Health Information Technology Advisory Committee
Public Health Data Systems Task Force 2021 Virtual Meeting

Meeting Notes | July 8, 2021, 10:30 a.m. – 12:30 p.m. ET

Executive Summary

The focus of the Public Health Data Systems Task Force 2021 (PHDS TF 2021) meeting was to finalize feedback from TF members on the series of recommendations to the HITAC. The PHDS TF 2021 co-chairs, Janet Hamilton and Carolyn Petersen, opened the meeting, discussed the agenda and reviewed the final draft recommendations under consideration. PHDS TF members were invited to discuss the topics and to provide feedback. There were no public comments submitted by phone, but there was a robust discussion in the chat feature in Adobe Connect.

Agenda

10:30 a.m.	Call to Order/Roll Call
10:35 a.m.	Opening Remarks
10:45 a.m.	Review Recommendations Under Consideration
12:15 p.m.	Public Comment
12:20 p.m.	Next Steps/Final Remarks
12:30 p.m.	Adjourn

Call to Order

Cassandra Hadley, Acting Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the meeting to order at 10:31 a.m. and welcomed members to the meeting of the PHDS TF 2021.

Roll Call

MEMBERS IN ATTENDANCE

Janet Hamilton, Council of State and Territorial Epidemiologists, Co-Chair
Carolyn Petersen, Individual, Co-Chair
Danielle Brooks, AmeriHealth Caritas
Denise Chrysler, Network for Public Health Law
Jim Daniel, Amazon Web Services
Steve Eichner, Texas Department of State Health Services
Claudia Grossmann, Patient-Centered Outcomes Research Institute
John Kansky, Indiana Health Information Exchange
Bryant Karras, Washington State Department of Health
Nell Lapres, Epic
Denise Love, National Committee on Vital Health Statistics
Arien Malec, Change Healthcare
Clem McDonald, National Library of Medicine
Abby Sears, OCHIN
Sheryl Turney, Anthem, Inc.

MEMBERS NOT IN ATTENDANCE

Steve Hinrichs, Individual
Jim Jirjis, HCA Healthcare
Steven Lane, Sutter Health
Les Lenert, Medical University of South Carolina
Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin
Larry Mole, Veterans Health Administration

ONC STAFF

Cassandra Hadley, Acting Designated Federal Officer, ONC
Brett Andriesen, ONC Staff Lead
Brenda Akinnagbe, ONC Staff Lead

General Themes

TOPIC: OPENING REMARKS

The co-chairs opened the meeting, discussed the agenda, and explained that the PHDS TF is in the process of wrapping up its work in advance of its presentation to the HITAC on Wednesday, July 14, 2021.

TOPIC: REVIEW RECOMMENDATIONS UNDER CONSIDERATION

The co-chairs reviewed specific areas of the draft recommendations document that was populated with information accumulated from the surveys/questions provided to PHDS TF members as homework and the draft crosswalk, as well as from discussions held during meetings.

Key Specific Points of Discussion

TOPIC: OPENING REMARKS

Janet Hamilton opened the meeting, reviewed the agenda for the meeting, and explained that new topics would not be discussed at the current meeting. Carolyn Petersen welcomed members to the final meeting of the TF, summarized work completed, and thanked them for their engagement and thoughtful input on the PHDS TF's recommendations. The TF is in the process of completing its work and will present to the HITAC at its July 14, 2021, meeting.

TOPIC: REVIEW RECOMMENDATIONS UNDER CONSIDERATION

Carolyn explained that PHDS TF would continue to review draft recommendations, including several major areas for discussion. The final meeting before the HITAC presentation will be used to achieve consensus on the final recommendations.

Carolyn explained that the TF would work through its recommendations to reach a group-level agreement. If members do not agree with a recommendation, they were encouraged to submit a public comment during the July 14 HITAC meeting or in the public chat to save alternate opinions as part of the public record. Steve Eichner and the co-chairs thanked the ONC staff for their assistance on the TF's work and documentation. Carolyn reviewed the overall structure of the document and briefly described the structure. Also, she explained that any items the TF did not discuss at the current meeting would be moved to a special section at the bottom of the document. Janet asked TF members to review all recommendations to ensure they list all necessary and appropriate key partners/actors. In response to a question from Bryant Karras, Carolyn stated that ONC is flexible and will determine when it is appropriate to work with non-governmental agencies.

CROSSCUTTING RECOMMENDATIONS AND DISCUSSION

Carolyn invited the TF to review the crosscutting recommendations, which are not specific to one aspect of public health IT, and to submit feedback.

DISCUSSION:

- Steve Eichner commented that the TF should include an appendix with definitions for all acronyms used.
  - Carolyn responded that she and Brett had just discussed that suggestion prior to the meeting and voiced her agreement.
- John Kansky suggested clarifying the wording in the PHDS TF Cross-Cutting Recommendation 02 to state whether the health data ecosystem plan mentioned would be specifically for high consequence health threats or would cover them, among other things.
  - Carolyn responded that the initial framing for the recommendation came from the Executive Order on Ensuring a Data-Driven Response to COVID-19 and Future High-Consequence Public Health Threats.
  - Danielle Brooks asked if the wording "equitable approach" to the last sentence of Recommendation 02 to continue to emphasize health equity by design.
- Jim Daniel suggested adding the Centers for Medicare and Medicaid Services to the TF's Recommendation 04 e. (in reference to working with labs).
- Danielle Brooks suggested adding "payers" to Recommendation 04 a.
- Denise Love inquired about the wording of Recommendation 04 f. and suggested adding "payers" there, as well.

SYNDROMIC SURVEILLANCE RECOMMENDATIONS AND DISCUSSION

Carolyn invited the TF to review the syndromic surveillance recommendations and to submit feedback.

DISCUSSION:

- John Kansky inquired if his suggested recommendation (to leverage normal/traditional data sources for automation of reporting to lower burdens) was included in the document.
  - Janet Hamilton added the wording "traditional and non-traditional" to the Recommendation 05 intro text.
  - John noted his comment was included as a bullet point under the recommendation.
  - Bryant Karras and Arien Malec suggested reviewing the list of goals under Recommendation 05 to ensure that everything TF members suggested was covered. Arien suggested breaking the recommendation into two, with one focusing on traditional and then broader/non-traditional sources.
  - Clem McDonald suggested naming specific sources, like Superscripts for pharmacy, and stated that automation could be drawn directly from labs.
  - Denise Love stated that many non-traditional data sources are not real-time, so the wording would need to be updated to include non-real-time data sources that have importance to pandemic relief efforts.
    - Carolyn responded that the phrase "real-time, when possible" would be added to the text.
  - Danielle Brooks asked to add the phrase "reduce algorithmic bias" to the machine-learning bullet.

LABORATORY AND CASE REPORTING RECOMMENDATIONS AND DISCUSSION

Carolyn invited the TF to review the laboratory and case reporting recommendations and to submit feedback.

DISCUSSION:

- Arien Malec voiced his support of the recommendations and suggested that the TF provide a cross-reference to the similar recommendations issued by the first iteration of the Interoperability Standards Advisory Task Force (ISP TF). He suggested adding this to the first set of the PHDS TF's recommendations around the deployment of orders and results and will provide additional guidance. He shared a reference in the public chat in Adobe.

- Nell Lapres requested clarification on the goal of Recommendation 08 c. She submitted the following comment:
  - o "Depending on the EHR implementation process, the actual configuration of the system is dependent on the healthcare organization so it would be an organization decision if a content change is made making it challenging for an EHR to force an org to do additional testing. If the goal is to speed up onboarding, I would recommend changing this to promote a more standardized onboarding process or investing in ways to automate testing. Otherwise, we should remove this bullet point."
  - o Carolyn suggested changing the wording to say that how the certification fits in requires additional discussion.
  - o Janet asked Nell to suggest specific language to reflect the intent that there will be an onboarding process for public health, and if changes are made with the EHR vendor, there could be a long break in reporting to public health.
  - o Nell will provide language that mentions automating testing or focusing on using errors to identify and more proactively correct issues.
  - o Janet inquired if there are recommendations around the length of downtimes for public health reporting. Carolyn stated that they would review the language from Nell.

- Bryant Karras asked if the word "certification" could be replaced with "regular quality assurance testing." He discussed scripts created by EHRA that could be useful to public health reporting measures and agreed that the quality assurance systems need to be updated on a regular basis.
  - o Nell commented that she would work with Bryant to develop the language.

HEALTH EQUITY DATA RECOMMENDATIONS AND DISCUSSION

Carolyn invited the TF to share feedback on the health equity data recommendations.

DISCUSSION:

- Steve Eichner asked for standardization of terms throughout the document, including "STLTs" (State, Tribal, Local, and Territorial) and others.
  - o Carolyn responded that the ONC team is working on standardization and the list of acronyms and other abbreviations.
- Danielle Brooks commented on Recommendation 11 c. that the wording "underrepresented geographic locations" should be added.
- Arien Malec inquired if one of the recommendations reflected the need for individuals to be involved in the specification of their own identifying/self-reported information and in validating information.
  - o Danielle Brooks agreed and stated that the most real-time data should be used.
  - o Carolyn offered to review the comments to ensure that they reflect these sentiments.
  - o Janet suggested that the Individual Engagement and Health Equity sections of the document should be cross-referenced to check for alignment.
  - o Danielle inquired if a recommendation around reducing the duplication of documentation was added somewhere in the document. Katie Tully from ONC looked for the information and noted the request.

- o Danielle requested that the full demographic data wording (example from first sentence of Recommendation 11) should be replicated throughout the document to emphasize consistent data collection. Also, she asked if a recommendation to prioritize ethnicity over race would be appropriate to add in this section. She thanked the other TF members for their work and focus on this area.
- o Carolyn thanked Danielle for her expertise on the health equity section.

STANDARDS DEVELOPMENT AND ADOPTION RECOMMENDATIONS AND DISCUSSION
Carolyn invited the TF to share feedback on the one recommendation in the section.

DISCUSSION:

- Denise Love noted her support for the recommendation but explained that the Standards Subcommittee of the National Committee on Vital and Health Statistics (NCVHS) is currently working on related recommendations. She inquired if the TF would care to incorporate those in future PHDS TF recommendations.
- Bryant Karras stated that the HL7 v2 and Clinical Document Architecture (CDA) standards need further advancement and continued support, in addition to the Fast Healthcare Interoperability Resources (FHIR) -based standards and suggested the TF include a mention of the Standards & Interoperability (S&I) Framework.
  - o Carolyn thanked him for his comments and adding that some of the previous recommendations in this section were moved throughout the document to crosscut with other topics.
- Steve Eichner suggested linking to a library of services to support case investigation and suggested referring to specific tools and projects that facilitate the collection of additional case reporting information.
- Clem McDonald echoed Bryant's comments that support for HL7 v2 is needed.

FUNDING MECHANISMS RECOMMENDATIONS AND DISCUSSION
Carolyn invited the TF to share feedback on the ten funding mechanisms recommendations,

DISCUSSION:

- Arien Malec commented on Recommendation 21 that the TF should encourage public health to use both state and national shared infrastructure to address the mission, including health information exchanges (HIEs). The appropriate mechanisms are missing to flow public health information at the state and national levels (where HIEs) are not used, and he requested rephrasing the wording of the recommendation.
  - o Janet offered to work on the language with Arien and stated that public health can be encouraged to use HIEs, where available. However, she noted that HIEs have charged high fees to public health, so the recommendation must state that HIEs also present affordable options.
  - o John Kansky offered to assist with any further offline wordsmithing.
- Jim Daniel commented on Recommendation 20 that scalability is an important component of the recommendation and suggested moving its mention to the first sentence while adding a reference to cloud technology. He explained that recent issues with public health occurred because their cloud systems did not scale. He offered to assist with wording.
- Steve Eichner suggested that public health be given a role to define its own needs (like a customer) and offered to help draft wording.

- Bryant Karras commented on Recommendation 21 that there is a need to discuss overall societal costs, as opposed to individual costs, for maintaining systems. The TF could emphasize the economic factors and should state that public health should not have to bear the increased costs alone.
- Danielle Brooks suggested adding a recommendation to get appropriate and useful data from the criminal justice system for public health use.
  - o Bryant Karras suggested getting additional data from the Veterans Administration (VA), the Department of Defense (DoD), and others and inquired if the TF could make recommendations to encourage them to participate.
  - o Carolyn responded that the team would cross-check the document to determine where these suggestions would best fit.

POLICY RECOMMENDATIONS AND DISCUSSION
Carolyn invited the TF to share feedback on the ten policy recommendations,

DISCUSSION:
- John Kansky commented that he supported Recommendation 25 but that the last section might be too prescriptive/constraining in the suggestion in the second half of the recommendation.
  - o Carolyn responded that the wording was added recently to address health equity concerns.
  - o John stated that this recommendation might constrain some states from acting according to the recommendation.
  - o Denise Love also raised concerns around this wording, noting that it might constrain research for public health. She offered to help wordsmith the section.
  - o Steve Eichner stated that there is a concern that public health is not well-represented in TEFCA or its workgroups; hence, the wording of the recommendation. He discussed his own concerns as a patient with a rare condition and raised other concerns around the use of patient data for purposes other than the reason for which it was intended. The TF should ensure that the individual is including in determining where and how their data is used and for what purposes. He suggested including rare disease groups in the stakeholder groups that will contribute input.
  - o Carolyn voiced her appreciation for the comment, noting that she also has a rare condition. She suggested making the recommendation broader and more general so that it addresses public health, privacy, and health equity concerns.

INFRASTRUCTURE RECOMMENDATIONS AND DISCUSSION
Carolyn invited the TF to share feedback on the infrastructure recommendations.

DISCUSSION:
- Danielle Brooks commented that language in this section that public health and community organizations be mentioned as entities that should be engaged along with advisory committees and task forces.
- Denise Love asked if the TF was referring to standardizing dashboard interfaces or measures for the dashboards (or both).
  - o Carolyn responded that the interface would be standardized to display certain data points. This ties in with other recommendations around reporting standardized information for state/local use.
  - o Clem McDonald suggested that this recommendation around interfaces should avoid being too prescriptive.
  - o Carolyn stated that the recommendation was to reinforce the need for more standardized reporting and that the wording would be reexamined.
- Bryant Karras suggested that Recommendations 45 and 38 could be put adjacent to each other to due content (patient matching and National Patient Identifier).
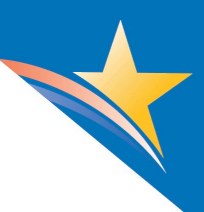
- o Denise Chrysler inquired if the National Patient Identifier (NPI) could be pursued or if this is not allowed under HIPAA.
- o Clem McDonald stated that updated news on the use of NPIs is coming from Congress and noted that the House has passed recent legislation to rescind the prohibition of NPIs, while the Senate has not. He stated that master patient index systems already exist, and there was already a proposal to improve content to help matching.
- o Denise Love suggested that standardization around algorithms for patient matching and the data elements that feed into them could be used to get around issues with the use of NPIs.
- o Carolyn thanked Denise for providing a specialized legal perspective on the topic.
- o Arien Malec suggested using the term "master patient or record locator" instead of "master patient index," which can be a more privacy-sensitive approach.
- Danielle Brooks submitted the following comments:
  - o Recommendation 35 should include the demographic information list/phrase.
    - ▪ Carolyn responded that the team would replicate language from Recommendation 11.
  - o The call-out to collaborate with healthcare partners should be more inclusive (include payers, etc.).

SITUATIONAL AWARENESS DATA RECOMMENDATIONS AND DISCUSSION

Carolyn invited the TF to share feedback on the eight recommendations.

DISCUSSION:

- Nell Lapres commented on Recommendations 42 and 47 that wording should be addressed to make expectations clearer for data reporting for EHR systems and other systems.
  - o Carolyn responded that she would look at the wording as she added it.
- Danielle Brooks asked to use language around under-resourced areas in these recommendations, as appropriate.
- Bryant Karras stated that some enhancements are analogous to improvements from Meaningful Use and another round of incentive programs may be required to get update, certified technologies in place. He stated that the Syndromic Surveillance and Situational Awareness sections should be placed next to each other in the document, to highlight parallels.
  - o Nell Lapres cautioned against duplicative reporting and to consider the appropriate source of data.
  - o Bryant responded that multiple data streams can report the same information and can boost confidence. Though, he recognized
  - o Carolyn added that the language would be reviewed to ensure that it is not too prescriptive.

INDIVIDUAL ENGAGEMENT RECOMMENDATIONS AND DISCUSSION

Carolyn invited the TF to share feedback on the eight recommendations.

DISCUSSION:

- Arien Malec commented that the wording in Recommendation 52 should be updated to recommend that ONC should work with OCR and CDC to provide the proper framework for patient access. He explained that many public health agencies are not HIPAA-covered, but the Right of Public Access may apply to them.
- Denise Love requested that "states" or "STLTs" be added to the stakeholders listed in Recommendation 49 and discussed her relevant personal experiences.

IMMUNIZATION RECOMMENDATIONS AND DISCUSSION

Carolyn invited the TF to share feedback on the immunization recommendations.

DISCUSSION:

- Nell Lapres commented on several of the recommendations, including Recommendation 61, that the goal should be to standardize and to create a more inclusive list of data elements that may not be required by law.
  - o Carolyn responded that she would examine the comments Nell left in the document and align the recommendations.
  - o Bryant Karras stated that, while the CDC may recommend the prioritization of immunization data elements, the STLTs have the latitude in determining which are used. He requested that the TF review the recommendation to ensure that the CDC will be able to do whatever the TF requests.
  - o Denise Chrysler commented that the CDC provides funding and has functional standards, which have a core set of data elements (optional and required). Many of the data elements that are required (race and ethnicity) do not make their way into state law or policy, so she saw the recommendation as consistent with how funding levers are used by the CDC and how the requirements flow down/get implemented. She stated that state laws determine the data that states are allowed to collect regarding immunizations and noted that some are much more restrictive than others, while many defer to the Health Department to define the data elements.
  - o Nell responded that having greater consistency across data elements would be beneficial (where possible) when state laws have not defined what is used.
- John Kansky inquired if wording could be added to Recommendation 64 to include HIEs but asked about the phrases "within the walls of public health" and "culturally."
  - o Bryant Karras stated that the wording comes from his previous comments and suggested removing "culturally." He was referring to the need to break down historic silos in public health (across diseases, systems, etc.) and related required change management/norms.
  - o John discussed unintended barriers public health faces with sharing immunization information and other data. He asked if adding "HIEs" would keep the intent of the recommendation.
  - o Bryant suggested wording around the need for internal and external collaboration.
  - o Denise Love suggested broadening the recommendation by using the phrase "public health ecosystem" instead of listing the more specific examples in the recommendation.
  - o Denise Chrysler stated that the organization should be called the Network for Public Health Law as a correction.
  - o Steve Eichner stated that "Death Registries" should be changed to "Vital Statistics Systems" and removing the capitalizations on disease reporting systems. He suggested some additional wordsmithing options, which were captured within the document.
  - o John Kansky suggested adding "external" before organizations if the TF does not prefer to use HIE. Denise suggested "public health ecosystem." TF members discussed how legal frameworks would impact the recommendation.
  - o Steve Eichner suggested creating another recommendation to encompass the TF's feedback around external organizations, noting that they have a different set of factors and challenges than internal organizations.
- Bryant Karras encouraged ONC staff to consider the sequencing of the sections of the document to emphasize policy recommendations. He thanked TF members and the ONC team for their hard work on the recommendations.
- Denise Love thanked the co-chairs for their leadership and ONC staff for their work. She inquired about the timeline for the TF's recommendations and how they will come to fruition, given the transitional period and necessary phases/levels of future work.

o   Brett Andriesen responded that the recommendations will be presented to the HITAC, and they will vote to determine if all are transmitted to the National Coordinator for Health IT, who will then review them and forward them to the rest of the Executive Order Workgroup. They will be able to incorporate them into their work. Implementation timelines will vary from short- to long-term. Recommendations that are accepted will be sent to various parts of HHS for future work.

Action Items and Next Steps

PHDS TF members were asked to turn in all final work to the co-chairs by the end of the day, as the TF's recommendations to the HITAC are due on July 9. The TF will present to the full HITAC at its July 14, 2021, meeting.

Public Comment

QUESTIONS AND COMMENTS RECEIVED VIA PHONE

There were no public comments received by phone.

QUESTIONS AND COMMENTS RECEIVED VIA ADOBE CONNECT

Abby Sears: Abby Sears is here

Rachel Abbey (ONC): Thanks Steve!

Cassandra Hadley: Thank you all for your work!

Steve Eichner: I would like to extend my gratitude to the staff that helped us develop the recommendations and preparte *[sic]* documentation.

Arien Malec: We also want to spell out acronyms when first used.

Arien Malec: CDC already collects pharmacy data from pharmacy switches (or did as of the H1N1 flu outbreak) Arien Malec: Again, I think this recommendation isn't clear — it says we are recommending "exploring", but we *also* want to recommend specific policy recommendations to further deploy & adopt.

Steve Eichner: The phraseology of real-time/timely data for SS should reflect real-time if availbale, *[sic]* and timely data if real-time access is not practical. I think that "timely" is more practical as, to me, "real time" implies access to data-in-place rather than data submitted/pushed, either on a scheduled basis or resulting from a "push" institgated *[sic]* by a provider selecting "complete" or some other similar action.

Arien Malec: Here's the ISP TF report: https://www.healthit.gov/sites/default/files/page/2019-12/2019-10-16_ISP_TF_Final_Report_signed_508.pdf

Arien Malec: particularly section B

Chris Baumgartner: Item b. I am quite concerned about trying to ask lab reporting to be a vehicle for data/information that labs should not be responsible for. Many of these are better suited for eCR.

Chris Baumgartner: If Labs don't get that info from the ordering provider it is very difficult to report. We have seen this with the required COVID reporting. Many fields are not populated.

Arien Malec: The point of these recs is to flow the data with the order to the lab.

Arien Malec: eCR is great, but needs additional information on the report to reconcile.
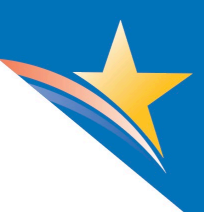
Chris Baumgartner: I feel we need to advance eCR to handle a lot of this rather than putting the burden on labs

Bryant Thomas Karras MD: S&I Standards and Interop

Bryant Thomas Karras MD: S&I not SMI

Brett Andriesen (ONC): We'll correct that Bryant - thanks.

Denise E Love: Is there a timeline or general idea for how long it will take for industry-wide adoption of FHIR---and how that transition should look like? Not sure how to address this.

Clement McDonald: Hear Hear to Arians proposed revisioin!!! *[sic]*

Nell Lapres: HIEs also may charge providers/healthcare organizations which may make it challenging for some organizations if HIEs are the required way to report to public health.

Nell Lapres: Also, agree with emphasizing scalability more.

Jim Daniel: @Kathleen Tully - I see your comment there, but also please include utilization of cloud technology for scalability

Chris Baumgartner: The challenge is PH is often also asked to support to many transport options which are costly to maintain. We need to reuse HIE's as shared transport. If we all invest in that infrastructure as a public utliity *[sic]* it can drive down cost for all. Point to point connections are too costly for PH with the volume of data we need to exchange and the # of partners we have to exchange with.

Steve Eichner: I woluld *[sic]* be happy to work quickly over the next 36 hours to update text- There are a lot of opporunitiies *[sic]* to partner with organizations such as HIEs, but there needs to be a needs assessnebt *[sic]* and sustainability plan, involving all relevant parties, as new tools are conceptalized.. *[sic]*

Meryl Bloomrosen: Regarding HIEs and public health- it seems worthwhile to hear about efforts under way via ONC's awards to HIEs---Strengthening the Technical Advancement and Readiness of Public Health via Health Information Exchange Program (STAR HIE Program) --https://www.healthit.gov/topic/onc-funding-opportunities/strengthening-technical-advancement-and-readiness-public-health

Nell Lapres: @Chris - understand the goal to reduce number of transport options. I want to make sure added cost isn't forced on providers in order for them to electronically report to public health.

Chris Baumgartner: Understood Nell. I feel all parties will have cost to become interoperable and meet the new Interop Rules. I feel those unavoidable costs can be minimized by ensuring shared transport is optimized.

Noam Arzt (HLN): Remember, most national networks do not focus on push technologies, other than Direct perhaps. We had to fight to get that into TEFCA...

Arien Malec: or record locator services

Noam Arzt (HLN): I don't think RLS solves this, RLS NEEDS record matching...

Bryant Thomas Karras MD: agree with @Noam... we need both RLS and MPI

Sheryl Turney: STLT includes states Noam Arzt (HLN): 57b is kind of odd... we have been working on a national rollout plan for IZ standards for years...
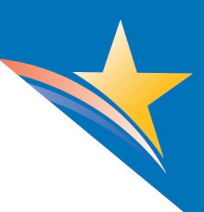
Noam Arzt (HLN): This data element discussion seems like a solution looking for a problem. Core data elements for IZ are not controversial and in my opinion compliance is pretty high.

Noam Arzt (HLN): 64 seems very oddly worded. "Interoperatng" *[sic]* as a verb is kind of weird... :)

Chris Baumgartner: For 64 are we referring to FERPA laws often preventing PH from using IIS data from schools?

Nell Lapres: @Noam - the focus is on additional optional data elements that are not highlighted by CDC but are required within a jurisdiction. Those optional additional requirements is what adds additional cost to implement/maintain systems. No concerns with the core data elements and getting to that level, the additional data elements on top of that which are required by a jurisdiction is where we could benefit from more consistency.

Nell Lapres: *more consistency where possible

Noam Arzt (HLN): What Bryant is saying is right, but cultural is not the word. He is describing organizational barriers. Cultural has a different connotation.

Noam Arzt (HLN): @Nell Well aware of all of this. But the recommendation seemed to imply that there were no standards for this in use when there are. So long as CDC is not authorized to enforce anything - there is no federal PH law after all - I don't see how this is actionalble. *[sic]*

Bryant Thomas Karras MD: disconected *[sic]* from audio ... calling back in...

Noam Arzt (HLN): Is just identifying policies enough?

Noam Arzt (HLN): That's all that #64 says...

Nell Lapres: Agree the core data elements exist. Maybe it should say reevaluate to confirm those core data elements are appropriately inclusive? There are recommendations elsewhere about certification of PH which I would expect would include trying to standardize requested data elements where possible by law. If the core data elements currently identified are not all that is required by the majority of IIS, should they be reconsidered?

Carolyn Petersen: Posting any additional comments in the public chat or presenting during Public Comment at the July 14 HITAC meeting is another option for sharing your perspective. The agenda will be posted next week on healthit.gov

Bryant Thomas Karras MD: can we look at table of contents if we have extra time? order of recs is important


QUESTIONS AND COMMENTS RECEIVED VIA EMAIL
The following public comments were received by email.

Joel R Greenspan, MD, MPH, Atlanta, GA, in response to PHDS Task Force meeting held on 07/08/2021:

ONC HITAC PHDS-TF-2021 Recommendation 05 – Syndromic Surveillance
If acted upon, this recommendation has great potential for evolving a next generation of syndromic surveillance systems (better referred to as systems to support community-based health situational awareness) that could expand and automate the spectrum of health-related information available to community-based and other population health decision-makers for early discovery and tracking of significant
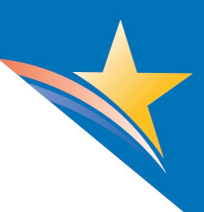
events. There has long been a need for local and state health departments to have easy access to real-time/near real-time actionable health situational awareness for a specific jurisdiction. ED-based syndromic surveillance currently limits this capability.

In the U.S. healthcare system today, standardized healthcare administrative data are an example of a non-traditional data source that has great potential to improve community-based health situational awareness as well as inform state and federal health authorities. In our system, a summary of virtually every provider/patient interaction in any out-patient setting (office, urgent care, etc.) is captured in a standardized format and sent electronically to payer organizations for reimbursement. Also, every prescription filled by a retail pharmacy company is similarly captured and sent into the e-commerce stream on the way to payer organizations. This process occurs in every U.S. community every day and each transaction captures core diagnostic, drug, date, location, patient demographics, and provider information. Providers and pharmacies are highly incentivized to initiate the reimbursement process quickly. Private industry has been able to tap into this large electronic administrative data stream to capture and accumulate giant warehouses of patient-centric, deidentified electronic healthcare reimbursement claims (eHRC) that contain the footprints of many significant public health events.

A next step for public health is to conduct a thorough evaluation of the potential of these data for capturing unusual, unexpected, or unexplained community events that require investigation and for monitoring ongoing routine and emergency public health events at the STLT and national levels.

I have had the opportunity as a medical epidemiologist to explore the potential of these large data sets from a public health perspective. For the record, I am sharing with the Task Force several use cases that document what can be discovered from these data that can benefit the public health system. While these use cases target infectious disease issues, I believe eHRCs have great potential to inform about chronic diseases, environmental threats, injuries, neoplasia, and reproductive health. A cloud-hosted, highly automated health situational awareness service could be crafted from these data that could inform all U.S. public health departments.

Both of the following use cases were presented at the 2015 National Preparedness Summit and were subsequently briefed to local, state, and federal public health officials. Detailed slide presentations accompany these summaries.

Use Case 1—CHIKUNGUNYA, U.S., 2014: This use case documents how large consolidated eHRC data sets can be quickly adapted to track emerging diseases threatening Americans. In early 2014, Chikungunya (a potentially severe mosquito-borne infectious disease that causes fever, joint pain, joint swelling, headache, muscle pain, and rash) began spreading in South and Central America and the Caribbean. U.S. visitors to these areas were becoming infected and returning to the U.S. where mosquitos carriers were present. This increased the threat that Chikungunya could begin to spread in U.S. communities. Careful and systematic tracking of infected persons in the U.S. was necessary to plan geographic-specific prevention strategies, but only a slow, incomplete national voluntary reporting system was available at the time to collect case reports. Retrospective research using de-identified electronic healthcare reimbursement claims (eHRCs) obtained through industry consolidators from community providers across the country examined near-real-time disease patterns of persons with possible Chikungunya infections in the U.S. during 2014. Had a system supporting this approach been operational in 2014 it would have been noted that: 1) One approach using a large industry warehouse of consolidated standardized eHRC data would have been faster at establishing syndromic surveillance of a new disease threat before traditional approaches could be revised and organized; 2) Chikungunya cases were appearing in the U.S. above expected baseline levels as early as February 2014 that would have supported coordinated STLT public health investigations, mosquito control, and national public information campaigns to begin early; 3) imported Chikungunya cases in the U.S. began to increase dramatically in June 2014, allowing authorities to better target prevention and control activities; 3) high quality age and gender patient information revealed specific demographic groups most likely to be infected who posed a threat to community transmission.
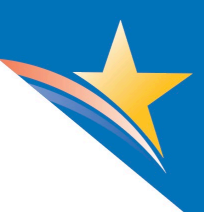
Use Case 2—PANDEMIC INFLUENZA A, GEORGIA, 2009-2010: We conducted retrospective research on out-patient influenza-like illness (ILI) and filled prescriptions for anti-influenza drugs during the 2009-2010 influenza A pandemic in Georgia and all its metropolitan areas. We used deidentified eHRCs obtained from community providers through industry consolidators for the analysis. Had this approach been operational during the pandemic: 1) deidentified patient information from two of every three Georgia primary care providers would have been available for weekly or daily ILI trend analysis without imposing any extra burden on provider practices (vs. <1% of GA providers agreeing to voluntarily report through ILINet); 2) anti-influenza drug prescriptions mimicked ILI trends in all communities and Rx claims from pharmacies had far less lag time in reporting than out-patient provider claims; 3) public health officials, decision makers, and citizens would have been able to track the pandemic not only in the entire state, but also in their own communities, leading to better-targeted, faster, and more responsible local response; 4) information for decision-making would have been available on a regular basis nearly two weeks before traditional ILINet state-based voluntary influenza tracking data was made public leading to more timely decision-making at all levels; 5) it would have been clear that influenza levels were above the expected baselines during the summer of 2009, especially among school-aged persons, suggesting that disease prevention policies in day-care and summer camps, if implemented, could have substantially reduced the disease burden in children and teenagers in the summer time frame, thus delaying or limiting the subsequent fall wave; 6) it would have been noted that not all GA communities experienced the fall acceleration of the pandemic at the same time, suggesting that school-closures in some parts of the state would have mitigated disease in those communities had it been implemented AND distribution of pandemic vaccine could have been targeted to the most unaffected communities rather than to communities that had already experienced peak disease.

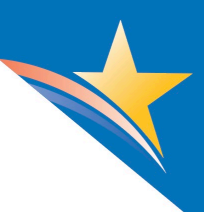Joel R. Greenspan then submitted the following PDF documents: (see icons below)

Resources
PHDS TF 2021 Webpage
PHDS TF 2021 – July 8, 2021 Meeting Agenda
PHDS TF 2021 – July 8, 2021 Meeting Slides
PHDS TF 2021 – July 8, 2021 Meeting Webpage
HITAC Calendar Webpage

Adjournment

Janet and Carolyn expressed their deep gratitude to all PHDS TF members and the public for their participation in the discussions and creation of the recommendations. Janet echoed Carolyn's comments and stated that she is looking forward to beginning work and future engagement in the areas of the recommendations. The co-chairs thanked each other and ONC staff for their work. The ONC team thanked all members for volunteering their time and for adhering to timelines.

Carolyn explained that topics that were not discussed within the document (and that have not been fully considered by the TF) have been moved to a separate appendix of topics that are "Open for Consideration." Any TF member feedback and public comments on these topics will be saved for future TF work.

The meeting was adjourned at 11:58 p.m. E.T.