Transcript

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

October 12, 2022, 10:30 AM – 12 PM 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	Health Gorilla	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
Abby Sears	OCHIN	Member
Vivian Singletary	Task Force for Global Health	Member

Name	Organization	Role
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
Carol DeFrances	Centers for Disease Control and Prevention	Presenter

Call to Order/Roll Call (00:00:05)

Michael Berry
And hello, everyone. I am Mike Berry with ONC, and I would like to thank you for joining the Public Health Data Systems Taskforce. We have a guest presenter with us today, and I would like to thank them for joining us today. All taskforce 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. I am going to begin roll call of our taskforce members. When I call your name, please indicate that you are here, and I will start with our cochairs. Gillian Haney?

Gillian Haney
Good morning, present.

Michael Berry
Arien Malec?

Arien Malec
Good morning.

Michael Berry
Rachelle Boulton?

Rachelle Boulton
Good morning.

Michael Berry
Hans Buitendijk?

Hans Buitendijk
Good morning.

Michael Berry
Heather Cooks-Sinclair? Erin Holt Coyne?

Erin Holt Coyne
Good morning.

Michael Berry
Charles Cross? Steve Eichner?

Steven Eichner
Present, good morning.

Michael Berry
Joe Gibson?

Joe Gibson
Good morning.

Michael Berry
Raj Godavarthi?

Rajesh Godavarthi
Good morning.

Michael Berry
Jim Jirjis? John Kansky?

John Kansky
Good morning.

Michael Berry
Bryant Thomas Karras?

Bryant Thomas Karras
Hello, everybody.

Michael Berry
Steven Lane?

Steven Lane
Good morning.

Michael Berry
Jennifer Layden? Leslie Lenert? Hung Luu?

Hung S. Luu
Good morning.

Michael Berry
Mark Marostica?

Mark Marostica
Present, good morning.

Michael Berry
Aaron Miri?

Aaron Miri
Good morning.

Michael Berry
Alexandra Mugge?

Alexandra Mugge
Good morning.

Michael Berry
Stephen Murphy?

Stephen Murphy
Good morning.

Michael Berry
Eliel Oliveira?

Eliel Oliveira
Good morning.

Michael Berry
Jamie Pina?

Jamie Pina
Present, good morning.

Michael Berry
Abby Sears? Vivian Singletary? Fil Southerland?

Fillipe Southerland
Good morning.

Michael Berry
And Sheryl Turney?

Sheryl Turney
Good morning.

Michael Berry
Good morning, everyone, and thank you so much, and now, please join me in welcoming Arien and Gillian for their opening remarks.

Arien Malec
Good morning. So, we are at the end of our F criteria. This is the last of our series of panels where we talk about the state of healthcare standards associated with the F criteria. We are down to F7, which is transmission to public health agencies for healthcare survey data. We will talk about this at the end of the

meeting, but our intent is also to follow this up with one more panel focused on public health data systems technology vendors, really hearing from the folks who build and deploy public health data systems, but the action after this meeting moves firmly into getting through all of the input and feedback that we have gotten and synthesizing that into recommendations, and so, we will spend a good amount of time here focused on the taskforce topics worksheet.

So, we have this important panel initially to talk about healthcare surveys, which occupy a somewhat different niche in the public health data systems and standards landscape, and I think we will hear a little bit about how healthcare survey data is special in just a moment. We will get through the discussion on healthcare surveys and then get into the taskforce topics discussion. So, with that, I am going to turn it over to Gillian, and then we can get into the discussion. Anything more you want to add?

Gillian Haney
No, not really. I think these surveys are looking at more of the provider universe of health data versus population health, so, as you mentioned, it is a little bit different. Our presenter today is Carol DeFrances from the Division of Healthcare Statistics at CDC's National Center for Health Statistics. Welcome, Carol, and the floor is yours.

(f)(7) Transmission to Public Health Agencies – Health Care Surveys (00:04:35)

Carol DeFrances
Great, thank you so much. Can you bring up my presentation, please? Great. I am very pleased to be here to discuss the National Healthcare Surveys, which are conducted by my division at NCHS. Next slide, please. The National Healthcare Surveys are a family of nationally representative surveys that examine healthcare provided across a wide spectrum of care, from ambulatory, to hospital, to outpatient and long-term care. They are establishment surveys, not household surveys. The unit of analysis for these surveys is the patient visit or encounter, not the actual patient. They provide estimates of the universe of encounters with providers, not the population.

Historically, patient-level data has been abstracted from medical or administrative data. They also include healthcare provider surveys to understand this population's experience providing care. Participation in the National Healthcare Surveys is voluntary. Next slide, please. This is a very busy slide, but it shows the spectrum of care covered by the National Healthcare Surveys. I am just quickly going to highlight the surveys. We currently have five that are active: Two physician surveys, the National Ambulatory Medical Care Survey, or NAMCS, that collects data from physician offices and health centers, we have the National Electronic Health Records Survey, NEHRS, which collects data on adoption and use of electronic health records, and we partner with ONC on the survey.

We have two hospital surveys, the National Hospital Ambulatory Medical Care Survey, which collects currently just emergency department data, and we also have the National Hospital Care Survey, which collects inpatient data and emergency department data. And then, we also have a long-term care survey, the National Post-Acute and Long-Term Care Study, or NPALS. NPALS covers seven long-term care sectors. For five of the sectors, we buy data from CMS. In two of the sectors, residential care communities and adult day service centers, we do original data collection. The Hospital Care Survey and the National Ambulatory Medical Care Survey are our first surveys to move to EHR data collection for patient encounters. Next slide, please.

Examples of the data that are collected: We collect facility and practice-level information, and then, for the encounter, we collect patient data and demographics, and we also collect personal identifiers for NAMCS and also hospital care, such as name, address, and Social Security number. We use that data to link to the National Death Index, CMS data, and HUD data, and also to trace repeat visits and hospitalizations. And then, there is encounter information: Reason for visit, diagnoses, and procedures. Next slide, please.

The users of our data are varied, such as students, researchers, the media, and policymakers, and the data are disseminated in a variety of ways. We put out preliminary data during COVID-19, we have public use files, we have restricted use files that are available through the NCHS Research Data Network, we produce reports, our data are used in peer-reviewed journal articles that we write and also that researchers write, and also, the data appear in official government reports such as CDC's MWRs, and also Health US. Next slide, please.

We have leveraged both standards and federal regulations to move to EHR data collection. The first HL7 standard that we used was clinical document architecture, or the CDA standard. Our latest, CDA Release 3, is streamlined by dropping lower-importance data elements and aligns with USCDI. To keep abreast of where EHRs are headed, we have developed a healthcare FHIR content IG that is currently being balloted by HL7. Our FHIR content IG is also aligned with USCDI. This content IG works together with the CDC MedMorph reference architecture to automatically extract data from a provider's EHR and send it to a CDC endpoint. By using the MedMorph reference architecture, we are aligning ourselves with other CDC programs that are using it, such as electronic case reporting and cancer reporting, which will hopefully reduce burden for both providers and EHR vendors.

We have also leveraged the CMS Promoting Interoperability program. We have about 95,000 providers and 350 hospitals that have registered their intent to send EHR data to NCHS and the National Healthcare Surveys Registry. At the moment, any EC, EH, or CHH can register with us, but due to infrastructure constraints, we only ask registrants that are sampled in our surveys to send us EHR data, and currently, the Hospital Care Survey is the only survey currently collecting EHR data in the format of our CDA Version 1.2 from registrants that are sampled hospitals. And we have over 100 EHR products certified to our CDA Version 1.2 IG, including most of the largest EHR vendors. Next slide, please.

We are building infrastructure and enhancing capacity to support EHR data collection. As part of the CDC Data Modernization Initiative, we are migrating to the cloud for the collection, processing, and storing of our EHR and claims data. Also as part of the CDC DMI, we are conducting a pilot test to test our FHIR app on several providers and build a data lake at CDC to process and store this data, and also trying to develop governance for the sharing of the EHR data with other CDC programs. Next slide, please.

I want to end with our vision for the future. We hope to utilize all National Healthcare Survey registrants, providers, and hospitals to submit data to us in the future using the FHIR IG that we are developing so that we can continue to create nationally representative data sets and also develop surveillance and research data sets. We hope to build a data lake at CDC to share with other CDC programs the EHR data collected by the National Healthcare Surveys.

By having the capacity to attain all visits for providers and hospitals, we can make timely and reliable estimates for conditions resulting from public health emergencies and even rare conditions, and we would

like to continue our methodological work, explore other data linkages to Medicaid and Veterans Affairs data, continue our natural language processing and algorithm development for opioid and other drug encounters, social determinants of health, and other medical conditions, and explore a use of privacy-preserving record linkages and development of synthetic data for public and restricted-use files. Thank you so much for the opportunity to present about the National Healthcare Surveys, and I am happy to take your questions.

Discussion (00:12:10)

Gillian Haney

Great. Thank you very much, Carol, for that incredibly succinct overview. As you well indicated there, this is a very different data set and use from the other public health criterion that we have reviewed, and I see that Arien has his hand up, so, Arien, please.

Arien Malec

Yeah, thank you. Again, thank you for the presentation. It was really, really helpful. The current F criteria here referenced the 1.0 or the 1.something guide. It just says "Release 1," right now, a 2014 guide, and it sounds like you have later guides that are more streamlined, and then you also have the FHIR guide. As we think about certification criteria for public health data systems, it sounds like your preference would be to see industry move to the latest implementation guide, and it also sounds like you have a preference for the FHIR-based guide, or maybe I am reading too much into that portion of your presentation.

Carol DeFrances

No, I think that is correct. We have a number of releases. We started out with 1.0, and we have 1.1 and 1.2. Most of the products that we have that are certified are to 1.2, and we actually have a 2.1, and now we are up to Release 3. There have been no products certified at this point to anything but the 1.2.

Arien Malec

Sorry, I am just looking at the criteria right now, and right now, the criteria reference 1.0, they optionally reference 1.2, which sounds like where the majority of certifications are, and then, you are SVAPed to Release 3, but nobody is taking you up on the offer to go to Release 3.

Carol DeFrances

Right. I guess I should give a little history. When we developed the IG, again, we did medical record abstraction onsite, and so, basically, when we did the first versions of the implementation guide, we just took those elements, put them in, and said, "Okay, we are going to collect this data," and we found out over time that we cannot collect some of those elements through the EHR because they were subjective. There was somebody looking through notes and going yes or no. So, we have learned that we needed to streamline. Also, too, the early versions of the IG were set up by survey, and we actually decided in 1.2 to make a switch. That version is actually by setting.

So, we have ambulatory, inpatient, and also ED, so we have learned as we have gone along. I think right now, though, that it has been very hard. We are small in the scheme of things because we are sample-based right now. Vendors have been reluctant to build products to us. They have, which has been wonderful, but I think moving to USCDI and FHIR, we are trying to go a little bit more mainstream, join other parts of CDC, so yes, our preference is to move to FHIR. We think that that is going to be the way for us in the future.

Arien Malec
Thank you so much.

Gillian Haney
Carol, could you talk a little bit about the sense of scale in terms of how many provider organizations are participating, or is the intent to broaden that distribution?

Carol DeFrances
Right. So, in the registry, like I said, we currently have about 95,000 ECs and 350 hospitals. We had a lot more, but the PI rules have changed, so now we are a bonus, so we have had a lot drop out, but the hope with the remaining would be that over time and with building of infrastructure, we would bring all those 95,000 providers and all those hospitals on and collect the data, not only for use by NCHS, but for other parts of CDC as well. That is our hope.

Gillian Haney
John?

John Kansky
John Kansky from the Indiana Health Information Exchange. That was actually a really good setup for my question. So, the approach, and the movement to the cloud, and the movement to the standards and FHIR makes total sense to me. This is really a question about given the challenges, I am sure, of having consistent coverage across the country, but also given that it is voluntary and the changes in PI that you mentioned, has there been any consideration of trying to fill in gaps or augment the data you are currently getting by leveraging health information exchanges?

Carol DeFrances
No. We have considered it. Currently, we are purchasing data from third-party vendors to supplement the data we collect. I did some work initially a few years ago with HIEs, and again, we have had some discussions, but it kind of led nowhere, but I think we are open to that in the future. Yes, we would consider. I think trying to get these data is difficult. We go to individual providers, and as you can imagine, working with the physician office, trying to get the interface on, is a big ordeal. So, I think we are open to looking to other places where we could possibly get the data, and again, we could revisit that in the future.

John Kansky
If there is interest, I might reach out to help broker a discussion about pilot projects or something. Thank you.

Carol DeFrances
And again, we would love that, John. Thank you.

Gillian Haney
Bryant? You are muted, Bryant.

Bryant Thomas Karras

Apologies. Carol, two quick questions. I will ask the more sensitive one first, and you can answer quickly, and then we can follow up. You mentioned Social Security numbers are collected for the ability to longitudinally link data and desire to move towards privacy-preserving record linkage methodologies. Especially with the movement to the cloud, are you doing anything to protect those Social Security numbers, like hashing them as they are received or creating an implementation guide, a hash, of the Social Security numbers so that you are not collecting plain-text Social Securities?

Carol DeFrances
Right. So, I should say we ask for it, we do not always get it, and sometimes we only get the last four digits, so we do not always get it. We are looking into other ways to protect that data. I do not want to go into them all, but the way it is stored and so forth, it is locked down, as you can imagine.

Bryant Thomas Karras
Pointedly, are those data elements shared with researchers, or just used internally?

Carol DeFrances
No. So, the linkage variables are not shared with researchers, and there is no intention to share that data. It will only be used for linkage purposes.

Bryant Thomas Karras
Thank you. My second question is kind of a follow-on to Gillian's. It seems like there has to be a perfect alignment of people who are randomly selected for survey and people who have a certified technology. Of that join, how many today are actually able to send you automated electronic record system extracts? I imagine it is a relatively small number.

Carol DeFrances
Right. As I said in my remarks, we are only collecting it for the National Hospital Care Survey. At the moment, we have about 50 hospitals that are in the sample. I think you were asking for problems, and this is another: Actually getting the data. We probably only get it from half. We have a really hard time also getting the data from even a sampled hospital that is in the registry. We do a lot of one-on-one work with them, but even just getting the approvals from them to send the data, sometimes we do not get it because we cannot get the approvals. We are on production schedules, we have timelines, so that has been difficult.

We do testing and validation with the hospitals, and again, there have been a lot of issues with the data quality when we do the testing and validation, so there is a lot of work with the hospital with their vendor. A recent example: We had several hospitals send us data, and there was no identifier in the header to identify where the data came from, so we had to go back, and it was two different vendors, and it has been corrected, but we had to work to get that corrected. So, there is a lot of back and forth, even just to get the data, as you can imagine.

Bryant Thomas Karras
And then, from our experience getting CDAs from the hospitals in our jurisdiction, even when you get the data, when you actually dig into it, there are a lot of empty fields that were customized during the implementation and are not appropriately extracting out what you thought they were going to be abstracting for you.

Carol DeFrances
Right, and that was one thing, too, in the certification process. There is no context-based testing for us. It is not required, so we did not have it, so the format is correct, but the required shells were not there. So, I know we are currently getting some data from health centers, and I was talking to staff preparing to come today, and they were telling me that with diagnoses and active problems, they were looking, and they could not find them in the field where they were, but subsequently, we looked, and they were in a different spot. So, we did find them, but they were not where they were supposed to be, so we have issues like that as well. The custom elements that we want are usually not there, so there have been issues.

Bryant Thomas Karras
Thank you so much. We may want to follow up with you as we make thoughts around next-level deeper certification going into the content validation rather than just structural validation so that there is more consistency. It might be useful to follow up with your staff to see how that implementation guide could be translated into certification criteria for the senders.

Carol DeFrances
That would be great. I think another thing, if I could, is the competing standards. Historically, we at NCHS have put out our diagnoses in ICD, and so, when we approached hospitals, we asked if we could get the diagnoses in ICD-10 CM, and that has been hit-or-miss too. We get them in SNOMED and have to convert, which we do, but as you know, there is information that is lost, and we have recently been working with medication data, and again, we get the data in RxNorm, Multum, NCD…

Bryant Thomas Karras
NCPDP, everything.

Carol DeFrances
Yeah, everything, and again, it is doable, we are doing it, but it would be really nice if we could specify and say RxNorm and get the data there. As you know, it takes a lot of time to put this all together, and there is always information that is lost when trying to convert, so that has been another issue, but we are doing the best we can.

Gillian Haney
Sounds like there are some opportunities there for sure. Hans?

Hans Buitendijk
Thank you. I have a couple small questions. From your perspective, do you see the CDA-based Release 3 that is currently SVAP as the last CDA-based specification and that, moving forward, you are shifting everything to the FHIR-based approach, or do you still see a potential release after it that is CDA-based?

Carol DeFrances
I think we are seeing moving to FHIR. I think that is where we want to go, and again, as I mentioned in my remarks, we have been part of the CDC MedMorph project that has been going on, trying to improve getting data to public health, so I think that is where we see ourselves going, is to FHIR.

Hans Buitendijk
And based on that, with the FHIR-based approach that builds on MedMorph, do you see that the acquisition of the data and the submission process is intended to follow the entire guide, or do you see that the report itself, the survey itself, is really the core of it and the method by which that is being obtained, acquired, and shared with CDC is still open?

Carol DeFrances
Again, we are aligning, and I think that is really a fundamental shift too. In moving the FHIR guide, we really aligned more with USCDI, so, in some sense, we dropped elements, and expected payment was one of them, but again, we felt it was better to align ourselves more with the standard, that we had a better chance of getting the data, and then, over time, as the USCDI changes, we could make requests for adding elements. Again, there are a lot of requests for data, particularly for hospitals and physicians, and I think our hope is if we could streamline what we are asking, bring it in, and then share it with other parts of CDC, that would be great strides, less burden for the provider, and also, I think the EHR vendors would be more likely to work with us and support what we are trying to do so they did not have to do custom interface for our surveys.

Hans Buitendijk
Maybe to clarify my question, it was not as much focused on the report itself, the content, more of the exchange, transport, and methods to acquire data because MedMorph and ECR are a particular style of acquiring the data that uses the FHIR-based APIs on the EHRs, and for certain parties, that may or may not be the most appropriate way to get it. Other ones might be providing the specification of the data, like today with the CDA, in FHIR format, and then, at that point in time, I will figure out how to get the data, as long as there is an agreed-to submission that may not follow all aspects of MedMorph, and that is where I was trying to understand if the intent was really to stick to MedMorph as is or focus primarily on the content, i.e. the equivalent of CDA and then moving forward in FHIR, and let the method have more flexibility.

Carol DeFrances
At this point, I do not know if I can really answer. We are just in the midst of doing our FHIR pilot, so we are actually trying to recruit providers to do it, so I am not sure if I could answer. I think we need to see how it goes with just doing it on a few providers. I think we are open, though, to how we can best get this data, and if it is not using exactly the MedMorph architecture, I think we can make that decision down the line, but truly, how do we get this data and do it with the least burden on the provider and the vendor so that we can get the information that we need to put out the official statistics that we are supposed to produce?

Hans Buitendijk
I would agree. The report, the content, the payload is the critical part that we are all relying on. There are some potential variations, as we have learned, that some may want to take advantage of based on the actual systems that they have. That is where I was going. Thank you.

Gillian Haney
Any other questions for Carol? Carol, thank you so much for coming on. You are welcome to stay on, but we will be shifting over to putting together our proposed recommendations, and you are under no obligation to stay on, although you would be most welcome.

Arien Malec
There is much sausage that will be made in the next hour. Carol, thank you so much. That was fantastic.

Carol DeFrances
Thank you so much, and I appreciate the opportunity, and if there are any other questions, please reach out to me. Thanks so much. I think I am going to drop off.

Gillian Haney
Okay, thank you. Okay, well, with that, I think we have quite a bit of time today to really start working through the proposed recommendations on the worksheet and the comments. I am trying to remember where we left off last time. I think we were in syndromic surveillance.

Task Force Topics Worksheet (00:30:51)

Arien Malec
Yeah. So, Liz, have we moved some of the content over to the transmittal? Maybe we can just cover where we are right now in terms of… I went back and marked a bunch of stuff that was ready to be moved over transmittal versus stuff that still warrants continued discussion. Is Liz on today?

Liz Turi
I am here. I have not transferred it over, but I will today.

Arien Malec
Got it, cool.

Gillian Haney
Could we just quickly review which ones we agreed will be transferred over, just a quick highlight?

Arien Malec
Of course.

Liz Turi
Arien, you had marked the ones that are ready to transfer as “transfer,” right?

Arien Malec
Yup.

Liz Turi
Perfect.

Arien Malec
All right. Ooh, they got compressed.

Liz Turi
Yeah.

Arien Malec

I am trying to move my…there we go. So, these are mostly the ones that we have already gone over multiple times. So, the first one is related to immunization registries. If we could just move over one little bit…all right, cool. So, I think I put in a general overview set of criteria, and we should figure out how we want to handle this particular issue, but whether we want to make recommendations that ONC create certification programs for public health broadly or make more specific recommendations related to each of the F criteria, but here, there are gaps in the existing certification criteria where we want to add transport to the existing criteria, so, "We recommend that ONC coordinate with public health," and we have to find the right word for "public stakeholders" that includes…

Bryant Thomas Karras
Not "stakeholders."

Arien Malec
…STLTs, CSTE, ASTO, etc., so we have a set of public health actors, and Gillian, we might want to create a defined term and ten reference that defined term throughout the document. The intent here is that ONC would coordinate with, in this case, AIRA, STLTs, CDC, and other folks who have expertise and interest in the correct running of immunization registry. I think we would look at Hans's modification. The intent of this one is to also certify to the transport spec as well as to the content spec, both for immunization reporting and query retrieval.

Hans Buitendijk
And Arien, to clarify, both the comments in Rows 4 and 5, Nos. 2 and 3, are not realizing yet what the G column around transfer exactly meant. There seemed to be an opportunity to consolidate, so that is where the comment came from, we can keep it separate, or we can combine it as suggested.

Arien Malec
Yeah. Once we get this over into transmittal land, we want to have a transmittal that reads well.

Steven Eichner
Just as a reminder, public health gets to determine the transport mechanism.

Arien Malec
Yeah, no doubt. This is a question of certification criteria, where the certification criteria do not currently include certification to any transport.

Steven Eichner
Right, but I want to make sure that the recommendation clearly clarifies that public health has the right and responsibility to select and mandate the transport criterion for its jurisdiction. It might be one of a number of flavors, but we cannot be limited to a single transport standard.

Arien Malec
This, again, gets into what certification is, which probably warrants discussion, but again, the notion of certification is that we are certifying to a floor in ways that would improve the ability of public health authorities to be able to serve their mission. Raising the floor does not mean that every jurisdiction has to

use the floor. It does mean that jurisdictions that do not use the floor will have more special effort than jurisdictions that do use the floor.

Also, raising the floor does not limit local jurisdictions from raising the ceiling. Raising the ceiling, again, requires more effort than sticking with the floor, but there are often reasons associated with SVAP and others to raise the ceiling, so I do not think anything we are talking about for certification binds organizations from using things that are not certified in the same way that the EHR certification program does not bind organizations from using capabilities that are certified. There are some cases where there are programmatics that may specifically tie back to certification. These days, for CMS, we have required the use of certified technology, and only in limited situations have we required the use of the actual certified standard.

Steven Eichner
However, part of the reason that we are here is because of challenges or issues that providers have raised with public health putting requirements that are legitimate requirements under current jurisdictional law that are not contained in certification criteria, so the recommendation really does need to include language that recognizes the role and responsibility of public health jurisdictions to be able to designate what they need.

Arien Malec
Yeah, I think this topic belongs in an overview section or a general section, and not attached to each bit of certification, but again, as a taskforce member, you could say that we should not certify to a transport mechanism, and then we could have that conversation, because you want to preserve the ability to select your own transport mechanism and you fear that certification would limit your ability to select a transport mechanism. I think we heard in the immunization hearing that in most cases, most jurisdictions and most EHRs were, in fact, using the CDC transport implementation guide, and that it would be useful to certify to that guide. I am going to go to Bryant, who has his hand up.

Bryant Thomas Karras
I think it is related. I just wanted to emphasize that the floor problem and the exact wording in the certification is problematic in that the federal rule states that the state and local health jurisdictions can determine the transport mechanism. The certification has “ors” around different transport mechanisms that can be included in the process for the EHR vendor to get certified, and when there is an “or,” the vendors tend to take it literally and only do one of the transport mechanisms, thereby effectively eliminating the ability of the state or jurisdiction to make that self-determination of what is the most efficient, cost-effective transport mechanism in their jurisdiction, and we need to get these two things aligned, Arien.

Arien Malec
No doubt. If there is an alternative transport mechanism that has an implementation guide around it, that would be a potentially useful thing to put.

Bryant Thomas Karras
There is, and the vendors have all chosen to treat it… It was written that way in the certification process. They can do this one or this one to get certified. They do not have to do both of them, thereby being ready for whatever jurisdiction, and then, as you said, that creates customization dilemmas in those jurisdictions that have chosen the other of the two.

Arien Malec
Hans has his hand up.

Hans Buitendijk
This is always a hard topic because on the one hand, clearly, the needs of different jurisdictions and authorities are different, and that can create variation that can create challenges in the ability for overall provider-level technology developers to support them, so I think the part of the recommendations that is critical is that it is coordination and alignment on these methods so that solutions are being found. If you look at the case reporting APHL AIMS flow, where you have a couple of different options to get the same content across that were by way of mechanisms like a hub there is opportunity to have flexibility, that we need to figure out where you can have the flexibility and where you can still get the alignment. So, I think coordination is critical. It is not, in that sense, that this is the only way in which it can be done at a national level, that we have figured it out on how that works, so that balance needs to be maintained. Otherwise, we are going to continue to have a large set of variations that are probably not necessary to maintain.

Arien Malec
I am reading the actual certification criteria and the clarification on Sub-bullet 3. "While no transport standard is required for this criterion, an expert panel convened by CDC and AIRA has recommended a SOAP-based standard for transport of immunization data." So, right now, the current state is that there are no transport requirements that are enshrined in certification, and all this recommendation is recommending is that we add a transport requirement to the set of certification criteria. Gillian?

Gillian Haney
Yeah, I just want to bring back a point that you mentioned briefly around this, and maybe when we pull transport certifications to more of an overarching statement around this, that would cover all criteria.

Arien Malec
So, that is the approach that I would recommend as well. I feel like if each attempt to add certification gets involved into a debate on states and localities' flexibility and legal ability to do something else, then that is something that really belongs in an overarching comment about what is the role of certification, what is the authority of public health authority, and what is the intent of the certification programs. So, the intent of a certification program is to help public health do its mission cheaper, faster, and more effectively. Clearly, if we are recommending certification criteria that do not, in fact, help public health do their job cheaper, faster, and more effectively, we should not make those recommendations.

The notion here is that by certifying both parties to a common transport standard, we would reduce the needs of states to be able to create their own transport requirements, and that would help states and localities get their job done cheaper, faster, and more effectively. If we do not believe that is true, we should not make the recommendation, but as an overview, we should make it clear what the role of certification is and welcome anybody who wants to write that into the overview section. I am more than happy to take a pass at that, and we can consider it in a subsequent meeting.

Gillian Haney

Also, to Bryant's point, I think we just want to make sure we have this data flexibility and the authority, though, to go to higher standards as they become available.

Arien Malec
Right. That is also enshrined in SVAP, and we should re-endorse the notion of SVAP, that creating a floor is intended to create a common mechanism, not intended to limit the ability of STLTs or other public health authorities from mutually agreeing on, endorsing, or requiring higher forms of interoperability. Again, just to be super clear, it also does not create an assumption that every STLT will use the common floor, it is just a recognition that STLTs that do not use the common floor will find the sledding harder going than STLTs that do.

All right, let's go to the next criterion. So, I am sort of getting lost between Hans's revision and the original one. Okay, cool. So, we have two recommendations here, one of which I think probably should be lifted out into a more general-purpose one. So, the first one is that I think we heard testimony from AIRA that there is indeed STLT variance in terms of the use of the existing HL7 implementation guide, and I have to find the actual AIRA report because I was not able to find the AIRA report that was referenced on their public website, but if you go through the variation noted in that AIRA report, most of it is due to inventory requirements and consent requirements, and then, I think we also heard that there is increasing variance in the use of more specific race/ethnicity tracking, and so, that forms these two requirements, one of which is more general-purpose than the other.

Specific to immunization, we recommend that ONC coordinate with whomever is referred to by our term of art that we have to find to update the immunization implementation specification to better support predictable variations and inventory consent requirements. Potentially, we could add other state-by-state or locality-by-locality variations. The second one is that same recommendation relative to a more expansive race/ethnicity coding system, and again, I want to remind people that the state of play is that race and ethnicity is coded to the full CDC code set, so there are no requirements to only use the OMB 5+2, but the only subset that is certified to is the OMB 5+2, which creates a floor that is too low in the nation, and so, we are proposing recommending that ONC work with other relevant organizations to create a slightly more expansive race and ethnicity coding system that can serve as the need for a common floor and reduce the need for jurisdictional variation. Comments, questions? All right. There is a lot going on in the chat.

So, in the fourth one, I think we recognize that there are two current test methods that are noted in certification. One was the original immunization test method. Since the original immunization test method was promulgated, AIRA, in conjunction with HIMSS, created the HIMSS IIP set of test methods and associated implementation guidance, and in their current certification criteria, ONC allowed for use of either test method. This recommendation states that ONC should deprecate the non-HIMSS IIP test method and standardize on the HIMSS IIP test method. Questions, comments? Cool. Noam says it is HIMSS-AIRA IIP, but if you go to the AIRA site, it is actually labeled "HIMSS IIP," so I use the terminology that AIRA uses. Ike?

Steven Eichner
Sorry, I was unmuting. Quick question on what is the impact of the changing in the test criterion on the public health side.

Arien Malec
So, my understanding from the AIRA presentation is that most EHRs already certify to the HIMSS IIP certification criteria or test methods, and that most public health data systems, most immunization information systems already align to the HIMSS IIP certification criteria. I believe there will always be corner cases, but the AIRA criteria are the criteria that almost everybody uses, and the only reason that the original test method exists is that ONC has been relatively conservative in its regulatory process to not remove criteria. It was easier for ONC to preserve methods to voluntarily adopt the HIMSS IIP criteria than it was for them to remove the older method. Hans has his hand up.

Steven Eichner
I have a follow-on. So, abstracting that concept, a more general recommendation might be to look at revising the testing criterion across the board to better reflect compatibility of the test criterion with existing public health data systems.

Arien Malec
I agree with that. That is the AIRA-HIMSS IIP criteria, so the intent of the AIRA criteria was to look at real-world implementation and create an implementation guide and test methods that harmonize to the real-world experience for both immunization actors, government actors, and **[inaudible – crosstalk] [00:51:50]**.

Steven Eichner
Understood. I was looking at conceptually expanding that to be syndromic surveillance through other exchanges that are occurring as well, obviously not the same tool.

Arien Malec
No, that makes sense, and I think we do have specific recommendations in each of those areas that we effectively do a rev to look at real-world experience and rev to where we have variation. Hans?

Hans Buitendijk
Yes, I have just a clarifying question around this. There are indeed a number of systems that use the HIMSS IIP, but others do not necessarily do that, so the question comes from a community perspective. If we go that route, would that require people to be part of HIMSS IIP? Is it going to be flown into existing ACB? So, I think we want to focus on the method being adopted in such a way that it does not incur additional efforts otherwise.

Arien Malec
Yeah. I was thoughtful as I was constructing that language at that point, and I think the way that the language reads states that, so we recognize the HIMSS IIP test method as the method used for certification and deprecate the current primary test method. We are not saying in this recommendation that we use the HIMSS IIP AIRA test program and ACBs, that we are really talking about adopting the test method, but Hans, I am happy to accept any friendly amendments here.

Hans Buitendijk
I wanted to ponder that a little bit because the term became clear, but I am not sure if everybody interprets it that way. I am trying to figure out how to make sure that is not misinterpreted.

Arien Malec
Yeah. Well, this may be an area to say, "For clarity, we intend…" I have a tendency, as I think people who have worked with me before know, to sometimes be hyper-nuanced in how I am using language that may be crystal clear only in my head about how hyper-nuanced I am using the language, so this may be an area where we want to put a "for clarity." All right, Item 5. Are these really the only ones that have been noted as transferred? Cool.

Liz Turi
Yeah, I filtered through.

Arien Malec
Got it. All right, Item 5. "We recommend that any certification criteria for public health data systems interoperability be modular and provide health authorities maximal flexibility in selecting certified technology which may be owned, or managed, or consumed as a service, or through intermediaries, state HIEs, APHL, and others, according to legal policy procurement rules governing public health." Ike suggests adding "legal policy, procurement rules, and practices governing public health." So, basically, we intend certification criteria to be modular, we intend the certification criteria to allow public health agencies and authorities to mix and match certified technology in order to serve the public health mission, and we recognize that the choice of technology and the deployment of technology is going to follow legal policy practice and procurement rules. John?

John Kansky
Thanks. I like and support this recommendation. I added an observation which references this which I believe is separate, but it is calling that out. Speaking of hyper-nuance, it is basically trying to suggest that yes, this is a good recommendation, but even if the world does what this recommendation says, there are potential policy barriers that prevent a state or jurisdiction from taking advantage of this flexibility, and what we might recommend the ONC do about that is a different question, but I just wanted to call out that that observation is on Row 70 or something like that, if you see it as related.

Arien Malec
Absolutely. This is going to be an area where the answer is "it depends." If the policy barriers are state law, then ONC is not going to be able to do anything about state law. If the policy barriers are, for example, the common rules associated with minimum necessary under HIPAA, that would be an area where I think it would be appropriate for us to make recommendations that ONC work with OCR and…sorry, Gillian, I always forget the plethora of acronyms associated with the national public health authorities. What is the national public health law forum?

Rachel
Network for Public Health Law.

Gillian Haney
Network for Public Health Law, good one, Rachel. NPHL.

Arien Malec

NPHL, thank you. Acronym translation. ONC, NPHL, and OCR would be appropriate actors to be able to streamline the federal policy associated with the limitations. John, that is how I would think about that, is if there are specific limitations that are in ONC's purview to do anything about, then that would be appropriate. If the limitations that you have are state-law-based limitations, then that is not going to be a helpful thing for us to comment on.

John Kansky
Well, speaking specifically about state law or state policy issues that you referenced, I have learned that with taskforce recommendations, obviously, you have to state what is in scope and you have to consider that ONC only has its scope, and therefore, recommendations range from laser-focused and implementable to wimpy and vague, and we try to avoid the wimpy and vague recommendations, and at the risk of asking the taskforce to consider vague and wimpy, I think that ONC might, within its purview, at least direct some attention to the variations in state law that stand as barriers to the goal of complete public health reporting and possibly go so far as to say hey, here is some guidance on what appear to be best practices. That is the best I have.

Arien Malec
Yeah, guidance and best practices may be appropriate. If there are specific items that are known best practices where we can create guidance and we can create specific recommendations, I think that is a reasonable thing for us to consider. I think the general statement that states should behave themselves will A). Not be able to pass this taskforce, and B). Not be implementable in practice.

John Kansky
Last comment, and then I will let you go. If some of the smart people on the taskforce put energy into thinking about this for **[inaudible] [01:00:10]** F criteria really might pertain to, we could probably craft something more specific. It sounds like a lot of work, and probably, what I am trying to suggest would be done outside the taskforce.

Arien Malec
Yup, cool. Okay, so, I think what we heard in this review is the need to create some preamble or some overarching text on the role of certification and on the reality that public health authorities are indeed public health authorities, that are duly designated under state law, and, in our federal system, have the rights that are granted, and that the intent of a certification program is to reduce implementation burden and serve the public health mission, but that doing so in no way limits the ability of states and localities as authorized to do other things. Joe?

Joe Gibson
Thinking about that, I keep thinking about emissions standards for cars and how much of what we are proposing is tied to the reality of what public health agencies are using out there right now. If you change emissions standards for cars, it is going to take years to get the cars off the road that fall below that standard, and you have to set a standard where all cars being sold can meet that standard to do that migration, so you cannot set a standard that is going to be too expensive for people to implement as they buy into a new system, and you have to give enough lead time that the folks who have old systems that are not going to meet the standard can bring it up to standard. I do not know the field enough to have a good sense of whether what we are proposing is appropriate to the field. We are saying everybody should do this and we

all should be on board with this new standard, meet this new standard because it is going to make everything work more efficiently, but part of the picture is what is out there now, and how much is it going to take to get to this standard, and how much is it going to cost to get to this standard?

Arien Malec
Thanks, Joe. So, first of all, are there objections to taking this material, with any modifications that we have discussed, to a transmittal draft? And again, that changes nothing in terms of our ability to change language, change wording, etc., it is just making the primary the transmittal draft, where we can read the material together as a more coordinated set of recommendations, for example, for immunization. So, any objections to moving this over to the transmittal draft? Wait two beats…okay. So, moving to "overarching," we have already discussed this one. Okay, let's scroll down one, and this is one where there is a noted observation, but as yet no noted recommendations. Hans is making a recommendation, and I actually think this one probably is ready to move forward to the transmittal, that we start aligning on the US@ guide relative to address information associated with patient matching. Comments on that one? Okay.

If we go on to the next one, Vivian recommends specified functional use of systems in lieu of certifying a system that has the capabilities required. So, I think 63 was the one that we noted that was the duplicate…6 and 63. So, I think 6 is the one where I do not actually have any recommendations, and let's hold until we get down to 63. This is duplicative with the other recommendation that we just discussed, but Jamie makes recommendations on race/ethnicity, preferred language, and SOGI data. So, in USCDI V.3, we do have significant revisions to SOGI information. Steven, it has been so long since we did the USCDI portion of the taskforce. I do not remember the state of preferred language in USCDI V.3. If you are able to comment…

Steven Lane
I do not think it is in there. I will go double-check.

Arien Malec
Okay, cool.

Steven Lane
Can whoever is driving expand the window under the observations? I remember typing a comment in this one.

Arien Malec
Okay. Erin has her hand up.

Erin Holt Coyne
Yeah, hi. I just wanted to clarify the observation I made on this one. I believe that the current cross-paradigm implementation guide that is out for ballot right now addressing gender identity, sex for clinical use, and so forth does speak to ability to pre-adopt, and basically, I am just correcting my observation here. With that, though, there would likely need to be specific guidance to ensure that that pre-adoption is done in a standard way if it was going in that direction.

Arien Malec

Okay. And this is where I was going in this conversation of USCDI V.3, that there are areas where we may have made substantial progress in USCDI V.3 and we could handle some of this stuff with a catchall reference to USCDI V.3, with respect, for example, to gender identity, sex for clinical use, and reported sex and gender, which are clarifications that we went in depth on in USCDI V.3, and then, there is the weirdly much more difficult area of common subsets for race and ethnicity, where, as far as I can tell, everyone recognizes that the OMB criteria are problematic, and yet, I do not actually know what the current status is for aligning to a better common subset. Steven, I saw you point at something for USCDI 3 for preferred language. It is in USCDI V.3? Cool.

Steven Lane
Yes. In fact, it is also back in V.1.

Arien Malec
Okay. So, I think we are there for preferred language in USCDI, and then, because all of the implementation guides for public health were done pre-USCDI, that would warrant relooking at implementation guidance for alignment to USCDI V.3, and that would pull the area of preferred language in, so I think we are actually in relatively good shape in terms of having the overarching policy framework in everywhere but race and ethnicity expansive subsets. Bryant?

Bryant Thomas Karras
I was just going to say I think that CDC has convened a taskforce which is working to publish and expand out those race and ethnicities. We need to make sure that we figure out how to be future-proof as those become published, but also, as I said before, I think that in some criteria, it may not go far enough, and I think it is one of those things that will continue to evolve to get to the right place eventually, so I hope that we do not end up with another sticking point in time that we look back at 2022 as the time we got stuck with that particular vision of race and ethnicity instead of being able to evolve forward.

Arien Malec
Well, definitely, aligning race and ethnicity subsets under the SVAP would be useful, and then, I think the structural issue that everyone is struggling with is that if we have a race and ethnicity subset that is needed for public health and a different, smaller one that is where EHRs are certified to, we know what the end of that story looks like, which is yeah, we can send over the expansive subsets and certify to sending over the expansive subsets in our public health implementation guides, but we will not, in fact, collect expansive information. Hans, you have some comments here.

Hans Buitendijk
On the note of whether these particular ones should be part of SVAP, vocabulary in general has the opportunity to go more quickly without being mentioned in SVAP, so I think we need to look at what parts are really the vocabulary, the extensions of the code sets, the value sets that are in play that can take advantage of being treated like vocabulary SNOMED, LOINC, etc. You can keep on adding and have a more current version that you can start to use, versus what do you do in the actual standard, where you may, in certain areas, create more specific value sets around it. But, by having that code system that can expand over time… I think we have to be careful about that from where we ask that to become.

Arien Malec

I do not think that is our problem because I think if you look at what is currently required in certification, aligning to the full CDC vocabulary set is required in certification, and if you look at the full CDC value set, it is hard to believe that that value set is anything but broad and expansive. The issue is that, in fact, we limit in certification to the OMB subset, and that forms the boundary for data collection. All right, let's move on. I think we have enough to work here. I am seeing good comments on the move for OMB to look at revision to the OMB subset, and so, there is no shortage of work going on here, there is no shortage of recognition that it is a problem, there is a shortage of an actual subset that we can point to. Gillian?

Gillian Haney
I was just waiting to comment on this next observation.

Arien Malec
Okay, cool. So, this next observation is… I think I would propose that we note this one as out of scope.

Gillian Haney
Agreed. That was my comment.

Arien Malec
Which is not to say that it is not useful, but it is not specifically relating to… Yeah, Liz, we need to add the "out of scope" public health topic. It is not specifically related to the F criteria or public health data certification. So, unless there are profound objections to noting this one as out of scope, I will suggest we move on. I will wait a couple of beats, and let's move down to the next one.

Okay, I am going to suggest that we handle this one with our overarching… What is the intent of certification? As an editorial and as a taskforce cochair, I think we will drive ourselves crazy in predictable positions. This is something I started this taskforce observing. I think we will drive ourselves crazy with predictable positions. We can make the case that there is too much jurisdictional variation, we can make the case that EHR vendors and provider organizations do not, in fact, offer the data that they need to, and that the blame for lack of good-quality data for public health lies with either of those two extremes. Our goal as a taskforce is to create a common floor that reduces burden both for EHR developers and providers and burden for public health, and helps public health better serve the mission.

And so, areas where we focus on what is a natural place to raise the floor are going to be productive areas; areas where we focus on limiting the ability of EHR vendors to do X or Y or limiting the ability of public authorities to do X or Y are not going to be productive. So, that is an editorial, but I think it is an editorial founded in seeing this debate play out 10,000 times and trying to chart a course towards some common subset. Okay, Les has an overarching comment, so I think we did move to overarching, "Combine recommendations to convene to create standards for…" Okay, so, what we want here, and we discussed this last time, is… We do not have a standard. We do not have an implementation guide. We do have some underlying standards, including CDS Hooks.

What we have observed is that there is a role to play, and I think we saw this play out in Zika. There is a useful role to play for public health to push informational information to provider organizations, and there is a role for public health to provide decision support or to make decision support available to EHR actors, and that we do not currently have standards and implementation guidance that are fit for purpose for those

two purposes. What we would like to do is create an overarching recommendation that ONC use its convening authority to convene public health stakeholders, or whatever our approved term is for that, and standards development organizations to explore and create implementation guidance, pilot and test it, and, if appropriate, create certification programs at some time in the future.

So, I think we have identified this as a need, as something we may want to have happen where we do not have standards on the ground, but we do need to create recommendation language. Les, if you are on, you are invited to create that. If I have time, I may do the work as well. So, I think 41 gets into the unhelpful debates. Go ahead. Does somebody want to speak?

Bryant Thomas Karras
Yeah, a comment on the last one before we move on. Although, Les, I agree with you that CDS Hooks would be ideal, the fact that the immunization exchange…the state of the art is a 2.5.1 method is going to make it difficult to leverage that in the short term, but if what you are recommending is that there be a convening and a future work moving towards leveraging of CDS Hooks once those FHIR APIs can be leveraged by an IIS API.

Arien Malec
That is exactly the intent. We do not have a fit-for-purpose standard right now, so there is nothing to certify to. As we saw in Zika, I think we recognize that providing decision support that is related to public health crises, like we saw in the early days of COVID as well, is an important function of public health, and so, therefore, what I believe we would like to recommend is that ONC use its convening authority to convene stakeholders to explore standards and appropriate implementation guidance. CDS Hooks would seem like it would be a natural choice. I do not think we want to name CDS Hooks at this stage except as one of the choices that ONC might want to consider. Les?

Leslie Lenert
I would just go back and say that vaccine forecasting is really decision support, and that if we could even begin with using the same language across different areas, we would make some progress, but in this particular situation, as we are talking about an IIS returning a vaccine forecast to an EHR, we definitely need to have some discussions as to what the best way would be to do that, and that CDS Hooks is a logical standard for that, and that we need to move away from the idea that every IIS does this differently, or does it in text-only format.

Arien Malec
Right. So, again, I think we are saying we have identified this as a common public health need, we see it in vaccine forecasting, we saw it in Zika, we saw it in COVID…

Leslie Lenert
Yeah, and in particular, in case reporting, when we want to have two-way communication, the pathway back into the EHR does need to be specified, that the current approach to specifying that is a direct message. It probably does not get that in front of the physician.

Arien Malec

Perfect, cool. So, I think we have a path forward. I think Les has volunteered to draft some language. Thank you, Les. Once we have that language drafted, we will review it and consider it for going forward. Both Hans and Noam note that agreeing on a common go-forward does not mean that we have to completely deprecate the existing things that are certified against, but we would want to provide a path forward. All right, let's go to 41. That is the area I think we just want to observe and move on with, unless we can turn this into recommendations, and again, I think the recommendation that wants to happen here is the recommendation of the intent or purpose of the certification program to raise the floor and reduce implementation burden, and the ability of public health to meet its mission without implying a limit on public health authority in any way. All right, let's go on to the next. Oh, we are in public comment time. Time flies. So, let us go to public comment, and then, after public comment, there is one of these that I wanted to move forward to because I think it actually starts to get to the core of what we are talking about here.

Public Comment (01:22:20)

Michael Berry
Thanks, Arien. We are now going to open up our meeting for public 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 are 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. I am not seeing any hands raised, Arien, so I will turn it back to you and Gillian.

Arien Malec
Awesome. All right, Liz, if we can put back the spreadsheet. And by the way, the use of the chat feature, if you are using that, is another way to meaningfully engage in the conversation, and is strongly encouraged. Okay, so, 42. This was in response to some of the comment that we heard relative to trigger criteria, LOINC subsets, early-days procedure and diagnosis codes, etc. We have certification criteria to conform to value sets. We do not currently have certification criteria that address updating value sets, and so, here, we are proposing recommendations to "certify to the ability of systems to update value sets that ONC, in conjunction with relevant stakeholders, create operating rules for the updating of value sets, and that ONC work with federal partners and relevant stakeholders to create mechanisms to encourage provider organizations to adhere to those operating rules."

So, the notion of an operating rule comes from the HIPAA transaction world, where there are well-recognized operating rules for, for example, use of eligibility that sit above the implementation guidance and make recommendations related to, for example, the transaction times that an eligibility transaction may take. Here, I think what we are looking for is recency of updates of value sets and the same kind of thing for trigger conditions for ECR. Comments? Okay. Let's move past 43 because there is one that I want to get to.

Gillian Haney
So, are we moving 42 over, then?

Arien Malec
I think we have not heard objection to moving 42 over.

Hans Buitendijk

Arien, on 42, we may need to have a little bit of clarifying language that we require some work on what the tools are for the standards to get that data across. They are not always well defined yet.

Arien Malec
Not always well defined, and this may be an area where, as we have done in the past, we start with functional criteria, show the ability to do the update, and then we get to use of the associated FHIR value set standard or other named implementation guidance. So, here at 44 is the one that I have been talking about. I do not think we are going to have time to drain this one, but this is a broad, overarching set of criteria. Recommendation A, that "ONC establish a certification program for public health data systems with public health data system analogs to the existing F criteria, along with new certification criteria for TEF queries supporting case investigations." We could potentially punt that one because I do have another one that is associated with TEF queries supporting case investigations.

"Recommend that ONC work with CDC and other federal agencies to…yada, yada, yada, that any federal program tied to certification contemplate the timeline disruption effort and funding associated with technology modernization to achieve certification." So, here, and we could flesh this point out, I think we are responding to the sentiment and feedback, most recently from Joe, but from a number of taskforce members, that we want to recognize that public health data systems are up and running, that data flows are up and running, that we want to reduce variation and reduce burden and improve the ability of public health to achieve their mission, but we do not want to rip and replace existing systems. So, that is the intent of the perhaps overly finely written "contemplate timeline disruption and fund associated with technology modernization to achieve certification." And then, the last one is "We recommend that ONC work with CDC," and then, Gillian, I am looking to you to find the right language for "public health stakeholders."

Gillian Haney
It will be "public health authorities."

Arien Malec
Do you intend, again, to exclude CSTE, ASTO, AIRA, etc. from that term?

Gillian Haney
No. Perhaps we could say "and data partners." I will come up with the right wordsmithing language that will work, but, "public health authorities."

Next Steps (01:28:32)

Arien Malec
So, if you can do that, we will use that as our common tool, our common language. Here, we want to create outcomes and metrics associated with certification so that we are actually achieving the mission, and again, I think this is an area that we welcome feedback on, welcome collaborative editing of this recommendation, but this one should be a pretty foundational recommendation, and one that we should spend some time talking about next meeting. All right, I think we successfully drained every last minute of time. I think we have one focused on law and one focused on public health developers coming up. Tomorrow, we are doing our brief update to HITAC, and we have a monthlong push to create final recommendations, so it is absolutely crunch time.

Gillian Haney

On that cheery note, have a great afternoon or morning, wherever you are, and keep those comments coming in the worksheet. Thank you very much.

Arien Malec
Thank you so much.

Hans Buitendijk
Take care.

Adjourn (01:29:54)