we may want to look at that. I can bring it back and see whether there is any particular comments on that. It has not come up in the EHRA discussion as needing to be commented on yet.

Arien Malec
Got it. Got it. I mean the perspective here is that EHRA is working with HIMSS on this test method, and most of the energy and effort is going there. They have got a certification. They have got a partnership with Drummond for doing certification against that test method. It feels like most of the energy is going to the test method. It feels inefficient to have a second test method that then needs to keep up with all of the updates to the HIMSS IIP test method.

Gillian Haney
Moving further down. Recommending that both sides of the exchange same standard and also include transport and that another recommendation that HL7 implementation guide be tightened to reduce ambiguity and align in a common interpretation. I think we are seeing a call for that in many areas.

Arien Malec
Yeah. Hans, can we align that with rows one through four of a...

Hans Buitendijk
If we are talking about row nine, number seven, yes.

Gillian Haney
Row eight.

Arien Malec
Yeah, row seven, row eight, so I think it is my three that calls for certification to the transport method.

Hans Buitendijk
Yep.

Arien Malec

Then maybe it is two that calls for certification for transport and calls for reduction of variability and alignment, so if we can just consolidate it down to…

Hans Buitendijk
It can consolidate. Yeah.

Arien Malec
Okay.

Hans Buitendijk
I think that we wrote them all at the same time.

Arien Malec
That's right.

Hans Buitendijk
That makes a lot of sense. I think in the number seven is that finding a way, and it is one approach that is being suggested in seven, we had our deviations, customizations, variations. How can we work that through a common channel so that you get practically that superset, subset approach where this recognition of if you do it, this is the way to do it, and this is the full set that is available to you, and there is consistency there.

Arien Malec
Yep. Hans, why don't you and I just take some off-line work via email just to see where we can consolidate.

Hans Buitendijk
Sounds good.

Arien Malec
Perfect.

Hans Buitendijk
Yeah.

Gillian Haney
I am hearing from a common agreement for a constrainment of the standard there I think in some degree. Okay.

Hans Buitendijk
On this one I think that anything on patient matching we probably want to combine into a general theme recommendation, and then have subsets under there. I think based on some of the discussion in the chat that came up today, we may want to consider including and expanding on improving patient matching. The demographic data sets, that needs to be agreed to. The components of that, here it talks about some of the awareness and how matching characteristics are being used, transparency, confidence levels that are appropriate to be reached according to that. Perhaps we can also bring in some of that, what's the role of

networks, national, state, otherwise to help and hands on the really putting the links together and take advantage of what they have already are doing or about to do.

Gillian Haney
Bryant, I see your hand's up.

Bryant Karras
Yeah, Hans I think this is really important and has been really highlighted by the pandemic and the small number albeit of people who made a state transition during the pandemic and received one dose in a sequence from one state, and it is stored in one state immunization registry and then the second dose in another or folks that live on state borders like Vancouver and Portland and may have inadvertently crossed state lines. I think do we want to make reference to, now the acronym just flew out of my head, the multistate immunization hub. Oh, what is it called?

Hans Buitendijk
IIS?

Bryant Karras
No, the IIS multi **[inaudible] [00:01:16:08]**.

Arien Malec
IZ Gateway.

Gillain Haney
IZ Gateway.

Bryant Karras
Gateway. Thank you. The IZ Gateway specifically in that it needs more investment or incentives for states to fully get on boarded. Then second point, and this goes back to recommending the impossible, do we recommend a national patient identifier which I know is legally not possible at this moment, but maybe the federal government can request some changes in legislation.

Arien Malec
Okay.

Gillian Haney
That would be quite a conversation, I think.

Arien Malec
I was going to say we could ask for it, but we should not hold our breath.

Hans Buitendijk
I would agree is that I think that while we can indicate that that would be helpful, even if it is agreed to today, that will be five, 10 years by the time that it is probably rolled out with what needs to happen to make that

work, so what do we do in the meantime? I think some of these other things, demographic data, network alignment, etc. would tremendously help. It is not going to be perfect, but it would help tremendously.

Gillian Haney
I agree Hans. I think that both can be pursued in parallel. I mean from someone who spent a lot of doing deduplication during the pandemic and trying to keep up, just getting completeness of demographic information goes a long way to meet automated thresholds and just go directly into their surveillance system without manual review. There are definitely opportunities for improvement to reduce manual processes.

Arien Malec
Hans, we should probably recommend that each of the appropriate implementation guides be updated to include the Project US@ guidance. I love that recommendation. Maybe we pull one out and make a note urging one as well.

Hans Buitendijk
Yep. Yeah, that one. Then I am not sure what is best that I create another line for talking about how patient matching and the national networks and state networks etc., how they can build on each other.

Arien Malec
Yeah.

Gillian Haney
Can you send a link out to that please so that…

Arien Malec
Yeah. Okay, **[inaudible] [01:18:29]** Project US@, yeah. I will drop that in the chat. Hans, I was intending to add a recommendation an overarching recommendation that Public Health Data Systems be certified to query TEFCA networks, and that would be an appropriate place to drop that comment in.

Hans Buitendijk
Okay.

Gillian Haney
I see that we are at 11:50. Lauren, do we have a bit more time to keep going or do we need to...

Arien Malec
Usually give ourselves five minutes at the end for public comment.

Gillian Haney
Just five, so we have an additional five minutes?

Lauren Richie
Yeah. Maybe just go another couple minutes.

Gillian Haney

Okay.

Lauren Richie
I mean if we don't have public comment, we can always come back and fill the rest of the time.

Gillian Haney
Okay. Thanks, Liz, for rescreening again. Okay. If you could scroll down a little bit more, again strengthening alignment with data streams and other public health reporting streams. I see that that is inherently very sensible. Okay. Sorry, it is harder for me to read these are they served on the fly here. Use of the HL7 CDC implementation guide along with AIRA to develop those testing tools, I think that we did hear quite a few calls for additional testing and to maybe tighten up some of the criteria within. Vivian, I do not know if you are on the call still, but maybe you would like to speak to this.

Vivian Singletary
Yes. I am here on the call. It was just from our presentation from AIRA it sounds like, we have talked about this already, the variation in terms of the implementation of the use of some of the guides, and it was pointing out that having these testing tools helped cut down on that variation because everybody reads into these guides a little different, so having those tools created in addition to the guides to tighten that up.

Gillain Haney
Thank you.

Arien Malec
Yeah. And Vivian, can you look at three and maybe one through four, and just see if the recommendations there already account for that, or if there is new stuff that we need to add to that just so we can consolidate.

Vivian Singletary
Yes. I think we can consolidate with three. That would be appropriate.

Arien Malec
Cool. Thank you.

Gillain Haney
Okay. Can you scroll down please? We have a set of several comments, but not so much recommendations. In terms of, I think they are sort of all structured within the context of reducing variability. I think one of the other common threads is there is a little bit of, or not necessarily consensus about what is actually allowable within the implementation guide and what is true variability. I think we need to flesh that out because I think there is still quite a bit of variation that is allowed within the implementation guide, and maybe that is an area that we could look to to tighten up a little bit. Could you please scroll down a bit more? There is a comment about different standards for vaccine forecasting. I think there are different rules on the ground there, and this is a bit of a challenge in terms of clinical decision support. It is not an area... I don't know. Les, if you want to say something a little bit more specific about what your recommendation would be for this. Maybe he had to drop. Lastly, I will look at Abby's recommendation here that recommendation that public health work with CDC specification to ensure that registries do not have that

variation, so really importing a single standard for EHR and other IT standards that would have a single HL7 interface. I think that seems...

Arien Malec
Yep. Same comment **[inaudible] [01:22:50]**.

Gillian Haney
The same type of comment. Yeah.

Arien Malec
Can combine this one, Abby.

Gillian Haney
Yeah. If I am counting correctly, I think that we probably could combine many of these comments and recommendations into maybe four or five, so maybe we can do some of that in the interim week. Okay, I do see that we are at 11:55, so Lauren, do you want to open up the line to see if there is public...?

Public Comment (01:23:23)

Lauren Richie
Great. We will ask the… Thank you to the Accel team. Yeah, if you would like to make a public comment and you are on Zoom, please use the hand raise function found at the bottom of your screen. If you are only on the phone, please press nine to raise your hand. Then once called upon, press six to unmute yourself. We will just give it just a few seconds, and then we will check with the Accel team to see if we have any comments on the line.

Accel team
Yes. We have one hand raised for Noam Arzt.

Lauren Richie
Great. Go ahead Noam.

Noam Arzt
Hi. Can you hear me okay?

Gillian Haney
We can.

Lauren Richie
We can.

Noam Arzt
Thanks so much. Good discussion, guys. I have actually a request and not so much as a comment that I did send in via email as well under the guise of full transparency. It would be great if you could post even just a read-only version of the spreadsheet that you are working on between meetings, so that those of us out here could sort of see a little more closely exactly what you guys are thinking about and have an

opportunity to comment on it sort of before it is too late at the end or before it is too long at the end. I do not know if that is possible. It would be useful Thanks very much.

Gillian Haney
I will defer to ONC on the rules around that but noted.

Arien Malec
I think generally the way this works, Noam, is that as we get towards draft, all of the information that is presented gets attached to the meeting notes. Then we have ample opportunity between as we are finalizing the recommendations, and then they go to the full HITAC. There is an opportunity for comment there as well. Then to extent that anything comes out of our recommendations as the HITAC to the national coordinator and get placed into rule making, there is opportunity there. We can look at what we can do internally to have the sausage making more transparent, but there is going to be plenty of opportunity to get a view on what the recommendations out of this task force are, and then also review them prior to their discussion and potential approval by the HITAC. Appreciate the comment.

Lauren Richie
Thank you. And I do not see any other hand at this time, but just confirming do we anyone else either on the phone or have a hand raised?

Accel Team
I do not see any other hands either.

Lauren Richie
Great. Okay. I will turn it over back to our cochairs for the last two minutes for our next steps.

Next Steps (01:23:23)

Gillian Haney
Well, thank you everybody for a very robust discussion again today. I think we are identifying some very common themes as I have said before, and I would like to encourage everybody to continue using the tracking document to indicate concrete recommendations that we may all consider. Arien?

Arien Malec
No, absolutely. I think if we just look at our perspective calendar, we are going forward with syndromic surveillance in our next meeting, and then after that I believe we are going to cancer registries and there is one other F criteria in there.

Gillian Haney
Survey recruiting.

Arien Malec
That is right.

Unknown speaker
A-U-A-R.

Arien Malec
Yeah, yeah. Perfect. Just if you have got people that you think would provide appropriate information or testimony on those topics, send them our way, and get your mental engines revving for having those conversations, and then we will be thick into recommendations writing. Anyway we will continue to send out homework, continue to engage with the spreadsheet, and we just encourage folks to continue up the great work that has been going on. This pace will continue fast and furious.

Gillian Haney
Thank you so much.

Lauren Richie
Thank you everyone, have a great day.

Arien Malec
Thanks all. All right.

Lauren Richie
Bye bye.

Adjourn (01:28:16)