Health Information Technology Advisory Committee

Public Health Data Systems Task Force 2021 Virtual Meeting

Meeting Notes | June 3, 2021, 10:30 a.m. – 12:00 p.m. ET

Executive Summary

The focus of the Public Health Data Systems Task Force 2021 (PHDS TF 2021) meeting was to continue to review feedback from TF members and to work to create a series of recommendations to the HITAC. The PHDS TF 2021 co-chairs, Janet Hamilton and Carolyn Petersen, opened the meeting, reviewed the agenda and PHDS TF charges, and thanked members for their responses to PHDS TF homework. TF members were encouraged to continue to respond to homework prompts. The TF reviewed a draft crosswalk document populated with information gathered by surveying TF members and from discussions held during previous meetings. There were no public comments submitted by phone, but there was a robust discussion in the chat feature in Adobe Connect.

Agenda

10:30 a.m.	Call to Order/Roll Call
10:35 a.m.	Opening Remarks
10:40 a.m.	Review Recommendations Crosswalk
11:45 a.m.	Next Steps
11:50 a.m.	Public Comment
11:55 a.m.	Final Remarks
12:00 p.m.	Adjourn

Call to Order

Mike Berry, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the meeting to order at 10:32 a.m. and welcomed members to the meeting of the PHDS TF 2021.

Roll Call

MEMBERS IN ATTENDANCE

Janet Hamilton, Council of State and Territorial Epidemiologists, Co-Chair
Carolyn Petersen, Individual, Co-Chair
Danielle Brooks, AmeriHealth Caritas
Jim Daniel, Amazon Web Services
Steve Eichner, Texas Department of State Health Services
Claudia Grossmann, Patient-Centered Outcomes Research Institute
Steve Hinrichs, Individual
Jim Jirjis, HCA Healthcare
John Kansky, Indiana Health Information Exchange
Bryant Karras, Washington State Department of Health
Steven Lane, Sutter Health
Nell Lapres, Epic

Les Lenert, Medical University of South Carolina
Denise Love, National Committee on Vital Health Statistics
Arien Malec, Change Healthcare
Clem McDonald, National Library of Medicine
Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin
Abby Sears, OCHIN
Sheryl Turney, Anthem, Inc.

MEMBERS NOT IN ATTENDANCE

Denise Chrysler, Network for Public Health Law
Ngozi Ezike, Illinois Department of Public Health
Larry Mole, Veterans Health Administration

ONC STAFF

Mike Berry, Designated Federal Officer, ONC
Brett Andriesen, ONC Staff Lead
Brenda Akinnagbe, ONC Staff Lead

General Themes

TOPIC: OPENING REMARKS

The co-chairs opened the meeting, reviewed the agenda and PHDS TF charges, and thanked members for their responses to PHDS TF homework. TF members were encouraged to continue to respond to homework prompts.

TOPIC: REVIEW RECOMMENDATIONS CROSSWALK

The co-chairs presented a draft crosswalk document that the co-chairs populated with information accumulated from the surveys/questions provided to PHDS TF members as homework, as well as from discussions held during meetings.

Key Specific Points of Discussion

TOPIC: OPENING REMARKS

Carolyn Petersen opened the meeting, thanked members for providing feedback to the co-chairs over the past week, reviewed the agenda, and informed members that the meeting would move quickly. Janet Hamilton thanked members for their responses to PHDS TF homework and encouraged them to continue to respond to homework prompts. Carolyn briefly reviewed the PHDS TF charge, which was:

- Charge – This Task Force will inform HHS's response to President Biden's Executive Order on Ensuring a Data-Driven Response to COVID-19 and Future High-Consequence Public Health Threats.
- The PHDS Task Force shall:
  - Identify and prioritize policy and technical gaps associated with the effectiveness, interoperability, and connectivity of information systems relevant to public health. This would include a focus on surveillance systems, infrastructure improvements, health equity, clinical engagement, research and innovation, educating and empowering individuals.
  - Identify characteristics of an optimal future state for information systems relevant to public health and their use.

TOPIC: REVIEW RECOMMENDATIONS CROSSWALK

Carolyn explained that PHDS TF would review a recommendations crosswalk document, which is based on

the surveillance guiding questions shared with TF members and the feedback submitted by TF members as part of their homework. TF members who have not submitted feedback within the shared Google documents were encouraged to enter their information as soon as possible. She directed TF members to examine the draft crosswalk document.

Janet reminded TF members to focus their recommendations on items that are within the TF's scope where there are interactions between clinical data systems/healthcare and public health.

Carolyn presented the draft recommendations crosswalk, which included potential gaps, opportunities, and recommendations for the following topics/questions across ONC's target area of Surveillance*:

- Syndromic Surveillance on Influenza Like Illnesses (ILI)
- Electronic Laboratory Reporting (ELR) and Adoption of Implementation Guides (IGs)
- Improve Funding
- Formation of a standing public health group
- Major gaps in standards adoption for key surveillance use cases
- Technology and infrastructure factors affecting key surveillance use cases
- Patient privacy, digital access, and social justice factors affecting key surveillance use cases
- Policy, licensing, and legal factors affecting key surveillance use cases
- Federal/state/local factors affecting key surveillance use cases
- Health equity in surveillance systems
- Enhancing data sharing between public health and social services
- Streamline data sharing from large hospitals/provider networks
- Long-term and Post-acute care
- Engaging community providers in public health reporting
- Common themes encountered that impacted the timing and completeness of COVID-19 result data reported to state and local health departments
- Impacts to the timeliness of test reporting - How can the timing of reporting be improved?
- Common data quality or completeness issues encountered for COVID-19 lab data
- Approaches needed to improve the collection, use, and reporting of health equity data
- Where do we do it well in the lab? What are the barriers or limitations?
- Data beyond medical records and existing public health systems (other data needed for an optimal public health response)
- Samples collected outside of provider offices (drive through, pop up testing, at home testing etc.)

The PHDS TF will address the Target Areas of Infrastructure, Privacy and Security, Research and Innovation at future meetings.

DISCUSSION:

- Jim Daniel commented that the TF should consider expanding its recommendations on the Syndromic Surveillance topic beyond ILI. The Centers for Disease Control and Prevention was piloting monitoring of Google search for influenza in 2009.
    - Les Lenert agreed with Jim's comment and also requested that the topic be expanded beyond syndromic surveillance to include all early, real-time health system data/chief complaint monitoring information.
    - Bryant Karras stated that, in the early days, ILI was the closest way to identifying coronavirus-like illnesses and added that the prediction algorithms have been modified by the surveillance community since then. ILI was used as a shorthand. He stated that the most valuable opportunity was the ability to have better situational awareness via syndromic

surveillance feeds during COVID-19 relief efforts due to data that came from ambulatory and primary care (beyond emergency departments and care settings).

- Denise Love voiced her support for the recommendation but requested that non-traditional sources be evaluated by their availability, continuity, and quality before they are accepted as alternative indicators.
- Steve Eichner commented that data sources looking at employee absenteeism must be provided same day/near-instantaneously to be used effectively. Ensure that the data are maintained, urgent care data must be included, and hospitals/other providers must be encouraged to supply data from traditional settings (like ambulatory care).
- Les Lenert commented that data from point-of-care should also be included.
- Steve Hinrichs explained how employee absenteeism at large employers, like the railroads, was a useful predictor of the outbreak of disease. They endorse the idea of non-traditional sources.
- Jim Jirjis asked if there was an ability to monitor prescriptions filled at large pharmacy chains as a predictor of illness regionally. Clem responded that 70-80% of prescriptions pass through Surescripts, so they should have the necessary data.
- Janet summarized the recommendations, noting that the additional data sources suggested a need to be explored and developed in terms of usefulness and timeliness. A discussion should be held around how and when the data would be used (during an event, after, to monitor situational awareness, etc.).
- Bryant stated that pharmacies and laboratories were not incentivized to submit syndromic surveillance feeds under Meaningful Use. Incentives to encourage interoperability with public health are needed.

- Arien Malec commented on the ELR and Adoption of IGs topic that the Interoperability Standards Priorities Task Force (ISP TF) found that a piecemeal, non-standards-based approach was adopted for lab ordering/resulting for ambulatory care providers, so complete information has not been captured at the source and has not flowed to labs. Upgrading the systems listed in the recommendation would help labs achieve more complete information on orders, which addresses demographic information. Also, he suggested that testing certification criteria are needed for labs and public health.
  - Jim Jirjis stated that each of the players in this space, beyond labs and public health (including PPE and others), should be identified, and incentives for data in certification standards could be applied.
  - Steve Eichner discussed reasons why most labs would be hesitant to modify their business processes to include additional demographic information and suggested that other options for routing data (HIEs, etc.) could be leveraged. By reducing the need to modify systems that only use data on a pass-through, there is the added benefit of reducing identity theft. Also, providing testing information from a patient's regular care provider reduces the likelihood that data will be lost. Incentives could include fully funding the public health side and using regulatory levers to ensure that vendors are selling certified validated technology.
  - Bryant Karras stated that Meaningful Use was specifically directed towards hospitals, not providers, so the document should be updated. He stated that hospitals were not sufficiently incentivized to report testing data to public health. He voiced his agreement with Steve's comments around linking patients with primary care providers and medical record systems to ensure that results are available to everyone. Pilot attempts were made but could be better. Issues will increase now that at-home testing kits are available.
  - Clem warned against extending certification further and asked TF members to consider what is permitted by law. He stated that some of the TF's suggestions are too diffuse. He suggested that registration data be sent with ordering. He described issues with point-of-care tests, which are not electronic, and potential solutions.
  - Steve Hinrichs commented that only two data elements are required for identification and suggested that contact information (for the individual being tested) and their physician's

contact information should be added.
    - Danielle Brooks emphasized the need for greater specificity around contact information, like telephone number, and suggested that a universal methodology could be used to ensure that this information stays up-to-date and is useful downstream for public health.
- Nell Lapres commented on the Improve Funding topic that the language in the recommendations for certification for interoperability for public health systems should be made more specific. A minimum functional standard is needed, and the TF's focus should go beyond interoperability/adoption to the infrastructure and scalability.
    - Danielle Brooks stated that the crosswalk should recognize that not all states, counties, and public health departments are funded equitably at this time.
    - Bryant Karras stated that the TF should be careful with wording around certification, as nearly all states have a certified product that was purchased by the CDC and is interoperable. Challenges arise around implementation.
    - Steve Eichner stated that funding needs to be directed to public health for participation in broader environments and support necessary modifications, like leveraging Trusted Exchange Framework and Common Agreement (TEFCA). He stated that public health's voice on TEFCA workgroups needs to be amplified. Also, he suggested that Medicare and Medicaid funds could be better linked and leveraged by public health to request and implement Medicare/Medicaid technologies.
    - Steven Lane echoed Steve's comment that more robust engagement is needed between public health and TEFCA subject matter experts and stakeholders. He asked Steve or others to list more specific public health actors. Carolyn suggested that TF members add this information to the TF surveys/spreadsheets during offline work.
    - Clem discussed problems with naming specimens as an example of the disconnect between the CDC and public health. More dialogue is needed.
    - Denise Love emphasized the need for public health to be more involved in national work on standards development and suggested that HHS or the CDC consider funding a small group of public health experts to attend and participate.
- Steve Eichner commented on the Formation of a Standing Public Health Group topic and recommendations to address items that are out-of-scope for the current PHDS TF that there is an existing TF under the CDC, the Public Health (PH) Interoperability Task Force. He suggested that this TF could have its scope revisited so that it could be leveraged.
    - Denise Love stated that the National Committee on Vital Health Statistics (NCVHS) should also be involved in the standing public health group, as they are doing work on the convergence of clinical and administrative data.
    - Bryant Karras suggested prioritizing greater participation by states in the standards body development process, including HL7's Public Health Workgroup and NCPDP.
    - Danielle Brooks urged the PHDS TF to include health equity by design components and use past experiences, especially with COVID-19 relief efforts, to inform future work.
- Carolyn listed the major gaps identified in standards adoption for key surveillance use cases and discussed opportunities and preliminary recommendations. She asked TF members to comment.
    - Arien Malec commented that public health has better outcomes when it leverages existing standards and IGs. The system should be built to include public health instead of having public health-specific components. He discussed several examples of bespoke standards that were dropped in and did not fit. eCR and eCR Now are better approaches, but he stated that eCR should transition to a Fast Healthcare Interoperability Resources (FHIR) based standard because this will help public health tap into EHR data as EHRs move into FHIR-based application programming interfaces (APIs). He agreed with the recommendation to encourage ADT-based surveillance and explore leveraging eCR/eCR Now trigger-based approach to capture data from EHRs and registration systems. Public health should be viewed as part of a broader ecosystem.

- Steve Eichner emphasized the need to ensure that the standards and IGs that are released accurately reflect state/local data needs. CDC and ONC should work with state/local to develop data standards that support public health needs, and they may need to compromise if the data are already being collected. Flexibility is needed. He highlighted standards gaps for collecting disability information and how the data could be used.
- Clem discussed how standards are used as "slots," which are later used to determine where to put new elements. He emphasized the need for more cooperation between public health and providers to get better data and highlighted burdens (to practitioners) that have been created by certain data collection forms, which often lack consistency.
- Les Lenert stated that the ideal future state might not be eCR; it is automated case investigation through EHR. He suggested enabling public health to dig deeper into EHR data using FHIR queries and emphasized the need to think more about information ecosystems vs. information supply chains.
- Bryant Karras discussed the disconnect between providers/hospitals, state/local public health, and vendor communities when developing standards. He stated that it should not be optional for vendors to select what capabilities are/are not in place for implementation. States should determine which capabilities are in place.
- Sheryl Turney suggested that the intelligent query system should be extended beyond EHRs to any of the qualified entities that are authorized to perform research within the ecosystem. She stated that they should ensure that all partners in the ecosystem are included in these considerations.
- Jim Jirjis echoed others' comments about variations between states' IGs and standards, including additional data elements. He encouraged them to use all levers available to HHS to address the very large burden.
- Arien Malec highlighted the discussion in the public comment chat around states believing that they have the authority to tailor standards IGs, which leads to fragmentation, high costs, and low data access. There are strongly held beliefs that a national approach with a standard base ecosystem would allow maximum information flow with minimum overall investment. He suggested that the TF continues to discuss this topic in the future.
- Jim Jirjis discussed a number of comments he entered into the public chat feature and suggested that the TF request survey of all the public health questions that different states asked during the COVID-19 pandemic to identify key areas of focus and work to understand trends and outliers in the data set.

- Carolyn discussed the numerous gaps identified for the topic of "Technology and Infrastructure factors affecting key surveillance use cases," as well as opportunities and recommendations.
  - Bryant Karras asked for clarity around the term "direct messaging," which was listed in the opportunities. He described how Direct Secure Messaging differs from direct messaging and stated that one does not support bidirectional health messaging needed to exchange eCR and syndromic surveillance data.
  - Steven Lane responded that he meant the Direct Secure Messaging supported in the DirectTrust framework, noting that it is flexible and is already being used. However, public health entities are often not enabled to leverage it.
  - Bryant stated that they use more advanced standards because, though it is available today, it is not available to all channels/states/jurisdictions and may not be the best approach.
  - Nell Lapres stated that FHIR is a good long-term goal but asked if there is a standard that works today that solves needs now. She stated that they should define use cases for FHIR so that they ensure that existing gaps are addressed.
  - John Kansky highlighted recommendations he entered into the working document around Gap #6 and discussed relevant examples he experienced with Indiana's HIE.
  - Clem suggested reaching out to the communities that are providing the data to ask them to evaluate how questions are asked and generate data. Their input is important because data

collection is costly.

- Abby Sears asked the TF to make some sort of recommendation around patient matching and patient matching algorithms to solve related problems.
- Steve Eichner stated that FHIR standards are important but asked the TF to also consider patient privacy during population-level requests for patient data. Public health should be aware of why data is being collected, how it will be used, and how an HIE or others might reuse it downstream. The release of data should be considered to protect patient privacy.
- Jim Jirjis emphasized the need for bidirectional flows of data during patient encounters, especially when treating COVID-19. Also, he suggested adding record locator capabilities.

The co-chairs thanked TF members for their participation and feedback and explained that comments and points of discussion would be added to the crosswalk document. Janet explained that TF members should continue to think about different surveillance goals that correspond to different levels within public health and have different data needs. While the TF is working toward harmonization, they must still support state laws/activities that first governed public health surveillance.

Action Items and Next Steps

As their next steps, the PHDS TF 2021 were asked to respond to survey questions. Discussion items planned for the current meeting were not discussed during the meeting, so TF members were encouraged to review them. Members who did not submit feedback were asked to complete the questions.

TF members were encouraged to review the draft crosswalk document and to be thoughtful about potential TF recommendations to the HITAC.

Janet explained that feedback from the TF surveys and spreadsheets would be shared on a weekly basis going forward. Brett explained that new SurveyMonkey links would be sent to TF members, as well as links to the Google documents.

Public Comment

QUESTIONS AND COMMENTS RECEIVED VIA PHONE

There were no public comments received via phone.

QUESTIONS AND COMMENTS RECEIVED VIA ADOBE CONNECT

Mike Berry (ONC): Good morning, and welcome to the Public Health Data Systems Task Force! We will be starting soon.

Jim Jirjis: Jim Jirjis here

Sheryl Turney: i'm here waiting for operator

Denise Love: I am on the adobe but sound is not working

Claudia Grossmann: Claudia is here

Sheryl Turney: you have to call in for speaking

Sheryl Turney: i'm in

Sheryl Turney: in future are we able to have homework outlined greater than 1 day before the due date?

Denise Love: Agree with Sheryl. Can we post our comments on 3 and 4 late?

Bryant thomas Karras MD: I'm still not getting ANY emails from the system... will try to be more timely now that i know there was homework

Janet Hamilton: If you were not able to complete the homework - recognzing *[sic]* the tight timeline - you can still complete the homework

Leslie Lenert MD: ambulatory PLUS point of care testing for pathogens in that setting

Clement McDonald: is it really possible to get full feeds from practices many will not have the systems.

Jim Jirjis: any way to monitor pharmacy fills for medications that indicate an outbreak?

Clement McDonald: should be easy to monitor pharmacy fills. a huge proportion of them flow through Sure Scripts

Jim Jirjis: I agree with Clem. We should first investigate the feasibility of the approach. Not sure people have the IT systems that would tack absenteeism

Leslie Lenert MD: Yes, there are feeds from drug stores of purchases that have been used for syndromic surveillance. PBM's could be recruited to provide additional data

Jim Jirjis: Also making sure the technology is in place before a requirement to share occurs

Clement McDonald: Is it possible to get work absence data from schools and corporations? Can one get it quickly

Bryant thomas Karras MD: we prioritiezed *[sic]* large provider with systems already in place (Kieser Prov UW) that was easier for them to include all, rather than segregating ED data from the whole feed that was all in the EMR/EHR

Leslie Lenert MD: Many school districts have automated absenteeism tracking systems

Arien Malec: CDC already gets prescription data from multiple pharmacy switches.

Leslie Lenert MD: However, access to data in these systems may be difficult

Abby Sears: I love the idea of the surescripts connection. This would really create additional data sources.

Arien Malec: Medical clearinghouses see emergent events as well in claims.

Leslie Lenert MD: certifying and upgrading school absenteeism systems would be another opportunity

Denise Love: Can't data systems beyond surveillance systems---not realtime ---be used to validate and confirm patterns of care (APCD, Rx, absenteeism) even if lagging. Not all data systems will ever be "real-time", but combining multi-source data will yield broader views.

Steven Hinrichs: I want to add that epidemiology investigation is still needed to validate any leading indicator from absenteeism programs

Arien Malec: I'd also note that the issue for COVID-19 was not lack of indicators; the NYC/NYS ILI data was sending pretty clear signals.

Bryant thomas Karras MD: yes... agree we are still not getting address and phone on all results

Jim Jirjis: states have to offer real-time integrations vs batch (FTP) for timely reporting. These integrations should also be sophisticated enough to provide record level reconciliation capabilities through functional acknowledgments and agreed upon troubleshooting stds.

Abby Sears: + Jim

Jim Jirjis: the variation of data requests from state to state with ancillary information that wasn't readily available (eg- not part of ELR or VXU stds) or even technically possible (eg- vent machine info) compounded difficulties in leveraging existing integrations. The fact that some states outright denied submissions because nonstd or ancillary data elements were missing shows we collectively couldn't see the forest for the trees.

Nell Lapres: Understood Bryant, that's why defining a minimum functional standard that focuses on standard implementation and standards adoption could help bring more specificity to the "certification".

Denise Love: Agree with Steve--public health voice is lacking in all SDO and TEFCA venues due to lack of staff to continuously engage in the national process.

Leslie Lenert MD: Consideration should be given to a public health QHIN and/or ensuring all QHINs offer a standardized public health functionality

Arien Malec: I'd note that every ONC-led interoperabilty *[sic]* effort I participated in had ph as an actor.

Bryant thomas Karras MD: the PH acteors *[sic]* who aren't burnt out yet!

John Kansky: +1 on Dr Lane's opinion that increasing the PH focus in TEFCA development is a good idea

Arien Malec: Generally the issue is that ph is not funded; there's also been a CDC island for standards.

Leslie Lenert MD: +1 @Arien

Abby Sears: +1 on Steven Lane's suggestion around PH focus in TEFCA

Abby Sears: + 1 with Arien around the CDC comment

Steve Eichner: Perhaps ELC or other funding could include a requirement for staff participation in task forces/standards development/etc. and funding attached for that participation.

Denise Love: States don't have the staff to fully engage in these standards bodies--we need a better system of representation in public health to attend these meetings, communicate back to states, and funding to do so. The Public Health Data Standards Consortium existed but lost funding to continue its work fully.

Bryant thomas Karras MD: my adobe is not scrolling

Laura Conn (CDC): ELC funding has always supported participation in standards work but it does not get prioritized at PHAs and gets added as "another duty as assigned"

Steve Eichner: On equity: There is substantial focus on race/ethnicity issues, but very little attention iis being directed towards disabilities. What national standard exists for discribing *[sic]* the type of disability(ies) and invidudual has (e.g., sight limitations, limited walking range, wheelchair user, respiratory limitations, etc.)? Some of this data is useful for public safety/evacuation/electricty *[sic]* backups. It could also inform access to care and other issues.

Denise Love: Laura--agree, but that's why dedicated standards liasons *[sic]* to work across states/with states is important to continually engage in the standards process. It's tough for front-line workers to put on another

hat of national standards engagement and workforce turnover is such that consistent engagement does not occur.

Carolyn Petersen: +1 to Steve Eichner's comment about disability equity and the need to develop this

Laura Conn (CDC): There is a published eCR FHIR standard now.

Bryant thomas Karras MD: when you say ADT do you mean SynS ?

Arien Malec: WE DO NOT NEED STATE/LOCAL SPECIFIC "STANDARDS"

Arien Malec: We need national standards that are implementable across the country.

Steven Lane: +1 @Arien

Nell Lapres: Agree Arien.

Leslie Lenert MD: +1 @Arien

Jim Jirjis: +1 Steven Lane on the PH focus in TEFCA, perhaps a Public Health QHIN

Jim Jirjis: needs some TEFCA-like structure to align standards, IP's etc.

Abby Sears: +1 Arien In fact I would say.....it is irresponsible to continue to do so.

Bryant thomas Karras MD: yes but WA has passed laws to make some of the Optional data element required. but EMR/EHR have only built to the minimum

Arien Malec: exactly.

Jim Jirjis: +1 Arien to national standards

Arien Malec: that's going to happen 100% of the time.

Jim Jirjis: here' here Clem. In our 20 states there was enormous burden to handle all of this variation

Bryant thomas Karras MD: minimum is not suficiant *[sic]* for certification. they need to build to the whole standard.

Arien Malec: that's eCR #actually

Steven Lane: Yes Jim, the idea of one or more TEFCA QHINs focused on PH use cases continues to come up. I think that we still need ONC blessing for and guardrails surrounding specialized QHINs that may not be required to support all stakeholders/use cases. The other approach would be PH-specialized HIN(s) that could connect through any QHIN.

Arien Malec: but agree that we need ph ability to use HIE and national networks.

Clement McDonald: Hear hear! Leslie

Jim Jirjis: seems that since PH is a priority, Steven, it would be a good time to suggest such TEFCA-based approaches to align to standards, IP's etc.

Sheryl Turney: I ant to pile on to what Leslie stated. It seems that we would want electronic investigation of Public Health data by any authroized *[sic]* QE who may be performing research.

Arien Malec: Optional means optional

Jim Jirjis: Optional means subOptimal!

Leslie Lenert MD: +1 @Jiris

Arien Malec: If something needs to be required, it needs to be required. If something is optional, it's nice to have and most likely will never get filled.

Bryant thomas Karras MD: Optional to who, Fed Law states that States have authority to choose and make required

Denise Love: This is why we need a new model to harmonize data IG across states and consistently engage with state needs

Arien Malec: States are *never* going to succeed in this approach b/c the health information technology ecosystem is national.

Sheryl Turney: I also agree with Jim's comments on standardization beyond the states that allow data to be more fluidly used without normalization or translation.

Jim Jirjis: can there not be strings attached to the FTE funding for states to align

Jim Jirjis: the 80M in IT personel *[sic]* and the 7B in public health employees and training beyond that

Sheryl Turney: We need a naitonal *[sic]* approach or else we can never scale or learn more rapidly

Jim Jirjis: great point Arien

Sheryl Turney: I like that idea Jim on aligning funding to national standards

Leslie Lenert MD: agree with the national approach but it might take new legislation to establish the framework

Mike Berry (ONC): To clarify, we will open the line for public comment about 11:50 or so.

Leslie Lenert MD: for example, automation of case investigation might require standarizing *[sic]* definitions of notifiable diseases across states

Arien Malec: I'd note that PH was involved in the Direct Project standards development -- and that bidirectional asynchronous cases were explicitly designed for.

Steven Lane: Thanks for that historical perspective Arien.

Jim Jirjis: Seems like if we are working on bidirectional, shouldnt *[sic]* a record locator be part of the QHIN or HIN?

Arien Malec: <very old man voice> Back in my day…

Jim Jirjis: That was agents (providers, etc) could know what records exist on a patient, where they are located and retrieve the info

Jim Jirjis: way

Steven Lane: We should be able to both leverage currently available tools/standards (e.g., Direct) while incentivizing and driving toward the use of future standards (e.g., FHIR).

Abby Sears: We need to find some way to handle the matching issues and I am not sure that the recommendations respond to this issue.

Arien Malec: Competely *[sic]* agree -- public health use cases need to be part of TEFCA use of a record locator; also need policy goals that allow HIE/national networks to transmit.

Nell Lapres: @Steven - I agree with future standards but broadly incentivizing FHIR in the short-term could further exacerbate the challenges we have been talking about with different jurisdiction implementation. Agree long-term FHIR is a good goal, in the short-term we should focus on closing gaps (not disrupting working exchange of data)

Steven Lane: Note that a number of the rows in the spreadsheet are duplicative. It would be helpful if TF leadership could reconcile these duplicates and accept appropriate changes and resolve comments in the document to make it easier for TF members to provide additional/novel input.

Leslie Lenert MD: Our charge is both to identify gaps and define a future state

Resources

PHDS TF 2021 Webpage
PHDS TF 2021 – June 3, 2021 Meeting Agenda
PHDS TF 2021 – June 3, 2021 Meeting Slides
PHDS TF 2021 – June 3, 2021 Meeting Webpage
HITAC Calendar Webpage

Adjournment

Janet and Carolyn thanked everyone for their participation.

The co-chairs shared the ongoing timeline and work plan for the PHDS TF 2021 and stated that the next TF meeting would be held on Thursday, June 10, 2021, from 10:30 a.m. to 12:00 p.m. E.T.

The meeting was adjourned at 11:57 a.m. E.T.