Health Information Technology Advisory Committee

The Office of the National Coordinator for Health Information Technology

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) PUBLIC HEALTH DATA SYSTEMS TASK FORCE 2021 MEETING

June 24, 2021, 10:30 a.m. – 12:00 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Janet Hamilton	**Council of State and Territorial Epidemiologists (CSTE)**	**Co-Chair**
Carolyn Petersen	**Individual**	**Co-Chair**
Danielle Brooks	Amerihealth Caritas	Member
Denise Chrysler	Network for Public Health Law	Member
Jim Daniel	Amazon Web Services	Member
Steven Eichner	Texas Department of State Health Services	Member
Claudia Grossmann	Patient Centered Outcomes Research Institute (PCORI)	Member
Steve Hinrichs	Individual	Member
Jim Jirjis	HCA Healthcare	Member
John Kansky	Indiana Health Information Exchange	Member
Bryant Thomas Karras	Washington State Department of Health	Member
Steven Lane	Sutter Health	Member
Nell Lapres	Epic	Member
Leslie Lenert	Medical University of South Carolina	Member
Denise Love	Individual	Member
Arien Malec	Change Healthcare	Member
Clem McDonald	National Library of Medicine	Member
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Member
Larry Mole	VA	Member
Abby Sears	OCHIN	Member
Sheryl Turney	Anthem, Inc.	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Cassandra Hadley	Office of the National Coordinator for Health Information Technology	ONC Staff

Brett Andriesen	Office of the National Coordinator for Health Information Technology	Staff Co-Lead
Brenda Akinnagbe	Office of the National Coordinator for Health Information Technology	Staff Co-Lead

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

Operator
All lines are now bridged.

Michael Berry
Great. Thank you very much. Good morning, everyone. I am Mike Berry with ONC. We really appreciate you joining us today for the Public Health Data Systems Task Force. I am going to get started with roll call. So, when I call your name, please indicate you are here. Let us begin with our co-chairs. Carolyn Petersen?

Carolyn Petersen
Good morning.

Michael Berry
Janet Hamilton?

Janet Hamilton
Good morning.

Michael Berry
Danielle Brooks?

Danielle Brooks
Good morning.

Michael Berry
Denise Chrysler?

Denise Chrysler
Good morning.

Michael Berry
Jim Daniel? Steven Eichner?

Steven Eichner
Good morning.

Michael Berry
Ngozi Ezike? Claudia Grossmann?

Claudia Grossmann
Good morning.

Michael Berry
Steve Hinrichs? Jim Jirjis?

Jim Jirjis

Here.

Michael Berry
John Kansky?

John Kansky
I am here.

Michael Berry
Bryant Karras?

Bryant Karras
Good morning.

Michael Berry
Steven Lane?

Steven Lane
Good morning.

Michael Berry
Nell Lapres?

Nell Lapres
I am here.

Michael Berry
Leslie Lenert? Denise Love? Arien Malec?

Arien Malec
Good morning.

Michael Berry
Clem McDonald? Aaron Miri? Larry Mole?

Larry Mole
Good morning, sir.

Michael Berry
Abby Sears, I believe she is away and will be rejoining us at another time. Sheryl Turney? All right. Thank you, everybody. Now I will like to turn it over to our co-chairs, Carolyn and Janet. Thank you.

Opening Remarks (00:01:46)

Carolyn Petersen
Good morning. Thanks, Mike, for all your help. Good morning and welcome to everyone. I know we are coming towards the home stretch in our task force work, and I really appreciate everyone hanging in and

following along with the homework and the discussions. We have discussion today of some of our draft recommendations and also some time talking about the last survey questions, and then we anticipate reaching out to you to work on specific recommendations. But I will leave that discussion for our ONC team leads, Brett and Brenda. I will now pass the mic to Janet for her comments.

Janet Hamilton
Great. Thank you so much, Carolyn. Just really looking forward to the discussion today. I am sorry I had to miss our last meeting. We were having a large conference. And I would just say, boy, is the work of this group going to be so meaningful for our public health membership. So, just really want to thank people for your time. As well as when we do get into some of the next steps and the looking at some of the homework and other things, I really would encourage people to think about which items maybe they want to volunteer for. We are in this home stretch. And really just look forward to all of your participation during these calls but also to helping us really get the language of our recommendation articulated in the most useful and productive way. So, thank you, all, so much.

Review Recommendations Under Consideration (00:03:40)

Carolyn Petersen
With that, I will ask Accel if you could pull up the Google Doc with the draft recommendations in it. It is going to lead a discussion on the funding recommendations. That would be of interest to everyone. For those on the phone, we are just working through the technical aspects of bringing up the document on the screen. We will start the discussion momentarily.

Sheryl Turney
Oh, and, Carolyn, I am on. This is Sheryl Turney. Sorry for being late.

Carolyn Petersen
Thanks, Sheryl. Glad you were able to come today.

Leslie Lenert
Hi, this is Leslie Lenert. I am also on.

Carolyn Petersen
Thanks, Les.

Jim Daniel
And Jim Daniel as well.

Carolyn Petersen
Hi, Jim.

Jim Daniel
Hey.

Kathleen Tully
Hi there. There is Katie. Can everyone see this Google Doc now?

Michael Berry
Yeah.

Kathleen Tully
Great.

Janet Hamilton
Thanks so much, Katie. This is Janet. I do not know if you are able to make it a little bigger for folks, too. Maybe zoom in a little bit. And while you are working on that – yeah, that looks much better on my end. Thank you.

So, the first section for discussion for the group that we thought we would like to focus in on is really this funding piece. I think if you can think all the way back to some of our early meetings when we were really working on soliciting opening comments and even the hearing that was held outside of this specific workgroup, but one of the major things that came up was really the funding for public health to support data efforts. And so, we really wanted to ensure that we had a time for this group to look at that and to look at the language that we have proposed here. I would just say, I think there was broad consensus that public health had never been funded at the level that it needed to be funded to do the work that it needs to do to really be a population-focused activity that is receiving, collecting, aggregating, and turning disparate bits of data into information and ensuring that useful, meaningful, information is also provided to the public. Being able to do that at a true population scale in addition to technical infrastructure needs resources to do that.

So, this first part of the discussion is around funding. There are some recommendations that you will see here on the screen. I think what I will do in the interest of time, for folks on the phone too, is go over the these recommendations, these four that are on the screen, and then ask folks to provide input on the recommendations themselves. So, the first one being, "Congress should appropriate to CDC robust, annual, sustained funding to support development and maintenance of public health data systems capable of supporting routine and large-scale responses." The second one, "CDC should develop plans for cross-program funding of technology investments that support interoperability across public health systems." The fourth one, "CDC should allocate funding for capability development, for example contract tracing, that serves multiple public health goals separately from disease-specific funding. There should be a minimum functional standard for public health that focuses, not just on interoperability and standards development, but also, ideally, addresses infrastructure expectations to improve scalability." And the fourth one being, "ONC, CDC, and CMS should invest in education campaigns to enhance knowledge and identify opportunities to incentivize."

So, with that, we would love to take comments. If folks can raise their hand and offer either specific or more broad comments. I would really ask people to think about if there are gaps. We would really want to address and close any gaps that you see in this, and to be thinking about this in a really holistic approach, and ask folks to also reflect on the language. Is this language adequate enough to represent some of our other discussions around the need for intersection between healthcare and public health? Also, is the language maybe well enough fleshed out that supports the public health system and the reflection of the fact that public health is a state, local, tribal, territorial, as well as federal function. And so, maybe I will just stop there with some of my opening comments. And it looks like we have quite a few hands raised.

Danielle Brooks
Janet, this is Danielle. I am having technology challenges, but would love to comment in a polite order. Is there a way for me to raise my hand via the phone? Or would you just like to wait to the ending of comments? I just want make sure that I am respecting the process.

Janet Hamilton
Thanks so much, Danielle. We will – we, I say myself and Carolyn – will try to remember to ask for folks just on the phone. But how about you go ahead now, and then we will look at the hands raised.

Danielle Brooks
Oh. Sure. I did not mean to jump the line.

Janet Hamilton
That is quite all right. I feel like we often leave the phone to the end. So, let us go ahead and see what your thoughts are. Then on my screen, I will just say I do not see the documents anymore, and so I do hope we can bring that back up. Okay, great. Thank you.

Danielle Brooks
Sure. I will keep my comments quick. One of the things just observing the overall funding, I applaud the recognition in needing stronger, more consistent funding. I think from an equity standpoint, I do not want the standard to be written with the assumption that funding is equitable right now. And there may need to be some kind of equity considerations in this funding model, meaning making sure that areas that are traditionally underfunded do receive proportional funding to be able to participate in this infrastructure, as there may be greater funding needs compared to a larger system. So, I just wanted to raise that to make sure that we are continuing to make that equity-focused. Thank you.

Janet Hamilton
Okay, great. Maybe a way to represent that too is also across jurisdictions and ensure that we are looking at that as a way to ensure that those equity considerations are represented. Okay. Let us go to Denise.

Denise Love
Yes, thank you.

Denise Chrysler
I assume – oh.

Denise Love
Denise Love? Are you going to Denise Love?

Janet Hamilton
Yes, please.

Denise Love
Okay, thank you. On these recommendations, they are broad, and they cover a lot of ground. I think it also leaves some interpretation to the eyes of the beholder. Because I am working with the national committee on vital and health statistics right now on an ICD-11 workgroup, we all agree that part of the public health

infrastructure truly is the administrative data systems and ICD-11. So, would this be broad enough to cover an evaluation of ICD-11 for sufficiency for the healthcare and the public health infrastructure?

And, oh, one more thing on the infrastructure on the third one. For the infrastructure to improve, the other component to that is improve scalability and infrastructure. I am assuming that also includes social-determinance of health, the ability to capture that in the data systems and scale those. So, I am assuming it is in there. I just wanted to underscore that is an important component to the NCVHS and to the healthcare system, but also the administrative data systems for interoperability as we start looking at the WHO's adoption of ICD-11 and how that fits with the infrastructure.

Janet Hamilton
Sorry. Let us go to Les Lenert.

Leslie Lenert
Hi. Yes, thank you. These are wonderful recommendations. I think the first thing I would add though is to say that it should appropriate fund – I would like to, as I put in the comments, say that the appropriation should be to strengthen public health data infrastructure and through CDC, but it obviously would be directed to…

Janet Hamilton
Hey, Les, I am getting a little bit of background.

Leslie Lenert
Okay. Is that better?

Janet Hamilton
I think so. It sounds like maybe someone is not on mute also. So, I think we heard you say support specifically for data and also through CDC. So, if you want to pick up that thought again.

Leslie Lenert
Yeah, through CDC, instead of to CDC, because much of the funding has to come to state and local governments, right, with requirements for this. So, recommendation one. Recommendation two, across public health platforms and – big "and" – support interoperability across platforms and with the clinical care system.

Janet Hamilton
Okay. I think those are great suggestions. Thanks for bringing those out. And, yes, recognition. When we say the public health system, that includes state, tribal, territorial, local, as well as the federal level. And it would probably be good to specify that. Thank you very much. Okay, let us go to Bryant next.

Bryant Karras
Thank you. I totally agree with making – I would hope it goes without saying when there is an allocation to CDC that that is a passageway for providing those funds to state, local, territorial, tribal partners. But I think it is worth being explicit in these recommendations every time. My comments is, the second recommendation I feel like needs either expansion or an additional one inserted between it and the next one. There needs to be funding requests, investment, and allocation in public health informatics, research, evaluation, platform, enhancement, and innovation, not just in the standards in interoperability, but in the

capacities and capabilities themselves before we are able to really state what those minimum standards are that are mentioned in the next recommendation. And I think that that might be an investment that is not just in CDC, but potentially could be in ONC, CDC, NIH, NLM, and CMS. I think there are a lot of different – HHS – agencies that could invest in advancing these public health capabilities on both sides of the partnership. I will work on some specific language and put it into the document.

Janet Hamilton
Great. Thanks, Bryant. If you want to put something in the chat too, that would be great. I think one thing I heard, it is not just evaluation, but ongoing evaluation to report the development. Okay.

Bryant Karras
Yeah. Yeah. As a continuous process, you are absolutely right. It is not a one-and-done. To stay current, we need to keep that investment. NIH and NLM have a robust extramural program to do that kind of work. Whether CDC adopts those kinds of approaches to invest in our academic partners in respective states and jurisdictions or we leverage preexisting mechanisms through NIH and NLM.

Janet Hamilton
Okay, great. Let us go on to Arien Malec. And Denise –

Arien Malec
Hey, thank you.

Janet Hamilton
Sorry, Arien. Let me just double check if, Denise, your hand is still raised or if it is a new one. And if you want to just look at that little area and make quick comments. That would be great.

Denise Love
No. Denise Love is fine.

Arien Malec
Thank you. So, first of all, I wholeheartedly agree with all of these comments. In the first recommendation, I think this is implied, that it might be appropriate to state robust, annual, sustained, and consistent funding. One of the things that we have heard is that the variability in funding creates mission issues for states and localities because they cannot assume continued consistent funding.

The second comment is a structural that sort of encouraged the task force chairs to think about, as an advisory committee, we are structurally an advisory committee that makes recommendations to the national coordinator. We have gone off that mission, and I encourage us to go off that mission at times. I have tried to structure recommendations, wherever possible, as recommendations to the national coordinator to coordinate with blah, blah, blah, blah, blah. There are some cases where it is appropriate for us to sort of pull off that hat and use our public role to make recommendations directly to CDC. Or in this case, I think there are potentially recommendations to the administration as a whole relative to CDC's funding as part of the overall budget request and recommendations to Congress.

I think we should be thoughtful about the structure that we are making those recommendations in and just understand that we are structurally making recommendations to the coordinator, but we might think about a separate transmittal or a separate letter that we send to, for example, the majority and minority leaders

and the speaker of each chamber relative to recommendations to Congress that are not structurally part of the HITAC mission but are important enough recommendations that we should be making separately. So, let us be thoughtful about the structure that we make recommendations in and also be thoughtful about times when we deliberately work around that structure. Thank you.

Janet Hamilton
Excellent comment. Thank you. And well-articulated. Okay, let us go to Denise Chrysler. And apologies, Denise. Two Denises on the line, both of which I have worked with before and have amazing contributions. So, please go ahead, Denise.

Denise Chrysler
That is okay. I am accustomed to this. Just a couple questions. I assume this language implies workforce development, and it is not just limited to technology. Just a question, should that be explicit? The other question is whether we should be explicit here – possibly we are elsewhere – of the role of funding mechanisms to require compliance with minimum standards to ensure interoperability.

Janet Hamilton
Thanks, Denise. I think something explicit to mention, this is the technology but also workforce, and the data workforce is part of what we view as the infrastructure. I think that is a great suggestion. I do not know if you have any specific language there. But absolutely agree with that. Then, your other comment, I think, is certainly wise for us to take into account too.

Denise Chrysler
The reason for the second comment is because variability of state law gets in the way so much. But it is double-edged sword because there is just not a political environment in certain states to adopt what might be overall in the national interest. It is the cheap way or a key way to reduce variability among states or other jurisdictions.

Janet Hamilton
Excellent comments, Denise. Thank you. Okay, Jim Jirjis. Thank you so much, Denise, for you great comment.

Jim Jirjis
I am sorry. Can –

Janet Hamilton
Yeah, go ahead, Jim. Jim Jirjis.

Jim Jirjis
Yeah. I just wanted to support the second one, the "and clinical systems." That we should be more explicit about aligning with the national interoperability plan, TEFCA, etc. because one of the concerns is, if the public health systems are not overt in alignment with that, then we will be right back where we started.

Janet Hamilton
Okay, great. Thank you. Steven Eichner.

Steven Eichner

Good morning. Thank you. I did submit some written comments on the draft earlier today, but I want to highlight a couple pieces in funding right now. First, looking at the existing recommendations regarding cross-program funding of interoperability, it really needs to be supporting funding on information systems that can support multiple program areas and include interoperability between systems. One of the challenges that we faced in that past is that we get siloed funding that can only be implemented for a particular program in a separate silo. Public health needs the flexibility to combine that funding so that we can implement a single system to support multiple programs, such as implementing a single sign-on system that could support eCR and ELR, for example, but it is a reasonable one. Because that way, we can leverage our investments better and have a reduced number of systems to maintain, and that creates substantial efficiencies. Interoperability still needs to be there. But if we can get the data or approve data in systems to appropriately reuse modular technology, we will be a lot better off.

Secondly, there needs to be adequate funding provided to support public health staff in participating more heavily in standards development activities, in real-world testing of data standards and exchanges, and planning activities and feedback activities, such as these task force activities, as well as some strategic planning within the public health community where we share information and thoughts to help inform future strategies. Right now, so many have to wear so many multiple hats that there is limited time to focus on the important activities such as planning for the future to help us avoid some of the pitfalls we have experienced in the past. We are constantly playing catch up with additional funding to get ahead of the ball and remain ahead of the ball, and that will benefit everybody. Thank you.

Janet Hamilton
Okay, great. Thanks, Steve. Let us see. We have not heard yet from Jim Daniel. So, let us go ahead to Jim Daniel. Then, Bryant, you will have the last comment, and then I think we can move on.

Jim Daniel
Thanks, Janet. I just wanted to really emphasize Denise Chrysler's comment about how the crossfunding is really important for public health to build their systems appropriately. Really making sure that states are meeting interoperability standards at a national level is critical. I think the recommendation should really focus on tying the funding, as opposed to a specific program like has been done in the past, but really trying to tie that funding to meeting those interoperability standards. I know that is a real challenge with CDC cooperative agreements, and that is a policy issue I think that needs to be addressed to make sure that the funding is tied to meeting that deliverable of having these systems be interoperable, both with each other and with the clinical systems.

Janet Hamilton
Okay, great. Thank you, Jim. Really important comments there. Okay, Bryant.

Bryant Karras
Hi there. There was a comment earlier about incentivizing public health to utilize mechanisms and standards and leveraging connections between clinical providers, HIEs, and public health. I think that one of the things that is a challenge is that, looking within a program or a silo or a specific team responding or implementing a system, it may seem more advantageous, either time and development or financially, to do one-off solutions rather than leveraging a shared infrastructure or health information exchange pathways. And I think that we need to figure out how to help this response to recognize the sustainability benefit of building upon infrastructures and investing in reusable architectures rather than jumping to a quick solution.

That is going to take careful investment in ways that raises all state's capacity rather than admitting that some states do not have that infrastructure in place and are going to need to be invested in so that they can, in turn, leverage it. So, it is a long-term investment. Thank you.

Janet Hamilton
Great. Thanks so much. We are going to go ahead and move on now to the policy recommendation. I do not know if you are able to – yeah, that is great. If you could try to fit them all on the screen, that would be really helpful. Sorry, I saw them for a minute. So, we are just looking for that section. Okay, great. I am going to do a similar approach here and go through the different recommendations. Actually, I apologize. I did not check to see if we had any other phone comments on the last section. Were there any other folks who were only on the phone who wanted to make a comment on the funding piece? Okay, great.

So, let us go ahead now on the policy section. We will take comments on all of them, but happy if folks will point out specific ones as well as any specific language and, again, to look for gaps in what we have listed here. So, I will read them of for folks who are only on the phone.

So, the first recommendation being, "ONC and CDC should work with OCR to develop and release best practices and guidance for meeting with HIPAA minimum necessarily standards for reporting to public health authorities. Such guidance should be aligned with TEFCA to allow national networks and HIEs to serve as public health intermediaries." The second recommendation, "CDC and ONC should work to harmonize reporting requirements, roles, and capabilities across jurisdictions and states, including data elements, timelines for submission, and communication with providers." The third, "CDC and ONC should explore policy levers to require state use of federal systems when states are receiving federal funds." The fourth, "CDC and the ONC should explore creation of an ongoing public health task force or workgroup with adequate authority to address topics out of scope for HITAC Public Health Data Systems Task Force to ensure preparedness for future high-consequence public health emergencies." And the last one, "CDC, ONC should elevate federal policy barriers that prevent HIEs from participating in public health reporting and should analyze and publish guidance aimed at educating states about state-level policy barriers that prevent HIEs from participating in public health reporting."

And with that, I will ask for folks to think of gaps that are missing here as well as other tweaks to those existing language. So, we will start with Steven Lane. Steven, please go ahead.

Steven Lane
Thanks. Yeah. On the first recommendation, I keep trying to stress this. This is not just about reporting. We are also looking at case investigation, care coordination, and ongoing bidirectional data exchange between public health and providers. So, the clarification we need on minimum necessary is really not on reporting, because you report what you need to report, but also on responding to public health queries for additional information in the case of case investigation and for the ongoing exchange of data in the case of care coordination and management.

Janet Hamilton
Excellent.

Steven Lane

Again, we should be able to trust public health to ask for the appropriate data and not have to go through machinations to ensure that it meets the minimum necessary definition or needing to reassure providers who may get stuck on that point of origin.

Janet Hamilton
Thank you very much for adding that. I agree. Those were some great suggestions. Steven Eichner. Great. Thanks so much for those excellent suggestions. Steven Eichner.

Steven Eichner
[Inaudible] [00:37:27] recommendations. The first one, looking at the recommendation about additional guidance regarding minimum necessarily standards and HIPAA for HIEs, the guidance needs to specifically address what use of the data passing through an HIE that has been reported for public health may also be utilized, e.g., means that HIE use it for other purposes, or is it to be strictly transmitted to public health and not used for other purposes.

Looking at the second recommendation, there is a conversation of reporting requirements. Whatever recommendations are developed in that space must recognize that states may have different, very specific requirements for reporting data under state law and local control. Whatever the approach **[inaudible] [00:38:24]** needs to be able to support both national and local standards and investments.

Looking at the recommendation regarding task forces, rather than starting immediately to suggest the creation of a new task force, I think there needs to be an analysis of existing resources that exist in forums and either leverage an existing forum appropriately or, if necessarily, create a new forum to achieve the goals of informing HITAC in different spaces. There are already a number of different workgroups and task forces working on different aspects. And rather than creating a new resource, it may very well be possible to leverage or repurpose an existing framework that will help reduce redundancy by creating yet another entity with potentially overlapping responsibility. As I mentioned earlier, public health staff are already overburdened in many cases with extra work. While we are very interested in continuing to participate in these discussions, we may not have the resources to spend a lot of additional time in meetings. So, that is something that needs to be in consideration.

Finally, looking at policy barriers for HIEs, I think there needs to be a recommendation, rather than just looking at what prevents HIEs from participating and supporting public health reporting, but what are the policy barriers that impact reporting. Because there may be things that do not just limit or prevent participation, but there may also be improvements that can be made that enhance things that are working but not as well as they could be. So, I would hate to set our boundaries on only, "Oh, if it does not work, here is what we need to do." We should also keep our eyes open for what can be improved as well; otherwise, we are not making necessarily a whole lot of forwards progress across the country. Thanks so much.

Janet Hamilton
Great. Thank you so much, Steve. Let us go to Denise Chrysler. Denise.

Denise Chrysler
Hi. Steve, Bryant, and a number of other people keep appropriately mentioning the use of existing infrastructure structures instead of always creating new or duplicate structures. In my work with cross-

jurisdictional exchange, we look at leveraging eHealth Exchange and using common trust agreements. The obstacle seems to often be there are no use cases. Or, actually, I believe one use case is for electronic lab reporting, and then there is one under development for electronic case reporting. But there are not use cases for public health to really fully utilize this infrastructure that clinical health is using all the time. So, I do not know quite how that gets incorporated, but it is one I have observed as one of the obstacles.

Janet Hamilton
Yeah, thanks so much, Denise. Really important point. Let us go to Jim Daniel.

Jim Daniel
Hi, Janet. Can you hear me okay?

Janet Hamilton
Yeah, I can.

Jim Daniel
Great, great. Yeah, I just wanted to comment on the recommendation for CDC and ONC should be using policy levers to require state use of federal systems. I think that one might be a little broad in scope, and I think we really need to think about what we are trying to say with that one. Coming previously from a state, I know that federally developed systems often do not meet the requirements of what a state is trying to do. They are often – there is an echo. They are often more about what is required from the states to send to the CDC. So, I think I really have to disagree with that one in the way that it is currently written.

We have to make sure that states are able to build out they systems that meet their needs. They are the ones who know what they need and how they need to accomplish that work. Putting the requirements in there that we talked about earlier about meeting interoperability standards and tying funding to that, I think, are critical, but requiring them to use federally developed systems, I think, could really hinder their ability to do their work.

Janet Hamilton
Thanks, Jim. I think that is a really important point. I think also given what we see in today's world, there is a lot of really good infrastructure that states have in place, particularly for some really core things. And so, would just ask if maybe others have some comments. So, go ahead, Steve.

Steven Eichner
Janet, can I just add quickly onto that one? I am sorry. I did have a comment on that one earlier **[inaudible] [00:44:33]**. I am also very concerned about that requirement, in part because of what Jim Daniel is speaking, but also in part as to what are the effects downstream. In many cases, states are also providing shared technology services in support of our local health departments. I know that we are running into some challenges in terms of what technology we are implementing and how that best supports local needs that may go beyond what the state may be focused on in terms of its activities, and working with local health departments to establish appropriate interoperability so the state is getting what it does need, at the same time supporting local health departments in achieving their specific business needs, which may involve more complex activities with data and services that occurring at the state level.

Same exact problem would happen if federal government mandated full use of federal systems on states. Or is the federal government prepared to provide full support, not just for state-level activities, but for downstream activities at local jurisdictions as well? That could be a very, very broad array of services and really challenging to implement. I think there needs to be a focus on interoperability with federal systems and encouragement to use shared systems where possible, similar to things that are coming out of CMS and, when you receive an APD awards, the ability to make that technology available to other states – the resources available to other states so that jurisdictions can leverage technology developed by our colleagues. Makes a great deal of sense. The federal government establishing key points for data exchange around select business processes also makes sense.

So, we need to think a little bit beyond a broad brushstroke about a singular statement of, "We are providing you money; therefore, you have to use exactly the system that we specify." It may actually not be in everybody's best interest and not result in the federal government getting the data that it wants and needs to make informed decision-making. Thank you.

Janet Hamilton
Okay, great. Thanks so much, Steve. Let us see. We have another comment from Leslie Lenert. Les.

Leslie Lenert
Yeah. So, again, to go back to that recommendation three, I would suggest modifying that to, "Should explore policy levers to incentivize state use of systems that comply with federal standards for public health data interoperability when receiving federal funds."

Janet Hamilton
Okay, great. Thanks, Les. I think that makes a lot of sense, that it is ensuring that states are able to provide the data and the interoperability requirements. So, for federal policy levers to incentivize state use of systems that comply with federal standards for public health data interoperability. I think that is what – or something like that, I believe, is what I heard as a modification.

Leslie Lenert
That is close enough.

Janet Hamilton
Okay. Great. Thank you. Okay, Denise Love.

Denise Love
Yes. I have a question on that though. Not that I disagree, but can't the standards or the content be required when receiving federal funds, even if the system is built out from state needs? Incentive is nice, but if they are not incented to do that, we still do not have standardized content. Maybe I am reading it wrong.

Leslie Lenert
I was thinking incentives like Medicare and meaningful use – have a stick and a carrot.

Denise Love
Right. Yeah, but I see still CMS enforcing that is variable. I have no problem with the comments, but I am wondering, can't standards be required when receiving federal funds? Is there a way to state that so that we are all sending the same information?

Leslie Lenert
Most RFAs that are put out to states do have a requirement for adoption of federal standards.

Denise Love
Okay.

Leslie Lenert
A least when I was running informatics at CDC, it was always written in.

Denise Love
Okay.

Leslie Lenert
They all meet the standards in name. But the implementations are often technically inadequate.

Denise Love
Okay. As long as that was clear.

Leslie Lenert
There would always be a paragraph just saying you will comply with all fed – you know, whatever.

Denise Love
Okay. All right. Thank you for clarifying.

Janet Hamilton
Okay, great. Looks like we have another comment from Bryant. Bryant, go ahead.

Bryant Karras
Yeah. It is on the same point. I think that incentivizing is good. And I would throw borrowing from meaningful use, CMS. I think standards and conditions, not just about the standards, but it is about the appropriate implementation of those standards. Because one can comply with the standard and still provide useless information. So, I think we need to take it a level further. And I would suggest that there might be some policy recommendations around – some of the other recommendations may tease at this – but around providing the resources for public health to agree upon those consistent implementation guides of the standards. I think that is what we have heard a lot of discussion on last week's call. We had a lot of chatter about, yeah, minimum or about the optional data elements.

And we really need to drive home consistent implementations and implantation guides that allow states to do what they need to do as well as provide those additional minimums up to the feds. There is kind of a two-tier that needs to come into play. I would like to see investment similar to what OMC did policy and innovation-wise around meaningful use of investment in standards and interoperability framework, where potential standards were further flushed out, the kinks worked out, the details so that a consistent and actually functional implementation guide could come out of the work. Thank you.

Janet Hamilton

Okay, thanks. Thanks, Bryant. I think the development of standards and collaborative development of standards is really key. Okay, let us take the last comment from Les, and then I am going to turn it over to Carolyn to move us on to the next part of our discussion. Les, go ahead.

Leslie Lenert
This is very important. I put it in the chat field, but I want to mention it. It is not enough just to have the standards. We need to have a certification body, and I would like to see that as a policy recommendation. That a certification body that is jointly managed by CDC and ONC be developed to certify public health systems for their compliance with national data standards.

Bryant Karras
Hear, hear.

Janet Hamilton
Okay, thanks, Les. I would just add and take the moderators prerogative that that would need to be a well-funded activity. Okay.

Bryant Karras
And include participation from states. It is not just about ONC and CDC.

Janet Hamilton
Great addition. Thank you. Okay, I am going to go ahead and turn it over to Carolyn. Carolyn.

Carolyn Petersen
Thanks, Janet. In thinking about how best to use our time during the meeting today, we had decided to dedicate some of it to these recommendations, this discussion we just had, and also to try to briefly go through the questions that were in the homework, the newer questions that were in the homework this week, and try to get some additional feedback and comments on those. ONC, are you able to bring – there we go. Great, thanks.

You have all seen these slides in your packet. Considering where we are with time, I am going to focus our discussion on the first three of the four slides related to this topic of administering medical countermeasures and developing temporary policies in standards of care. As we have in the past, I will read these, what is on the slide, and then ask for raised hands and comments from task force members on the phone.

So, this one relates to distributing a vaccine or medication. For immunizations, "What elements of systems were successful in tracking vaccine allocation and administration to hospitals and providers?" And, "What systems between public health and clinical settings were unsuccessful and may have impeded vaccine distribution and/or administration?" Then, for novel medications and treatment, "Were we successful in exchanging data between providers and public health on new medical interventions or medication? Where were the gaps?" Finally, beyond this high-consequence public health threat, "What interoperability might be needed between public health and clinical settings to adapt and adopt rapid implementation of new medical countermeasure?" And that could be things like natural disasters, environmental disasters, or other such things. Public Health Task Force members, if you would raise your hands, please, in Adobe. Let us start with Leslie Lenert.

Leslie Lenert

First comment is on the immunizations on the second point, which systems were not successful and may even impeded vaccine distribution. This emphasizes a previous point I have made. We have zero ability nationally, distributed ability, to allow public health departments to predict what the future holds one or two weeks in advance and to be able to distribute vaccines and/or countermeasures based on the predictions of this. People were using various public data tools created by private agencies to do prediction, but we need a national infrastructure so that vaccines go where the pandemic is, not just where the people are, where the politics are.

Secondly, I would like to say that for the medications and treatments – we have explored this in other places in ONC in our discussion in HITAC – but we really lack the ability to run large-scale, randomized trials with EHRs that evaluate new medical interventions and medications quickly. Most of the data for this area came out of the UK. And it is not because we did not have the EHRs; we did not really have the infrastructure to rapidly deploy pragmatic trials inside of electronic health records.

Carolyn Petersen
Thanks, Les. Let us go to Arien Malec.

Arien Malec
Thank you. Just on Les's last comment. The ISP task force made a set of recommendations about exactly that topic, to better deploy EHRs for prospective, pragmatic clinical research trials to be able to compare treatments emergently.

On vaccine distribution and allocation, I spent a good chunk of time trying to trace down where vaccines were being sent in California to very limited effect. We did not have the ability to evaluate vaccine distribution and administration by channel and be able to compare the effectiveness of channels and understand which channels were the most successful at getting vaccines into arms. In many cases, at the federal government level, CDC appeared to have more data access than was publicly available or made available to states. So, CDC was saying, for example, that the pharmacy channel was a more effective channel than the state distribution channel. But if you look at public data that CDC makes available, it is very hard to trace the validity of that statement. It is probably true, but it just underscores that we do not have the transparent means to be able to track vaccine allocations by channel and effectiveness by channel.

Then, thirdly, we have been to the point of getting allocation where we have case rates. We have overcovered, I think pretty objectively, the wealthiest ZIP codes and census tracts in, for example, the Bay Area with vaccine distribution administration and under covered the areas where we have the highest case rates for COVID-19. We need better tools to be able to track allocation and distribution down to ZIP and census tract to be able to evaluate, not just which channels are most effective at getting vaccines in arms, but also which channels are most effective at getting vaccines in arms where they most need to be. So, this is an area where investment in vaccine allocation, tracking, and distribution systems that is prospective for the next pandemic, but also for flu vaccination, for any COVID boosters that are needed is a useful investment for the future. Thank you.

Carolyn Petersen
Thanks, Arien. Steven Lane.

Steven Lane

Just a question first. I spent a lot of time collecting responses from within my organization to respond to the homework questions and got those all submitted. I assume the ONC team and the task force chairs will be reviewing all those responses, and we do not have a need to reiterate those points here. Is that true?

Carolyn Petersen
Yes, we do have the feedback, and we are hoping to find ways to direct task force members to incorporate that into the recommendations as you see fit.

Steven Lane
Great. Having said that, I will just highlight a couple of points that might be a little bit redundant with what Les and Arien said. One key point that I heard from my organization was we need to fully leverage deployed systems that exist rather than try to recreate the wheel in our enthusiasm to respond quickly, especially in so far as what we see, is that everybody is trying to recreate the wheel and be creative and innovative. And they end up creating a complete mess with disparate requirements and suggestions.

The other suggestion that came out is do not change systems in the middle of the process. It is better to invest in iterating and improving on existing systems because there is a cost, and delays related to system changes are really difficult to manage. The centralized systems should be used to create sort of the hub-and-spoke model for both reporting and information distribution. But that, again, we should rely on the systems that are in place for the actual generation and receipt of the data. There is a key need to harmonize both requirements and recommendations from CDC, state, tribal, and territorial entities, and locals. That the variances between those groups were just horrifying to deal with at the provider level.

Then, also, utilizing established distribution channels. When locals got involved in trying to distribute vaccine, medication, or what have you, that was not nearly as efficient as if they had leveraged the established distribution channels for pharmacy and for other products that exist out there. And then I just wanted to add that on the prior slide you made the point about preparing for natural and environment disasters. I will just add a personal commentary that I think COVID was simply a practice run for what we are all going to need to do as we deal with climate change and its consequences. So, we should really be thinking about that as we prepare our systems to be more functional and robust.

Carolyn Petersen
Thanks, Steven. Bryant.

Bryant Karras
Thank you. I think one of the things that I want to point on the immunization is a previously unrecognized need or role in centralizing or interoperating the scheduling of vaccine appointments and the prioritizing or regulating of what risk group gets vaccinated when. Public health had previously had a mechanism for a central registry of the delivered vaccines and a mechanism for requesting vaccine supplies, but there was no centralized or interoperable way for the public to find the nearest available vaccine appointment for themselves. I think the established systems were all within given siloes or within given health systems, and people needed go from one, to one, to one to try to find that last remaining appointment slot.

We spent a lot of time scrambling trying to make these systems work interoperably. We had some success in public-private partnerships to come in and try to make advancements. But those standards really need

to be advanced. I think there are some that came out of this experience, and those need to be invested in and solidified so that they are in place for the next event, whether it be natural or unnatural. Thank you.

Carolyn Petersen
Thanks, Bryant. Jim Daniel.

Jim Daniel
Yeah, just to build on what Bryant said, that is a very important piece, the scheduling work. I know that US Digital Services has put out some APIs on available vaccine appointments. I really think that needs to be expanded on to include APIs to actually schedule the vaccine appointment, not just to have vaccine availability. There are probably some policy issues in there as well that need to be worked out around who those open appointments are available to.

And in the beginning – this is a personal feeling of mine – when large provider organizations got vaccines and were only opening up those appointments to their constituents, I think that is part of what led to a lot of inequity in vaccine distribution. The people that we were really trying to reach out to are often those without primary care providers, and that was a huge block of vaccine appointments that were not available to them. So, I think it is both a policy and a technical issue – opening up those APIs to schedule wherever there are appointment available, but also making sure that those are not held closely just to certain parts of the population.

Carolyn Petersen
Thanks, Jim. Clem, go ahead, please.

Clem McDonald
Continue with that point. And I wanted to brag about Indiana, where I got my vaccine. They did this exactly right. There was like 45 sites in Indianapolis alone. You look on the web, and you can find whatever sites were available. You could pick a choice. There was no barriers. In fact, I know people who were not even from Indiana came in. If someone wanted a vaccine, they got it. They did start it out with the oldest, which is appropriate given the risk factors and all. But there is a model. They did it just right, and it was just as smooth as silk. So, I recommend people look at it a little closer if it has not been the same everywhere. I had assumed it was.

Carolyn Petersen
Thanks, Clem.

Clem McDonald
Indiana State Health Department organized the whole thing. They were delivering to hospitals, pharmacies, and all different places.

Carolyn Petersen
Thank you. Before we turn our discussion to the certified public health IT aspect, I just wanted to check if there are any task force members on the phone who have comments?

Danielle Brooks
No comments. I agree with most of the other comments. Thank you.

Carolyn Petersen
Okay. So, we have about 10 minutes before public comment, and I think we will spend that on this question related to certified public health IT. The question here for our discussion is, "How can bidirectional data exchange between public health and clinical data sources be leveraged through the CARES Act, CMS Interoperability rule, and/or the ONC information blocking rule or others? What pathways are there to use legislation or rules to create certified public health IT?" I see Steven Eichner has his hand up. Please go ahead.

Steven Eichner
Thank you so much. This is a really important subject to public health and care providers. I think it is really important that we provide a good definition by what we mean by bidirectional. There are three or four different scenarios. One is just provision in a one-way-only approach with perhaps a simple acknowledgement that a message has been received. Secondly, there is light bidirectional, if you will, where data may be submitted or provided from healthcare providers to public health, and an error report that contains protected health information returned to the provider for future action. Then through bidirectional interoperability, where both parties transacting on information will submit information or provide information to each other as simultaneous exchange or near simultaneous exchange.

As an example, looking at retrieving a vaccine forecast from an IIS and then providing the update on the vaccine status to for the patient back to the IIS. That becomes vitally important because both public health and healthcare providers have some challenges in supplying all data from all systems through this bidirectional exchange. Under state law, many of our systems and programs have different privacy constraints, and they are not offered as HIPAA-covered programs. They do not meet the definition of HIPAA and, subsequently, cannot transact, exchange based on payment, treatment, and operations because those regulations since they do not apply to non-HIPAA programs. In similar fashion, healthcare providers may be reluctant to share information from clinical research databases. There may be some prohibitions or limitations in sharing information about ongoing clinical research. So, that creates some challenges to be addressed.

Another issue that we need to be sure that we address is looking at bulk requests for population-level requests from public health. Specifically, there are many large health information exchanges that are very interested in accessing data from public health, and that is a wonderful thing. A potential challenge, however, is managing those data request flow. For example, in Texas, there are at least two HIEs that have population bases of over 6 million people – one at about 7 million, I believe, and one at about 10.5 million people. If you were to receive queries from those two HIEs on a daily basis for their entire population, it may have a very significant impact on our systems. So, we need to make sure that we are working in conjunction with HIEs and providers to balance access to those resources so that providers have access to the data we need in a timely manner to provide care to the people they are serving next. That may include providing sufficient enough time and access for a provider to query an IIS so they can ensure it got appropriate vaccine supplies for a patient appointment. But it does not necessarily mean that we download some data for the entire population on nightly basis, so we need to balance that. And that really impacts 21st Century Cures Act. Specifically, in terms of looking at data blocking requirements because, that could create some real challenges on the public health side.

That being said, I think there are some good opportunities to use 21st Century Cures Act's provisions to facilitate a change of data information blocking, doing things like modifying systems to address some of the

challenges with optional data versus required data by amending specification requirements to enable healthcare providers to select on the fly what may be required to be provided in their system if the state has extended the implementation **[inaudible] [01:15:46]** guide to require a field that may be optional other locations. And that would be an excellent opportunity to leverage 21st Century Cures Act to enable that and enable providers to report data efficiently without having to spend excess resources with HR vendors to implement the needed changes. Do see my written comments for additional content. Thank you so much.

Carolyn Petersen
Thanks, Steve. Steven Lane.

Steven Lane
Yeah. Trying to address this question specifically. I think that ONC has some real opportunities. We have discussed in various venues the possibility for additional versions of health IT certification, beyond the standard EMR certification that we have today. And I think that serious consideration should be given to creating a certification for other health IT systems such as public health data systems.

Similarly, within USCDI, there would be an opportunity to create a public health data class that could both point to an established data elements as well as the home for additional data elements that might be required specific to the public health use cases. I think less obvious would be the opportunity to consider public health users as actors under the information blocking rule. Again, thinking as a provider, it is very valuable for me to be able to get data from public health in addition to simply sending data to public health.

Then, lastly, I think the idea of looking at HIPAA, either giving covered entity status to some or all public health actors or defining specific public health use cases as covered use cases under HIPAA, or conversely potentially looking at public health as a component of treatment and/or healthcare operations, really defining certain use cases as being covered under HIPAA under one of those ways could be very helpful.

Carolyn Petersen
Thanks, Steven. I know that we have public comment on the horizon in a couple of minutes. But I would like to ask the task force members, both those on the phone and on Adobe, please raise your hand or let me know if you have comments. Bryant, I see your hand is up. Go ahead, please.

Bryant Karras
I just want to caution us. That last recommendation of making public health a covered entity comes with a tremendous expense. And I think the components and requirements that would be made, even a partial coverage, could bankrupt our entire public health system. So, I think we need to think careful about the implications of a suggestion like that.

Carolyn Petersen
Thanks, Bryant. Are there task force members on the telephone who have comments? Please just call out.

Danielle Brooks
No additional comments, but definitely would like to emphasize that last point about thinking very carefully about that broad recommendation for the covered entity status. Thank you.

Carolyn Petersen

Yes. We will be starting to draft the documents, the draft recommendations for finalization in our next two meetings. It will be an excellent opportunity to go in and look at the language and be sure that it is what task force members stand behind and feel good about taking forth to the ONC and to our national coordinator. Mike, did you want to take us into public comment?

Public Comment (01:20:10)

Michael Berry
Sure will. Operator, can you open up the lines for public comments?

Operator
Yes. If you would like to make a comment, please press star-one on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press star-two if you would like to remove your line from the queue. For participants using speaker equipment, it may be necessary to pick up your headset before pressing the star keys. We will pause for a brief moment to poll for comments.

Michael Berry
Okay. While we are waiting, I just want to remind everybody we will reconvene next Thursday, July 1st, at 10:30 Eastern Time. Operator, do we have any comments.

Operator
There are not comments at this time.

Michael Berry
All right. Thank you. Caroline, Janet.

Next Steps/Final Remarks (01:20:56)

Carolyn Petersen
I know that Brett and Brenda have some discussion for us about next steps. So, I will just thank everyone for your vigorous participation today and encourage you to be active in working with the document so that we can truly refine our recommendation to reflect your views. Thanks.

Janet Hamilton
This is Janet. I will just echo that. Thanks, Carolyn, for summarizing it so nicely.

Brenda Akinnagbe
This is Brenda Akinnagbe with ONC. Thank you all for the great discussion again today. Looking forward to our next steps, today is the deadline for the final survey questions. So, we do ask that you get those to us as soon as possible, as we are looking to incorporate all of your comments by the end of this week. From there, we will be reaching out to task force members to refine specific recommendations between now and the July 1st meeting. So, again, really looking to have all of the recommendations or all of the survey questions in by the end of today so we can go ahead and incorporate that into the draft recommendation document.

Additionally, to help with further refining these recommendations and to give the task force time to really work through these together, we are looking to extend the July 1st and July 8th meeting by a half hour

each. So, please keep an eye out for an email with additional information on that. And of course, since this is so much to go through, we are also considering the possibility of adding a meeting on Tuesday, July 6th, as well. So, please, again, keep an eye out for emails with additional information. And, Brett, please feel free to add on if there is anything else for our next step.

Brett Andriesen
Yeah. Thanks, Brenda. That was great. And thanks, everyone, for you great participation. I think we will also be reaching out via email to tap some of the task force members into smaller groups to have folks kind of work offline and further refine language around these recommendations. I know we are nearing the home stretch here with the July 14th HITAC meeting and our deadlines to have everything finalized. And so, just looking to find the right mix of activities, whether additional meetings, longer meetings, or some offline work by task force members to get things in good shape by then.

Carolyn Petersen
This is Carolyn. I do not have any additional comments. Thank you again for you participation, and we look forward to seeing you at the meeting next week and online in the draft document. Mike.

Michael Berry
Yep. All right. Thanks, everybody, for joining us. And we will see you next week. Have a great day.

Adjourn (01:24:14)