

# Meeting Notes

## HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC)

June 9, 2021, 9:30 a.m. – 2:45 p.m. ET

VIRTUAL



## EXECUTIVE SUMMARY

The co-chairs of the HITAC, **Denise Webb** and **Aaron Miri**, welcomed members, reviewed the meeting agenda, and the minutes from the May 13, 2021, HITAC meeting, which were approved by voice vote. **Micky Tripathi** welcomed members and shared remarks. Steven Lane and Leslie Kelly Hall presented the United States Core Data for Interoperability Task Force (USCDI) Task Force (TF) USCDI TF 2021 recommendations on the USCDI expansion process, which was followed by a HITAC vote. **Arien Malec** and **David McCallie** presented the Interoperability Standards Priorities (ISP) Task Force (TF) (ISP TF 2021) recommendations, which was followed by HITAC voting on several motions. **Steve Posnack** discussed ONC's Health Interoperability Outcomes 2030 project. **Carolyn Petersen** and **Janet Hamilton** provided an update on the Public Health Data Systems (PHDS) Task Force (TF) (PHDS TF 2021). One public comment was submitted by phone, and there was a robust discussion in the public meeting chat via Adobe.

## AGENDA

09:30 a.m.	Call to Order/Roll Call
09:35 a.m.	Opening Remarks
09:45 a.m.	Remarks, Review of Agenda and Approval of May 13, 2021, Meeting Minutes
09:55 a.m.	United States Core Data for Interoperability Task Force (USCDI TF 2021) Recommendations on Expansion Process – HITAC Vote
11:15 a.m.	Break
11:20 a.m.	Interoperability Standards Priorities Task Force (ISP TF 2021) Recommendations – HITAC Vote
12:35 p.m.	Break
12:45 p.m.	Health Interoperability Outcomes 2030
01:45 p.m.	Break
01:50 p.m.	Public Health Data Systems Task Force (PHDS TF 2021) Update
02:30 p.m.	Public Comment Period
02:45 p.m.	Final Remarks & Adjourn

## CALL TO ORDER/ ROLL CALL

**Mike Berry**, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the June 9, 2021, meeting to order at 9:30 a.m.

## ROLL CALL

**Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin, Co-Chair**  
**Denise Webb, Indiana Hemophilia and Thrombosis Center, Co-Chair**

Michael Adcock, Magnolia Health  
Lisa Frey, St. Elizabeth Healthcare  
Valerie Grey, New York eHealth Collaborative  
Steven Hester, Norton Healthcare  
Jim Jirjis, HCA Healthcare  
John Kansky, Indiana Health Information Exchange  
Ken Kawamoto, University of Utah Health  
Steven Lane, Sutter Health  
Leslie Lenert, Medical University of South Carolina  
Arien Malec, Change Healthcare  
Clem McDonald, National Library of Medicine  
Brett Oliver, Baptist Health  
Terrence O'Malley, Individual  
James Pantelas, Individual  
Carolyn Petersen, Individual





Raj Ratwani, MedStar Health  
Abby Sears, OCHIN  
Alexis Snyder, Individual  
Sasha TerMaat, Epic  
Andrew Truscott, Accenture  
Sheryl Turney, Anthem, Inc.  
Robert Wah, Individual

## HITAC MEMBERS NOT IN ATTENDANCE

Cynthia A. Fisher, PatientRightsAdvocate.org

## FEDERAL REPRESENTATIVES

James Ellzy, Defense Health Agency, Department of Defense (Absent)  
Adi V. Gundlapalli, Centers for Disease Control and Prevention (CDC)  
Ram Iyer, Food and Drug Administration (FDA)  
Jonathan Nebeker, Department of Veterans Health Affairs  
Michelle Schreiber, Centers for Medicare and Medicaid Services  
Ram Sriram, National Institute of Standards and Technology

## ONC STAFF

Micky Tripathi, National Coordinator for Health Information Technology  
Steve Posnack, Deputy National Coordinator for Health Information Technology  
Elise Sweeney Anthony, Executive Director, Office of Policy  
Avinash Shanbhag, Acting Executive Director, Office of Technology  
Mike Berry, Designated Federal Officer

## PRESENTERS

Leslie Kelly Hall, Engaging Patient Strategy, USCDI TF 2021 Co-Chair  
David McCallie, Individual, ISP TF 2021 Co-Chair  
Janet Hamilton, Council of State and Territorial Epidemiologists (CSTE), PHDS TF 2021 Co-Chair

## WELCOME REMARKS

**Micky Tripathi**, the National Coordinator for Health IT, welcomed everyone to the June 9, 2021, virtual meeting of the HITAC and highlighted the following items:

- Public Health Informatics & Technology Workforce Development Program: ONC received \$80 million to implement or expand training, certification and degree programs in public health informatics and data science at minority serving institutions and other colleges and universities. The funding will help to address the need for more public health professionals trained in informatics and technology, a need that has been highlighted during the COVID-19 pandemic.
- Trusted Exchange Framework and Common Agreement (TEFCA): a new timeline and milestones will be released in the coming months. **Micky** thanked The Sequoia Project, the Recognized Coordinating Entity (RCE) for its work on TEFCA.
- April 5, 2021, was the deadline for regulated actors to comply with the provisions of ONC's Information Blocking Final Rule. **Micky** explained that ONC has received an increased number of questions about information blocking and technical questions about electronic health record (EHR) certification. ONC welcomes continued engagement from the industry and is working to respond to questions and comments.





## REMARKS, REVIEW OF AGENDA, AND APPROVAL OF MAY 13, 2021, MEETING MINUTES

**Aaron Miri** and **Denise Webb**, HITAC co-chairs, welcomed members, and **Aaron** expressed his thanks for the update on TEFCA and the Information Blocking FAQs created by ONC. He announced that the HITAC's Annual Report Workgroup (AR WG) kicked off its meetings for the next fiscal year's report and asked HITAC members to contact him, **Carolyn Petersen**, or **Mike Berry** if they are interested in serving. **Denise** reviewed the agenda and list of planned presentations and reminded attendees that there would be several breaks scheduled throughout the meeting.

**Aaron** invited members to examine the minutes from the May 13, 2021, meeting of the HITAC. Members of the HITAC submitted no comments or corrections. **Aaron** called for a motion to approve the minutes, which was made and seconded.

**The HITAC approved the May 13, 2021, meeting minutes by voice vote. No members opposed, and no members abstained.**

## UNITED STATES CORE DATA FOR INTEROPERABILITY TASK FORCE (USCDI TF 2021) RECOMMENDATIONS ON EXPANSION PROCESS – HITAC VOTE

**Steven Lane** and **Leslie Kelly Hall**, co-chairs of the USCDI TF 2021, presented the TF's Phase 2 recommendations on the USCDI expansion process to the HITAC. **Steven** provided an overview of the TF roster, overarching and specific charges, background, and Phase 2 and Phase 3 workplans, all of which were included in the [USCDI TF 2021 presentation slide deck](#). The USCDI version update process and draft Version 2 of the USCDI (USCDI v2) were included on slides #5 and #6 in the presentation deck. The USCDI TF 2021 Tasks 2a, 2b, and 2c recommendations would be presented to the HITAC at the current meeting, leaving recommendations regarding Task 3 to be delivered in September. The TF's remaining tasks include:

- Task 2: Evaluate the USCDI expansion process and provide HITAC with recommendations for:
  - 2a - ONDEC submission system improvements
  - 2b - Evaluation criteria and process used to assign levels to submitted data classes and elements
  - 2c - Prioritization process used by ONC to select new data classes and elements for draft USCDI v2
- Task 3: Recommend ONC priorities for USCDI version 3 (USCDI v3) submission cycle

**Steven** briefly reviewed USCDI TF 2021 Task 1 recommendations on draft USCDI v2 changes and additions, which were included on slide #8 in the presentation. **Leslie** and **Steven** described the TF's Task 2 recommendations, which were centered around the USCDI expansion/update process and improvements to ONC's USCDI New Data Element and Class (ONDEC) Submission System. The TF's Phase 2 recommendations were included in summary in the [USCDI TF 2021 presentation on slides #9 through #40](#) and in detail, as high-level and specific recommendations, in the [TF's Phase 2 Recommendations Report document](#).

**Steven** explained that the USCDI TF 2021 reviewed contributions from a wide range of participants, including patients and patient advocates, to create its recommendations. He provided some background context for each of the Phase 2 tasks and gaps/opportunities the TF discovered. He stated that the TF worked to provide flexibility to ONC so that, for example, when a pandemic occurs or issues related to health equity are identified as a high priority, those priorities can be considered as leveling and advancement decisions are made during the annual review and versioning cycle of the USCDI. **Steven**





and **Leslie** explained that the TF often used the metaphor of the “nest” when looking at leveling in the draft USCDI versions. He invited HITAC members to submit comments and questions.

### Discussion:

- **Clem McDonald** commented that the extra data classes of narrative for radiology and pathology were removed, not the content, which was included in the standard.
- **Andy Truscott** emphasized the importance of this work and encouraged HITAC members to support including context passing in future work on the USCDI.
  - **Steven** responded that this feedback was useful and should be submitted as part of the USCDI TF 2021 Phase 3 work, which will include recommendations on the next version of the USCDI.
- **Steven Lane** highlighted a comment in the public chat from **Dr. Bryant Karras** about how public health submissions to the USCDI would be highlighted during the process. Steven explained that the applicable stakeholder group(s) should be identified with each submission.

The co-chairs thanked TF members and HITAC members for their diligent work and useful feedback. **Steven** explained that the Phase 2 recommendations were not meant to be dramatic but to highlight specific areas for improvement. Following the USCDI TF 2021 presentation and discussion by HITAC members, **Denise Webb** called for a vote on whether to adopt the USCDI TF 2021 Task 2a, Task 2b, and Task 2c recommendations and to transmit them to the National Coordinator for Health IT. **Arien Malec** made the motion, and **Andy Truscott** seconded it. **Denise** called for a vote.

**The HITAC approved the USCDI TF 2021 Phase 2 recommendations by voice vote. No members opposed, and no members abstained.**

Following the vote, **Steven** and **Leslie** discussed the USCDI TF 2021 approach and plan for Task 3 of its work, which will be presented to the HITAC at its September 9, 2021, meeting. This information was detailed in slides #41 through #43 of the presentation slides. The TF will look at areas of priority that ONC should focus on including as relevant data elements for Version 3 of the USCDI (USCDI v3) and beyond. Identified areas of study include social determinants of health (SDOH), equity and inclusion, ISP TF 2021 recommendations (which **Arien Malec** and **David McCallie** recently presented to the USCDI TF), and public health/recommendations from the PHDS TF 2021. The co-chairs invited HITAC members to provide feedback on the proposed Task 3 plans, especially in terms of the TF’s work cadence and recommendations around priority and maturity. **Leslie** emphasized the importance of the outcomes of this work, as it will impact data needs and policy in the future. Future USCDI TF 2021 meetings will include presentations on public health/from the PHDS TF 2021 and from the Centers for Disease Control and Prevention. After the publication of USCDI v2, the Gravity Project will also present to the USCDI TF 2021 on SDOH and the HL7 Accelerator project.

The co-chairs thanked the members of the HITAC for their comments and engagement and acknowledged the work of **Al Taylor** and the ONC team. **Clem** thanked the co-chairs of the USCDI TF 2021 for their dedication and hard work and called for a round of applause.

## BREAK

The HITAC took a short break. **Mike Berry** reconvened the meeting at 10:50 a.m., and **Aaron** welcomed HITAC members, presenters, and the public back to the meeting.

## INTEROPERABILITY STANDARDS PRIORITIES TASK FORCE 2021 (ISP TF 2021) RECOMMENDATIONS AND HITAC VOTE

**Arien Malec** and **David McCallie**, the Interoperability Standards Priorities Task Force 2021 (ISP TF





2021) co-chairs, introduced themselves. **Arien** thanked the HITAC for the opportunity to present and referred to ISP TF 2021 timeline, roster, mission, and charge, which is grounded in the 21<sup>st</sup> Century Cures Act (the Cures Act). Details of these items were included in the [ISP TF 2021 presentation slide deck](#).

**Arien** explained that the focus of the ISP TF 2021 was to identify opportunities to update the ONC Interoperability Standards Advisory (ISA). He explained that the TF conducted a Delphi Method process to prioritize interoperability needs based on ONC priority areas and TF member input. They assessed the standards landscape through multiple hearings on the following topics:

- Health Equity
- EHR Data Use for the “Learning Health System” based on COVID-19 experience in pragmatic trials, real world evidence, comparative effectiveness, etc. (e.g., UK RECOVERY trials).
- Burden Reduction and associated Clinical/Administrative Data and Standards Harmonization

**Arien** explained that the ISP TF 2021 also heard testimony on Public Health Situational Awareness and deferred recommendations for Public Health to the Public Health Data Systems Task Force 2021 (PHDS TF 2021).

**David** and **Arien** took turns presenting and discussing the ISP TF 2021’s high-level and specific recommendations, which were detailed in the [ISP TF 2021 Recommendations Report](#), and covered the following topic areas:

- Foundational Standards – Fast Healthcare Interoperability Resources (FHIR)
  - FHIR CDS Hooks or triggering offline workflows via FHIR Subscription
  - FHIR Questionnaires
  - FHIR Consent Directive
- Foundational Standards – Common Data Model
- Foundational Standards – Terminology
- Healthy Equity
- Electronic Health Record (EHR) Data Use for Research, Real World Evidence (RWE), RECOVERY-like Trials, Comparative Effectiveness
- Harmonization of Clinical and Administrative Data for Burden Reduction – which are in accordance with recommendations made by the Intersection of Clinical and Administrative Data Task Force (ICAD TF) to the HITAC previously
- Situational Awareness

The co-chairs provided detailed background and context information for each of the TF’s recommendations, which is accessible within the TF’s supporting documents and [within the transcript for the HITAC meeting](#). They highlighted specific standards/standards deployment problems and policy issues that the recommendations would address. **Arien** stated that the TF was very careful to build recommendations that were not calling for high position burden activities that subordinate clinical care to research needs. Instead, the ISP TF 2021 looked for the maximal use of data collected for clinical care to be used additionally for research needs. Also, the TF worked to address the needs highlighted by the COVID-19 pandemic and to policy levers to create appropriate incentives and requirements to better prepare for future emergencies and pandemics.

**Arien** explained that future ISP TF work is warranted on the topics of Care Plans/Chronic Disease Management, Data Sharing Federal & Commercial Entities, Portal Data Aggregation Across Multiple Portals, Occupation and Location of Work, and Data Exchange Formats for Price Transparency.







**Aaron Miri** thanked the presenters and invited HITAC members to provide feedback on the recommendations.

### Discussion:

- **Clem McDonald** submitted several comments, which included:
  - He cautioned the TF to revise the wording around a common data model to emphasize that harmonization between existing common data models is needed, not the creation of another new model. He stated that FHIR, PCORnet, and OMOP already harmonize with the USCDI.
  - He discussed the usefulness of the LIVD FHIR standard that provides a structure for laboratories to specify how their internal codes translate for tests/code values in LOINC and SNOMED. Most are Unified Code for Units of Measure (UCUM) codes.
  - **Arien** thanked **Clem** for the comments and emphasized his point that the TF wants to avoid recommendations that lead to the creation of yet another meta-model. Harmonization is being done, and the TF calls on ONC to support further development by working with the actors already involved.
  - **David** agreed with **Clem's** comments, noting that the TF tried to capture the spirit of them within its recommendations. However, the work that is already underway should be recognized, cataloged, and encouraged to smooth the path to bulk FHIR extractions and triggering clinical research from EHR data.
  - **Clem** discussed feedback he has received from PCORnet and funding concerns.
  - **Arien** highlighted the fine balance between making specific recommendations versus policy-oriented recommendations, which is where the TF has tried to focus its efforts.
- **Robert Wah** discussed challenges related to the TF's recommendation to harmonize with the varied spectrum of international procedural standards and classifications, noting that some countries do not have procedural codes, and others have developed their own code sets. He stated that the American Medical Association (AMA) testified before the ICAD TF about administrative simplification and how clinical workflow burdens for physicians could be decreased. The AMA would like to share its perspective on procedural terminologies and workflows with the TF before the recommendation is accepted by the HITAC.
  - **Arien** responded that the ISP TF 2021 received a letter of public comment from the AMA, in addition to the ICAD TF testimony, and he stated that the ISP TF 2021 tried to move its recommendations in line with the policy framework recommended by the AMA. He stated that the ISP TF 2021 did not intend to indicate that it was recommending the use of one terminology standard over another. Also, he explained that existing research communities, like the United Kingdom's work with the United States, should be considered when assessing research and data needs. He thanked **Robert** for his comments and stated that the ISP TF' 2021 recommendations are policy-oriented and in line with previous advisory committee recommendations.
  - **Aaron** stated that if there is a concern that further clarity is needed, it could impact the HITAC's vote on the ISP TF 2021 recommendations. He asked **Robert** to confirm whether additional work is needed.
  - **Robert** stated that he did not want to impede the process but was concerned about implementing the recommendations without fully considering their impact on the clinical workflow and potential burdens for provider offices.





- **Clem** voiced his support for Robert's concerns and added the NCVHS has made similar proposals with similar end goals but without the same specificity. He asked if NCVHS could be consulted and if the recommendations could be voted on by the HITAC without the one in question.
  - **Aaron, Denise,** and TF members discussed the parliamentary logistics of how the HITAC could vote on the recommendations, with one still pending and requiring further revisions.

As a result of concerns raised during the discussion period, **Robert** made a motion to table the ISP TF 2021 Recommendation #3, pending further work with the TF to make sure that it is clear and to avoid misinterpretation of the wording that was provided and to consider further investigation with the experts around procedural coding. **Clem McDonald** seconded the motion. **Denise** called for a vote on tabling Recommendation 3.

**The HITAC approved the motion to separate the ISP TF 2021 Recommendation #3 from the other recommendations by voice vote. Arien Malec opposed, and no members abstained.**

**Aaron Miri** called for a motion for the HITAC to accept the ISP TF 2021's remaining recommendations. **Steven Lane** moved to support the motion, and **Jim Jirjis** seconded it.

**The HITAC approved the motion to approve all ISP TF 2021 Recommendations (other than #3) by voice vote. No members opposed, and no members abstained.**

**Mike Berry** explained that given the two motions and the HITAC votes to approve both, the ISP TF 2021 would reconvene to address the concerns raised about Recommendation #3. Then, the TF could bring the recommendation back before the HITAC at a future meeting for a vote.

**Aaron Miri** called for a motion to send Recommendation #3 back to the ISP TF 2021 for additional analysis and revisions. **Arien Malec** moved to support the motion, and **Steven Lane** seconded it.

**The HITAC approved the motion to send Recommendation #3 back to the ISP TF 2021 by voice vote. No members opposed, and no members abstained.**

The HITAC co-chairs and other members thanked the ISP TF 2021 co-chairs and members for their work on the recommendations. **Clem** recognized **Arien** for his writing work on the report and documents.

## BREAK

The HITAC took a short break. **Mike Berry** reconvened the meeting at 12:30 p.m., and **Aaron** and **Denise** welcomed HITAC members, presenters, and the public back to the meeting.

## HEALTH INTEROPERABILITY OUTCOMES 2030

**Steve Posnack** presented ONC's Health Interoperability Outcomes 2030 project. He discussed work that has been done at ONC during 2010 through 2021 and explained that ONC is seeking feedback from stakeholders on health interoperability outcome statements for 2030. These outcomes could involve ONC or ONC playing a role in cooperation with other federal partners, consistent with the [2020-2025 Federal Health IT Strategic Plan](#).

**Steve** explained that a well-framed interoperability outcome would be stated concretely with a reasonably intuitive way to measure progress and/or whether the outcome has been reached by 2030. They should also be stated in an aspirational yet achievable way, before or by 2030, and submissions should describe in greater detail what metric(s) would be used or how the outcome/achievements would be measured.







**Steve** explained that ONC is looking for stakeholders, including HITAC members, to complete the following “fill in the blank” with their best formulation of a health interoperability outcome. Below are two alternative framings and examples to get stakeholders started, but all were encouraged to develop their own variations, as well.

- “Because of interoperability, \_\_\_\_\_ before/by 2030.”
- “Because of interoperability, before/by 2030 [who] will [what].”
- For example: “Because of interoperability, faxes are no longer used in clinical care before/by 2030. As another example, because of interoperability of health data, before/by 2030, everyone that is part of a care team will have accurate, up-to-date clinical information prior to providing care.”

**Steve** stated that submissions will be accepted on [healthit.gov](https://healthit.gov) through July 30, 2021. Submitters should focus on the following areas:

- Health equity
- Empowered consumers/consumer well-being
- Health IT usability & safety
- Public health
- Health IT infrastructure/data sharing expectations
- Care coordination/delivery
- Research into action/marketplace innovations

**Steve** referenced [his post on ONC's Buzz Blog](#) for additional information.

The HITAC co-chairs invited members to share feedback on the categories, content, and project presentation.

### Discussion:

- **Denise Webb** described a health interoperability outcome in which providers can access real-time, robust research, and can discover similarities/more information about a patient’s rare symptoms/diagnosis/disease from other cases identified in other locations around the world.
  - **Aaron Miri** voiced his support for her comment.
  - **Denise** added that she meant the clinical decision support (CDS) spectrum in terms of how providers can decide which treatments might work for their patients.
- **John Kansky** voiced his support of the seven categories that were identified but explained how the sixth category, care coordination/delivery has many good points. However, a statement that healthcare will be cheaper and of a higher quality because of interoperability was not included. He asked how they could prove that interoperability would lead to higher quality, safer, and less expensive healthcare.
  - **Steve Posnack** suggested several categories that could be created around costs, like care delivery, convenience, connectivity, and the overall community dynamic. He called for other healthcare stakeholder communities that might not have been represented yet, like nursing, to submit feedback.



- **Michelle Schreiber** described an outcome in which interoperability has driven value, including high quality, high safety, better experience, and lower cost for healthcare. Interoperability also supports care beyond the traditional boundaries of hospitals/facilities. Finally, health equity should be expanded to include equity for all consumers, no matter where they live. Also, she stated that all quality measures should be digital by 2030.
  - **Steve** thanked her for her comments and stated that indicators or measurements to capture the changes she described were needed. He explained that outcome statements should include a succinct way to measure the outcome described. He suggested that there should be proxies or other overall healthcare ecosystem changes that would show a decrease in costs, for example.
- **Ken Kawamoto** highlighted the difference between process and outcome and suggested that the lists ONC is compiling could be consolidated into outcomes that are enabled by processes. He stated that consolidation could also ensure that ONC is more accountable, which would lead to better clinical outcomes for patients. He would like to see the U.S.'s per capita healthcare expenditure go down by 2030.
  - **Steve** agreed with **Ken's** approach and explained that ONC planned to create a prioritized set of outcomes, which will become the focal point for future work. He described how ONC would reconcile submissions from various stakeholders, noting that there would not be just one federal approach, and he encouraged members to use the [HealthIT.gov](https://www.healthit.gov) website to submit outcomes.
  - **Denise** supported **Ken's** point about measurable performance metrics and stated that quantifiable measures are needed, as well.
- **Clem McDonald** suggested that a desired outcome would be to find a way to ensure that interoperability does not lead to an overload of information or data that are not useful because the important information is buried.
  - **Steve** explained that ONC's approach with its suggested wording of the outcomes is meant to inspire a sense of momentum and accomplishment. By setting desired outcomes, they could work backward to determine how to accomplish them.
- **Abby Sears** stated that OCHIN would be submitting comments shortly, which will be focused on equity, sharing data, and equitable access to all patient data across the care continuum. She suggested that "disabled patients" be replaced with the wording "patients at risk."
  - **Steve** thanked **Abby** for her comments and added that ONC is working on compiling incoming submissions. HITAC members will be sent an updated list. He discussed the prioritization of interoperability with equity by the current administration.
- **Michelle Schreiber** voiced her agreement with Ken's comments and suggested that ONC focus even more on workforce burden reduction via EHRs. They could measure that EHRs are no longer the single highest source of complaint from providers, for example.
- **Clem McDonald** commented that humans are fallible and might not understand how biology affects them.
- **Les Lenert** suggested emphasizing the notion of "systemness" and stated that, while interoperability should reduce medical errors, it should also ensure that test results are always accessible to patients and providers always follow up. To fail could mean loss of life.

- **Steve** discussed ways in which safety and technology, automation and connectivity, and convenience and burden reduction are connected. By listing potential outcomes, people might be able to attach their work achievements and contributions to particular interoperability outcomes.
- **Jim Jirjis** echoed **Clem's** earlier comments about biology and stated that, by better measuring outcomes, meaningful metrics can be created around preventing the number of people who have complications from chronic diseases.
  - **Steve** agreed and highlighted Jim's comments around focusing on specific impediments or pain points to assess workflows. If the workflow is not ideal, creating a better outcome and working backward to a solution could be helpful.
- **Clem McDonald** suggested an outcome in which new technologies and interoperability can be used to overcome diagnostic challenges, resulting in better health outcomes.
- **Steve Posnack** encouraged all attendees to submit outcome statements and to encourage their colleagues to share, as well. The more submissions ONC receives, the better trends, patterns, and options for framing out the next steps for ONC's work can be identified.
- **John Kansky** inquired about the end goal for this project and the actions that would be taken.
  - **Steve** responded that ONC would like stakeholders to rally behind main topics/themes and to channel their work towards them across the industry. ONC will look for top priority trends/topics and will create a concise document and plan for interoperability.

## PUBLIC HEALTH DATA SYSTEMS TASK FORCE 2021 (PHDS TF 2021) UPDATE

**Carolyn Petersen** and **Janet Hamilton**, the co-chairs of the PHDS TF 2021, introduced themselves and presented an update on the work of the TF. **Carolyn** provided an overview of the PHDS TF 2021 charge, including the updated charge scope, which were included in [the PHDS TF 2021 presentation slide deck](#). The updated scope included:

- The PHDS Task Force 2021's scope will focus on bi-directional data exchange between public health data systems and clinical data sources
- This will include focusing on challenges, gaps, and ideal future state for data sharing between public health systems and clinical data sources (EHRs, laboratory systems, vaccine management software, operational, other relevant data sources).
- Topics previously in scope that now will be recommended for future HITAC discussions include research and innovation, social services data, and in-depth analyses of specific public health data systems.
- Recommendations and discussions surrounding health equity and public/patient engagement will be addressed in each topic discussed instead of representing unique topics for meetings and categories for recommendations.

**Janet** summarized the PHDS TF 2021 draft recommendation topics under consideration, which were detailed in the PHDS [TF 2021 presentation slide deck](#). She explained that the TF focused on the overarching guiding principle that a 'new normal' should be defined where public health is part of healthcare; this holistic approach should be applied across the health ecosystem to ensure data is captured, passed, and shared across the infrastructure. Janet provided additional context and summaries of TF member discussions, and her comments are accessible in full [within the transcript for the HITAC meeting](#). Draft recommendations and TF member comments were detailed under the following topic areas:

- Syndromic Surveillance



- Electronic Lab Reporting, Adoption of Implementation Guide
- Increase Public Health Funding
- Formation of a Standing Public Health Task Force
- Major Gaps in Standards Adoption for Key Surveillance Use Cases
- Technology and infrastructure factors affecting key surveillance use cases
- Other (various draft recommendations)

**Janet** explained that the TF addressed health equity throughout its recommendations instead of as a separate topic area. **Carolyn** explained that the TF is working, through its recommendations, to bring together the disparate environments of public health and the clinical side of healthcare through the promotion of the bidirectional flow of data to create better outcomes for patients/consumers in the U.S. at state, local, and federal levels. She emphasized the need to foster trust with the public and better educate consumers on how their information will be used to serve them better.

A list of future topics and meeting schedules were provided on slide #15 in the presentation deck.

The co-chairs thanked the presenters and invited HITAC members to provide feedback.

### Discussion:

- **Robert Wah** thanked the presenters and suggested that the TF consider expanding the definition of public health to include non-communicable diseases, like hypertension and diabetes. They often are top contributors to morbidity and mortality and have also been risk factors for COVID-19. By considering non-communicable diseases in the TF's possible new types of data sources, new information (like weight and blood pressure information from machines in public places) can be fed into public health to inform their activities. Sources, like the weight/blood pressure machines that are integrated into people's lives through their daily activities (going to the grocery store, for example), might help reach underserved communities. Also, people using these machines are an audience for public health messaging information when they are using the machines.
  - **Janet** thanked **Robert** for the excellent comments and suggested that the near real-time chronic disease information would create a new economy of scale for public health data.
  - **Denise Webb** discussed her experiences in the Wisconsin Division of Public Health as the state health IT coordinator and explained that a number of public health programs had suggested that valuable data could be gained from ambulatory clinics (not just from emergency rooms/urgent care), especially around chronic conditions. She stated that having the ambulatory ADTs for syndromic surveillance could help inform other aspects of public health, not just infectious disease.
- **Steven Lane** suggested organizing the recommendations more clearly and consistently and asked ONC to call out electronic case reporting (eCR), specifically.
  - **Janet** agreed with his comments.
- **Clem McDonald** submitted several comments:
  - First, the fragmentation of public health cannot be solved solely with increases in funding. Though he acknowledged the variety of laws across different states, he suggested that public health work should be more connected or centralized.
  - Second, there are challenges around the questions used for collecting eCR data and managing the data. Feedback from the clinical side about what data to capture has been lacking.



- **Carolyn** stated that everyone on the PHDS TF 2021 recognizes the challenge of funding public health and the resulting limitations. The TF will remain generic in terms of recommendations around funding due to its charge and how the TF can best exert its influence.
- **Clem** asked the TF to consider pushing recommendations around funding for public health due to the upcoming increased amount of funding it will receive. A larger, interconnected system could be built with the funding instead of many smaller, boutique systems.
- **Les Lenert** suggested an outcome in which public health can do a single, automated query in a case investigation using a standardized pull operation. He encouraged the TF to stop working on case reporting, which is the push operation, and to focus on facilitating the standardized pull operation (using FHIR or CCDA) to automate case investigation and get additional data from the EHR.
  - **Janet Hamilton** agreed that a better process is still needed to get enough information to public health to take action on case investigations. Current processes do not meet the needs of public health.
  - **Les** agreed and suggested that the more automated case investigation can become, the better, and discussed related challenges, like getting the right triggers, evolving standards, and know what to lab results report to public health.
  - **Steven Lane** agreed with **Les**' comments and suggested that the focus should not move away from eCR but should expand to look at the continuum from reporting to investigation to case management. He agreed with **Les**' comments about supporting case investigation with FHIR-based queries and minimum necessary data. There should be an ongoing discussion between public health subject matter experts and treating providers to collaborate.
- **John Kansky** echoed **Robert's** previous comments and stated that nothing in the PHDS TF2021's scope stated that public health is solely about communicable diseases. He suggested that the TF's recommendations speak to chronic disease needs and suggested that the TF use the information around diabetes as an example.
  - **Janet** thanked everyone for their feedback and noted that the PHDS TF 2021 has not completed its cycle of meetings.
  - **Carolyn** invited HITAC members to forward any additional comments or pieces of feedback to **Janet, Mike Berry**, or herself.
- **Clem McDonald** suggested there should be more dialogue between public health and reporting physicians about what data are being shared. He discussed issues with eCR and suggested that giving public health the ability to pull data from the EHR could be more useful. He asked TF members to consider a recommendation around why certain disease data are being pulled, noting that it was obvious with COVID-19 but not necessarily other diseases.
  - **Janet** agreed that the public health response is a critical piece and that public health is not and should not create burdens for physicians in terms of time and effort. She stated that eCR happens because of triggers in the background, so systems just need to be set up to move data to public health from the EHR.
- **Les Lenert** suggested expanding the TEFCA recommendations and focusing on how TEFCA should address public health integration, possibly through a national health information exchange (HIE) system. Related laws and policies need to be in place. He explained how HIEs were ready to respond to COVID-19, but their responses were shackled by state laws or the lack of willingness of others to exchange data with HIEs.
- **Jim Jirjis** agreed with the previous commenters and suggested that a TEFCA-like solution would be useful to map a value set and set up monitoring systems when the next lab system comes online. He expressed concerns that incentives were lacking for states to agree to use a national model, so hooks and incentives are needed.



**Carolyn** thanked all the HITAC members who submitted feedback and explained that the PHDS TF 2021 co-chairs would work to incorporate them in the recommendations. She explained that the TF will work to keep its recommendations broader and will not be prescriptive due to the timeframe for the TF's work.

## PUBLIC COMMENT

**Mike Berry** opened the meeting for public comment and reminded attendees that written comments could be submitted at [ONC-HITAC@accelsolutionsllc.com](mailto:ONC-HITAC@accelsolutionsllc.com).

### Questions and Comments Received via Telephone

#### **Nancy Spector, American Medical Association (AMA):**

Hi. Thank you. My name is Nancy Spector. I work for the American Medical Association. Thank you for allowing my public comment. I wanted to speak with regard to the ISP task force report earlier and note that the AMA supports the action that was taken by HITAC to send Recommendation 3 back to the task force for further consideration. We also want to say that we agree with the HITAC that procedure coding experts would benefit the ISP task force's review of their recommendation. And we are happy to work with the task force in providing procedure coding terminology experts to help them with better understanding the industry needs. And we will reach out to ONC and the ISP task force co-chairs to assist with scheduling that.

### Questions and Comments Received via Adobe Connect

Mike Berry (ONC): Welcome to the June HITAC meeting! We will be getting started soon.

Adi Gundlapalli (CDC): Good morning Adi Gundlapalli here from CDC. I will join by phone a little later this morning. Thank you

Robert Wah: Waiting to get on phone connected

Terrence O'Malley: On the call now. Thanks.

Zahid Ali: Good Morning, Zahid here, I am for first time. Nominated as #FUTURE50 Health IT leader by himss

Leslie Kelly Hall: Please provide link to funding opportunity

Didi Davis: Thank you for the shout out for @Sequoia Project #RCE @Micky Tripathi.

Steve Posnack (ONC): Right now there's a "coming soon" for the funding opportunity for the PHIT Workforce program, but it will be here when the full announcement is published  
<https://www.healthit.gov/topic/onc-funding-opportunities/funding-announcements>

Steve Posnack (ONC): Also --- Save the date for the ONC TECH Forum Sept 16th and 17th

Robert Wah: 45 pages of minutes!!!

Zhan Caplan: There will also be an eblast and regular tweets about the funding opportunity when it is released.

Aaron Miri: @zhan <https://www.healthit.gov/topic/onc-funding-opportunities/funding-announcements>

Aaron Miri: @andy nice tip of the hat to CCAL







Andy Truscott: Credit where it's due Aaron!

Dr. Leslie Lenert: Hello: joining in a bit late

Jim Jirjis: Jim Jirjis Joining a bit late

Bryant thomas Karras: how will Public health submissions *[sic]* be identified? local state or CDC?

Bryant thomas Karras: my question related to dashboard

Leslie Kelly Hall: Great question Bryant. That is to be determined, we did not get to that level in this set of recommendations. Good consideration

Andy Truscott: !! Thank You Clem !!

Leslie Kelly Hall: Woo Hoo! Thank you!

Zahid Ali: Perfect. Thats *[sic]* amazing

Carolyn Petersen: Excellent work, USCDI TF!!!

Andy Truscott: I was presumptive with Context Passing (I'll raise the comment again here!)

Micky Tripathi: Thank you to the USCDI Task Force!!

Aaron Miri: Good job @ Steven and Leslie! Good leadership

Andy Truscott: As a Minion on the task force, I can vouch for the excellence of leadership from Leslie and Steven.

Leslie Kelly Hall: @ Andy never a minion....

Terrence O'Malley: Absolutely superb job, Leslie and Steven and the entire USCID TF

Leslie Kelly Hall: Thanks everyone!

Zahid Ali: Amazing work @ Steven, Leslie

Zahid Ali: I am looking forward to add value the best i can

Clement McDonald 2: Believe there is a typo on

Clement McDonald 2: 3b 3b. ONC to work with key Federal stakeholders (such as NLM, CMS, FDA, NIH, etc.) to transition the nation towards terminology meeting the policy through means including, but NOT limited to, licensing, working with terminology curator-- LEFT OUT NOT

Arien Malec: thanks!

David McCallie: Thanks Clem. We fixed that in the document but missed the slides

Clement McDonald 2: regarding the presious *[sic]* suggestions re mapping USCID to commonly used data model and HI7. It is little off. PCORNET, AND FHIR, PCORNET and OMOP already include-require the use of the big USCDI coding systems. So not at all clear what map USCID to them means/ Some of





the other existing models avoid the use of key USCDI coding systems.. [sic] And without standard coding systems data can't be combined [sic] even if the people use the same model. Think this bullet needs clarification., [sic]

Steven Lane: Looking forward to having Arien and David present to our USCDI TF next week on specific recommendations for future advancements in USCDI in alignment with evolving and emerging standards as identified in their HITAC presentation.

Abby Sears: Please remember that there is a huge homeless problem in this country and addresses are not available for a good portion of our most complex and fragile populations.

Mike Berry (ONC): Materials from today's meeting can be found on our website:

<https://www.healthit.gov/hitac/events/health-it-advisory-committee-35>

Clement McDonald 2: The issue regarding [sic] unification of billing and clinical [sic] data has been a long concern of NCVHS and they comment on it in their last report (2020) <https://ncvhs.hhs.gov/wp-content/uploads/2021/05/Report-NCVHS-2020-Accomplishments-final-508.pdf> They stimulated a committed [sic] Which I think is part of HITAC who also reported [sic] out. <https://www.healthit.gov/sites/default/files/page/2020-11/2020-11-17-ICAD-TF-FINAL-Report-HITAC.pdf> This committed overlapped a lot with HITAC. Believe we should at least cite [sic] this work but might be better to push for unification of administrative [sic] and clinical process as these reports suggested, did rather than being prescriptive

Abby Sears: Also the Latino population is often moving and do not have permanent homes and addresses

Robert Wah: To our chairs: Are we saving comments for all these recommendations after the full set has been presented?

Carolyn Petersen: +1 to Abby's comments re: meeting the needs of homeless and underserved populations

Clement McDonald 2: regarding 5a -- this is tightly connected to the early suggestion [sic] about common models. And worry that this proposal will slow down the current voluntary integration of common data models. There are 5-6 such data models. Three of them - FHIR, PCORNET and OMOP already use [sic] standard codes. 2 models reject one or more USCID big coding systems, A

Clement McDonald 2: more - think we would be better off proposing funding for conversion of the models that are willing to converge AND already use standar [sic] codes (USCDI) rather than creating new common model across all of the existing modesl [sic]

Steven Lane: Is it time to consider a Situational Awareness data class for inclusion in a future version of USCDI? The gap between USCDI V1 and All EHI includes a LOT of data outside the EHR/CHIT.

Steven Lane: Similarly a Research data class is worth consideration. Even small office EHRs should be able to share exchange data in support of research, e.g., consent, participation, if we are to support pragmatic community-based research. Comprehensive Situational Awareness also includes the situation in small offices and community care settings.

Clement McDonald 2: I agree with some of Bobs comment . These are tough problems. Don't think we can optimize [sic] on international and US requirements easi. [sic] Better to just propose more unified process for billing and care as proposed by NCVHS (see my other comement) [sic]

Steven Lane: Dropped from audio. Dialing back in.





Robert Wah: I just got cut off the phone. dialing back in

Robert Wah: Just got back in on the phone

Steven Lane: Great work Arien and David continuing the work of the ISPTF!

Robert Wah: Thank you to the Task force and our Co Chairs for handling this challenge!

Rachel Richesson: The HL7 Patient Empowerment work group members are articulating use cases and requirements around advanced directives, patient corrections, and patient-contributed data.

Ken Kawamoto: I added that in 6h

John Kansky: Because *[sic]* of interoperability, by 2030 healthcare will be higher quality, safer, and less expensive

Terrence O'Malley: A widely applicable "cost" measurement *[sic]* is "time required to accomplish". One would expect that "time" would decrease as interoperability increases. Think of the time difference between how you deposit a check today from your phone vs the trip to the bank 20 years ago.

Carolyn Petersen: You'll know that you've achieved equity when disparities in outcomes among groups disappear. People with disabilities, in particular those with intellectual disabilities, had higher rates of death from COVID than those without disabilities. Improving outcomes for everyone is important, but when we know that a particular group fares measurably worse than other groups, we need to focus efforts on reducing that the disparity experienced by that group.

Rachel Richesson: Because of interoperability, patients will be able to share their preferences with *[sic]* providers...

Ken Kawamoto: A key for what Clem is saying is to balance say the quadruple *[sic]* aims -- e.g., making sure clinical experience doesn't degrade with information overload

Susan Clark: Because of Interoperability health information will be received in the right format, in the right context, *[sic]* at the right time with the right applicability.

Sheryl Turney: This list appears different than the one that we were sent with the meeting documents. Will this updated list be posted online?

Mike Berry (ONC): @Sheryl - I believe the revised version is posted on our website: <https://www.healthit.gov/hitac/events/health-it-advisory-committee-35>

Sheryl Turney: Mike I had checked that first and its not there.

Sheryl Turney: Loved this idea

Mike Berry (ONC): [https://www.healthit.gov/sites/default/files/facas/2021-06-09\\_Health\\_Interoperability\\_Outcomes\\_2030.pdf](https://www.healthit.gov/sites/default/files/facas/2021-06-09_Health_Interoperability_Outcomes_2030.pdf)

Alexis Snyder: Its not about "healthy" its aabout *[sic]* living best life

Alexis Snyder: everyone's baseline "healthy" *[sic]* is different

Clement McDonald: hear hear!





Rachel Richesson: living best life.. as defined by patient. Aligned with patient goals and preferences and values.

Alexis Snyder: and getting needs met to accomplish such

Carolyn Petersen: +1 re: Alexis. "Healthy" and "quality of life" are lived experiences as defined by an individual, rather than as social constructs determined by external actors.

Alexis Snyder: yes!!

Jim Pantelas: agreed

Terrence O'Malley: We're listing ways that interoperability may improve outcomes, would it be helpful to think about ways to improve interoperability? Such as how to deal with information overload per Clems' comment. How to extend and expand capacity to participate in interoperable exchange.

Alexis Snyder: The ICAD task force made many recommendations on such..

Carolyn Petersen: Yes, these recommendations are Under Construction!

Aaron Miri: re: Ambulatory / LTAC / etc. - need levers to help facilitate *[sic]* exchange of that critical data and/or additional mechanisms to help facilitate *[sic]* acquisition of information systems to do that exchange of public health data/ information

Clement McDonald: CDC does not generally include the specimen in the test name . Hospital and commercial *[sic]* laboratories do. For many disorders th specime *[sic]* is very important . CDC counts on the SPC segment *[sic]* to identify the specimen. Most other care systems don't need it becausei *[sic]* it is stated in the name (and the standard code). Public health *[sic]* agencies foun *[sic]* the SPC segment to be missing most of the times. Would be better if both sides followed the same pattern

Carolyn Petersen: Sociotechnical as well as structural issues re: equity

Mike Berry (ONC): We will be opening the line for public comments after this presentation. To make a comment please call:1-877-407-7192 (once connected, press "\*\*1" to speak).

Robert Wah: Here is the info on Higi where more than 3 million BP and weights are coming in each month from over 10,000 digitally networked stations located where the public go everyday (rural, pharmacies, grocery stores). There are also almost 9 million patients who have registered so they can see longitudinal record of measurements so we have their contact information to have interactive relationship. More info at Higi.com

Steven Lane: @Les - These are not mutually exclusive. We need to support BOTH eCR and the ability to support a dialogue with clinical data and recommendations going between clinicians and PH.

Arien Malec: why don't we do published triggers that can pull a defined set of data out of EHRs where the triggers can be published by ph?

Arien Malec: That would be awesome, if we could do it. We could call it eCR.

David McCallie: Infrastructure to deliver on-demand data from EHR for PH could also work for "claims attachment" demands

Arien Malec: Definitely that too.





David McCallie: issue a time-limited auth token, triggered by PH need or by payment episode

Steven Lane: We should evolve further from PH Case Investigation to PH Case Management, a collaboration between treating providers and PH experts.

Clement McDonald: Dave and Arian keep the thread going !

Arien Malec: But eCR defines triggers that are published by ph authorities, and captures data via FHIR (eCR Now) or CDA (eCR regular)

Bryant thomas Karras 2: and recall that the eCR standard is just “electronic INITIAL case report “ ... it does need follow up

Arien Malec: Completely support public health ability *[sic]* to query -- we opened up CommonWell for that purposes & collaborated with CareQuality to make supre *[sic]* we had common rails

Arien Malec: it's a both/and

Robert Wah: @John Kansky Thanks for supporting and keeping Non Communicable Disease part of Public Health up on the discussion. NCD's are very important to change the curve of overall health.

Carolyn Petersen: Yes, yes, HITAC members -- Aaron and Brett and I want you!!

Steven Lane: Great meeting! Kudos to the co-chairs and the entire committee. I will need to miss the next HITAC meeting, which occurs right after the release of USCDI V2, but look forward to reviewing the recording and joining the discussion when I come back on the grid.

## FINAL REMARKS

**Mike Berry** placed a call for one or two interested HITAC members to join the Annual Report Workgroup and emphasized that good writers were encouraged to reach out.

**Mike** reminded members that the next meeting of the HITAC will take place on July 14, 2021, and added that all meeting materials would be made available at <https://www.healthit.gov/hitac/events/health-it-advisory-committee-35>.

**Denise** summarized the presentations given and the motions made at the meeting, and **Aaron** thanked the presenters for their thoughtful comments and discussions, as a multi-stakeholder group with diverse opinions, during the meeting. He added that CMS, providers, vendors, and the entire healthcare industry have been making changes because of Information Blocking. He encouraged the HITAC to keep these results in mind when providing feedback on current/ongoing initiatives.

## ADJOURN

The meeting was adjourned at 2:30 p.m. ET.

