Health Information Technology Advisory Committee (HITAC)

Public Health Data Systems Task Force 2022 (PHDS TF) Meeting

Meeting Note | September 21, 2022, 10:30 a.m. – 12:00 p.m. ET

Executive Summary

The Public Health Data Systems Task Force 2022 (PHDS TF) is a joint task force that consists of HITAC members, federal representatives of the HITAC, and several other subject matter experts (SMEs). The focus of the meeting was to review and discuss (f)(2) Criteria: Transmission to Public Health Agencies – Syndromic Surveillance. Gillian Haney and Arien Malec, PHDS TF 2022 co-chairs, provided opening remarks and reviewed the agenda for the meeting. The TF received presentations on the (f)(2) Criteria. The co-chairs presented updates made to the topics worksheet for use in developing TF recommendations to the HITAC and held discussion periods. There were no public comments submitted verbally, and there was a robust discussion held via the chat feature in Zoom Webinar.

Agenda

10:30 a.m.	Call to Order/Roll Call
10:35 a.m.	(f)(2) Transmission to Public Health Agencies – Syndromic Surveillance
11:00 a.m.	Discussion
11:25 a.m.	Task Force Topics Worksheet
11:50 a.m.	Public Comment
11:55 a.m.	Next Steps
12:00 p.m.	Adjourn

Roll Call

Mike Berry, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the September 21, 2022, meeting to order at 10:31 a.m.

Members in Attendance

Gillian Haney, Council of State and Territorial Epidemiologists (CSTE), Co-Chair
Arien Malec, Change Healthcare, Co-Chair
Rachelle Boulton, Utah Department of Health and Human Services
Hans Buitendijk, Oracle Cerner
Heather Cooks-Sinclair, Austin Public Health
Erin Holt Coyne, Tennessee Department of Health
Steven (Ike) Eichner, Texas Department of State Health Services
Jim Jirjis, HCA Healthcare
John Kansky, Indiana Health Information Exchange
Bryant Thomas Karras, Washington State Department of Health

Steven Lane, Sutter Health
Jennifer Layden, CDC
Leslie (Les) Lenert, Medical University of South Carolina
Hung S. Luu, Children's Health
Mark Marostica, Conduent Government Solutions
Aaron Miri, Baptist Health
Alex Mugge, CMS
Stephen Murphy, The Network for Public Health Law
Eliel Oliveira, Dell Medical School, University of Texas at Austin
Jamie Pina, Association of State and Territorial Health Officials (ASTHO)
Abby Sears, OCHIN
Vivian Singletary, Public Health Informatics Institute

MEMBERS NOT IN ATTENDANCE

Charles Cross, Indian Health Service
Joe Gibson, CDC Foundation
Rajesh Godavarthi, MCG Health, part of the Hearst Health network
Fillipe (Fil) Southerland, Yardi Systems, Inc.
Sheryl Turney, Carelon Digital Platforms (an Elevance Health company)

ONC STAFF

Mike Berry, Designated Federal Officer
Brenda Akinnagbe, Program Staff
Liz Turi, Program Staff

PRESENTERS

Rosa Ergas, MA Department of Health
Karl Soetebier, CDC
Aaron Miri, Baptist Health (HITAC and PHDS TF member)

Key Specific Points of Discussion

Topic: Opening Remarks

Gillian Haney and Arien Malec, PHDS TF 2022 co-chairs, welcomed everyone and reviewed the agenda for the meeting. Arien described the New York Times article, published on September 20, 2022, called "'Very Harmful' Lack of Data Blunts U.S. Response to Outbreaks." He discussed its applicability for the PHDS TF 2022, noting that the TF could tackle two of the most prominently noted issues in the article. These difficulties included the lack of real-time, easily available demographic information sufficient to localize and assess the burden of disease on particular communities and getting appropriate information for case investigation that helps characterize disease, burden, and outbreaks to conduct appropriate epidemiology. He invited the TF consider solutions to address the root causes for the outcomes listed in the article.

Arien commented that the topic the PHDS TF 2022 would consider at its current meeting, syndromic surveillance, faired reasonably well during the COVID-19 pandemic and discussed the use of dashboards to track the spread of the pandemic, as well as opportunities that could continue to improve this field.

Gillian explained that syndromic surveillance has been used for several years and is a less complex feed than electronic case reporting (eCR). Additionally, there is an established HL7 standard for syndromic surveillance with widespread adoption. She discussed the use and effectiveness of syndromic surveillance during the pandemic for situational awareness. She noted that a partially deidentified data set is sent to the Centers for Disease Control and Prevention (CDC) BioSense Platform, which does not link directly with states' case-based surveillance systems. She stated that syndromic surveillance has a broader application for public health beyond infectious disease and invited the subject matter expert (SME) presenters to highlight this and other topics during their presentations.

Topic: (f)(2) Transmission to Public Health Agencies – Syndromic Surveillance

The co-chairs welcomed SMEs to share perspectives on the use of syndromic surveillance.

Rosa Ergas, Massachusetts (MA) Department of Public Health, presented perspectives from the MA Department of Public Health on syndromic surveillance. She briefly discussed her background and experiences on making syndromic surveillance data useful for public health. She explained that MA has a robust network of emergency department syndromic surveillance providers and other partners (vendors, etc.), who are eager to support public health through quality assurance and completeness. She noted that issues can arise for vendors when the standards do not directly connect data elements or technical specifications with the needs of public health. They have experienced challenges with on-boarding urgent care locations, which has created issues with identifying emerging trends and regulating urgent care data. She suggested that having a clear, common understanding of the data elements necessary for public health utility across states and partners would improve outcomes. She emphasized the need for better data sharing and communication within local jurisdictions and to public health partners.

Karl Soetebier, CDC, introduced himself and explained that he is currently the acting lead for the National Syndromic Surveillance Program (NSSP). He agreed with Rosa's comments that there is a mature messaging guide for data in the CDC's feed. An incremental revision is in progress, which will go through the ONC Standards Version Advancement Process (SVAP) in the future. He described gaps and challenges related to upstream data, noting that even when it is certified, the data may not be as close to the source as possible; he recommended that this is one area the TF could examine to better define gaps related to the (f)(2) Criteria. He discussed how data is provided via a nationwide collaboration between state and local partners, and this broad group of stakeholders has different needs and areas of focus (e.g., capturing emergency department, urgent care, and inpatient visits). He noted that some jurisdictions want to use identified data in their local systems while others have not prioritized onboarding urgent care because they think their emergency departments already capture enough syndromic surveillance information. He described challenges related to the completeness, collection, and quality of data (e.g., completeness of race and ethnicity data has gone up since the beginning of COVID-19, but the quality of data could often be better). He noted that the quality of data is related to relationships between partners and healthcare facilities.

Aaron Miri, Baptist Health, echoed the other presenters' comments that syndromic surveillance has been in use for some time. He presented a provider's perspectives on how the COVID-19 pandemic has been handled in two different markets (Austin, TX, and Jacksonville, FL). He explained that the HL7 Standard in use works well but added that standards are constantly being updated (e.g., making new data fields mandatory in the electronic health record (EHR)). The broad data that is being gathered can be used to identify emerging diseases and to prevent large outbreaks (e.g., tracking vaccinations and symptoms in the student population at UT-Austin). He highlighted the usefulness of large data sets that are focused on emergency departments, noting that they can be used for tracking and tracing. He described the following gaps: dependency on the creation and propagation of new data elements for emerging illnesses (e.g., public health dependent on vendors to determine new data types during beginning of the COVID-19 pandemic), internal hospitals/providers do not have the resources to build emerging labs to enable monitoring, a lack in

funding has led to the continued use of a less common, highly specialized testing process is still paper based, lack of feedback on community or healthcare provider data that could help better inform clinical operations, lack of bidirectional information on community surveillance measures (e.g., local Internet searches on symptoms, wastewater surveillance, etc. are not routinely built into EHRs), need to incorporate standards for home surveillance and self-reported testing, and the dependence of quality and surveillance monitoring programs on HIPAA (confusion about how much data can be shared according to HIPAA). He thanked the Health Innovation Alliance for their help developing some of the information he shared.

The co-chairs facilitated a discussion session following the SME presentations.

Discussion:

- Gillian responded to several of the comments attendees shared in the chat in Zoom, and she explained that the data are query-based. There is no need to develop syndromes from which to trigger the data to be sent to the CDC BioSense Platform. The community of practice is robust in sharing this data, whereas electronic case reporting (eCR) and electronic laboratory reporting (ELR) are based on LOINC and SNOMED (or in concert with ICD-10 codes), which creates a different process for data sharing.
- Arien shared several comments in response to the panel presentation:
    - The existing implementation guide (IG) for syndromic surveillance is good.
    - The data that are put into the IG should be captured at the source, rather than taking it from secondary, downstream systems.
    - There are no CMS programmatics that hook into ambulatory and urgent care in the way that they hook into acute care. He invited ONC and CMS attendees to clarify this topic but advocated for the opportunity to make broader use of the syndromic surveillance IG certification criteria to get emerging information from these other sources.
    - Ike stated that the IG supports reporting from urgent care, but current federal regulations for promoting interoperability do not provide financial incentive for non-hospital providers to participate in syndromic surveillance reporting.
- Ike shared several comments:
    - The querying of syndromic surveillance data does not happen with public health querying information systems that are hosted by the provider. Instead, the Admit, Discharge, & Transfer (ADT) messages are forwarded to public health. Then, the complete database that consolidates data from multiple providers is queried by public health.
    - The TF could recommend changing the usage of syndromic surveillance data beyond population health level.
    - Investigate issues of data provenance and allow patients to understand how their data can be used.
- Mark described feedback he has received from clients, who asked that data be shared bidirectionally between public health agencies and hospitals/reporting agencies.
    - Gillian responded that all the data for syndromic surveillance are hosted by the CDC in “lockers,” which can be divided via filters to determine access. Hospitals can query their own data.
    - Ike added that, in Texas, participating hospital providers can query all their data, and they also have access to all the analytical tools developed by public health. Hospitals may only see their own data, but aggregated data is available statewide.
    - Mark suggested that public health should be able to actively alert hospitals that there may be an outbreak in the community instead of doing it passively. Ike agreed, noting that early warning detection was one of the original motivators for putting the syndromic surveillance system in place. TF members noted that the capability exists to open the data to additional users.

- Karl commented that there is a need for the human aspect in the syndromic surveillance process (e.g., for interpreting case data, building a case report). While the system can send unfiltered alerts to healthcare systems, public health analysts are needed within the process make the data actionable. Gillian agreed that there is an art to the science of interpreting public health data.

- Bryant agreed with previous comments about expanding the collection of syndromic surveillance data beyond emergency departments and shared his experiences collecting and sharing data from ambulatory care, primary care, urgent care, and select specialty care settings in Washington state. Washington has put guidance into place for hospitals and ambulatory care settings that gives them permission to participate. He suggested that incorporating inpatient records is beneficial for tracking and interpreting cases, as well.
    - Arien asked if the IG supports inpatient data collection and whether policy hooks that support emergency department data collection can be used to support broader use. Bryant responded that inpatient and ambulatory are both covered in the IG.
    - Arien discussed the usefulness of having an IG that could support hooks or other means that could be used inside EHR to be able to expose public health alerts (for validated alerts). He suggested that there is a need for bidirectional communication and there is a lack of an IG. The TF could make a recommendation to ONC to develop and test such a guide.
    - Karl explained that urgent care has not become a required reporting measure because it can be resource intensive to establish the necessary technical connections to move data. Also, having the personnel available to ensure data quality and review/act on the data can be another burden for some jurisdictions.
- Rosa responded to several previous commenters:
    - The IGs do allow for the transmission of data from urgent care, inpatient and ambulatory to public health. However, there is not a clear and shared understanding of which data elements should be used to share this information and to aggregate the patient care experience. Clarification is necessary. She described how MA has leveraged the CDC's work and works to integrate information to enhance the patient care experience.
    - Though the use of a bidirectional flow of data is desirable, its utility to hospitals and creating engagement with providers has proven challenging, as providers can get similar data from other places.
    - Automated alerts risk overwhelming providers with data that may not be useful to them. Syndromic surveillance has somewhat limited utility as an alerting mechanism, but it is useful for situational awareness, understanding health disparities, determining resource allocation, and creating prevention activities.
- The co-chairs thanked the presenters for their time and all commenters for sharing during the discussion.

Topic: TF Topics Worksheet

Arien thanked all who members who updated the PHDS TF 2022 Topics Worksheet. He described updates to the document, including a color-coding system (green = consolidated to recommendations text, yellow = in-progress, red = potential duplicate). He invited TF members to share feedback, using their full names with comments and briefly reviewed new information TF members added to the background/supporting references, observations, and recommendations columns of the working document. The co-chairs facilitated a discussion and shared comments.

Discussion:

- Arien agreed with comments that Les and Hans made that the PHDS TF 2022 should review, reindorse, and resubmit any applicable recommendations made previously by the Interoperability Standards

Priorities Task Force (ISP TF).

- Arien reviewed several recommendations and comments Hans submitted and suggested that the TF discuss them at a future meeting when Hans is in attendance.
- Erin commented that the topic of jurisdictional variations in ELR has been detailed in the ELR R1 IG and in various Laboratory Results Interface (LRI) IGs. She discussed variations in the method of documenting parent-child relationships and noted that work was done in LRI to clarify the syntax around reporting parent-child relationships. She stated that if one of the recommendations is to to widely adopt LRI, some of that variation could resolve because of the additional context, guidance, and clarity provided.
    - Arien agreed, noting that using the latest version of the LRI IG would improve ELR issues, and Hans entered supporting comments in the working document.
- Arien commented that he would create and share a series of recommendations with the PHDS TF 2022 that reindorse the ISP TF's previously submitted recommendations. Also, he suggested that the lab results that are sent to public health should contain complete and accurate demographic and contact information sufficient for person matching and starting a case investigation.
- Ike suggested that the PHDS TF 2022 address Ask at Order Entry (AOE) questions.
    - Arien commented that the issue with AOE is that there is a time-lag between getting context around the lab and getting AOE more broadly employed. He stated that the broader use of eCR would address this issue better than mandating use of a more flexible AOE system. He invited TF members to discuss this topic, noting that it previously came up in conversations around the use of ELR and eCR.
    - Gillian clarified differences between the use of and questions included in AOE versus electronic test orders and results (ETOR). Ike commented that the evolution of AOE has been around for a long time and described how it was first looked at in practice during the response to Zika. He stated that the issue, going forward, is looking at how testing for COVID-19 occurred at drive-through sites and using this information.
    - Arien commented that AOE is a generic capability that serves the need for orders to capture additional contextual information relative to the lab order (not a public health capability). Gillian commented that the ETOR should contain the standardized relevant demographic information.
    - Hung commented that AOE was used as a work-around during the COVID-19 pandemic to get additional information that was not otherwise available. Ideally, this information should be gleaned from the patient's information, rather than the information input by a clinician (not a controlled or standardized process). If this information could be pulled into reporting via an automated process instead of using AOE, that would be better.
    - Ike commented that the information could be lost to public health if patient data is not collected via situations where labs are the first point of contact (like drive-through testing or rapid testing). Arien agreed that there is a risk of reducing the contextual information available as more consumer-based testing is used; reportability decreases.
- Arien reviewed the comments and proposed recommendations TF submitted related to the (f)(5) Criteria on eCR and invited TF members to share feedback.
    - Vivian described the incomplete suggestion she submitted to standardize eCR standard and IG, serving as a means for broader adoption and eCR.
    - TF members discussed whether/how ONC could support and/or model standardized legislation for states that would allow state level health information exchanges (HIEs) to serve as coordinating entities for eCR and other types of reporting. Arien recommended that the legislation support modular certification for eCR in ways that would allow a provider organization to use their EHR or their partnership with the state HIE as the module (provider organizations can mix and match capabilities to meet certification). Ike suggested that public health should have input on its opportunities for connecting with healthcare, and TF members discussed the types of connections that providers and receiving systems are resourced to

support. Arien suggested that certification criteria should address the format so there is no mismatching.

- TF members discussed a recommendation Les entered in the spreadsheet that the CDC and other organizations should work with academia and the private sector to move the recognition of notifiable conditions to a probabilistic basis, computed when necessary, using artificial intelligence (AI) methods. It could be based on the evolving vector of clinical data, rather than rules executed at one point in time. Gillian commented that she disagreed with the recommendation and discussed the current role of the CSTE in establishing case definitions and determining what is nationally notifiable versus what is reportable within jurisdictions. Erin agreed, noting that there are variations between nationally notifiable conditions and state reportable conditions. Other TF members agreed, and Arien asked Les to update the recommendation to address the concerns raised by the public health officials on the TF.

Next Steps

Homework for September 28, 2022, Meeting – due by Tuesday, September 27:

- Please read and familiarize yourself with (f)(4) Transmission to Cancer Registries https://www.healthit.gov/test-method/transmission-cancer-registries
- Continue reviewing and adding comments to the Topics Tracker worksheet. Instructions on how to use the worksheet can be found on the instructions tab within the spreadsheet. The spreadsheet is accessible through Google Docs. Please contact Accel Solutions if you cannot access this document.

If anyone has questions, please feel free to reach out to the co-chairs or the ONC program team.

Public Comment

Mike Berry opened the meeting for public comments:

QUESTIONS AND COMMENTS RECEIVED VERBALLY

There were no public comments received verbally.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT

Gillian Haney: Hans will be a few minutes late as well I believe.

Jim Jirjis: Jim Jirjis joined

Erin Holt: Erin Holt joined

Steven Lane: All urgent care departments likely bill Medicare. We could look to CMS to drive the adoption of SyS in this setting.

Steven Lane: Many patients present to primary and even specialty care providers with potentially reportable syndromes. To make this channel most beneficial we should look to maximizing the signal from across the care continuum.

Jim Jirjis: Steven, agree. Seems like this would be an EHR certification capability ---making sure the EMR's make it very easy to identify reportable conditions and submit the report

Steven Lane: As with eCR, we could address this variability of interest, on the part of jurisdictions, by standardizing the data send from providers to a central hub, then allow jurisdictions to define rules for data

forwarding, or to take what they want from that generic feed, rather than require providers to interact independently with multiple jurisdictions.

Mark Marostica: One element I have heard from our PH clients is the need to be able to share and communicate syndromic data with area hospitals/clinics to assist them in understanding and monitoring emerging diseases and outbreaks.

Steven Lane: @Jim - Yes! We have proven with eCR that this can be done in a standardized automated manner with trigger codes (diagnoses, orders, results, etc.). Certified HIT could readily extend this functionality to accommodate SyS, independent of care setting.

Mark Marostica: I remember all too well

Arien Malec: I'm amused to hear CA as a locale that has well funded PH infrastructure.

Steven Lane: Thanks for that clarification/reminder GIllian. This suggests that it would be trivial to extend this functionality to settings of care beyond the Emergency Department.

Aaron Miri: Goes without saying as this is an under pinning issue against numerous issues - without a defined unique patient identifier or strategy to address; we will always have major gaps in our ability to truly respond with necessary speed in stopping an outbreak and breaking the chain of transmission

Erin Holt: Aaron to your point, not only do we need a defined unique patient identifier, but also appropriately documented assigning authority. This also extends to other entity identification as well, like facility, organization, sender.... While the IGs supports the representation and conveyance of this information it may not be wildly adopted and differences of opinion regarding certain identifier types, like OIDs.

Arien Malec: Again, we want to keep syndromic surveillance aggregate and population based; we should let eCR take the load on case investigation….

We should add this persistent “OID" issue to the recommendations -- on the need for provider directories that can be used to cross-index identifiers...

Aaron Miri: @arien - great point on cross indexing / correlating information to quickly digging in and find the root

Steven Lane: @Mark - There is no questions that our ultimate goal here should be a bidirectional communication, including alerting from PH to providers, ideally in a manner that can integrate alerts directly into their EHR workflows, as opposed to publishing a finding and expecting providers to read, understand, digest and act on these alerts in a manner specific to their own software.

Steven Lane: Is there a technical standard for syndromic alerts from PH to providers? If these could be sent (or published) in a standardized digital manner, provider systems could take the responsibility for visualizing and reviewing those alerts and determining which alerts to present to which users in what context.

Erin Holt: If we are solutioning for PH alerting providers based on information received from their facility, it might be worth evaluating what is working and what isn't with regards to the Reportability Responses and their adoption.

Gillian Haney: a lot of the alerts are based on local history to establish what is above base line

Bryant T Karras:

ED 17%

80% outpatient

3% inpatient

Arien Malec: The point of having a implementation guide and certification in place is to reduce the overall burden for adding urgent care & primary care into to the SyS net.

Steven Lane: @Erin - As eCR is adopted more broadly, more providers are receiving and filing the resultant Reportability Response into their EHRs. As eCR extends from COVID-19 to other reportable conditions, I hope that PH jurisdictions will begin to send more meaningful information in their reportability Responses, e.g., local antibiograms, recommended treatment, follow-up, etc.. Once these messages contain this sort of useful data, receiving EHRs should be able to route them to infection preventionists, care managers, and/or treating providers as appropriate.

Erin Holt: The language in the current implementation guide is tailored toward hospitals and emergencies departments, so it doesn't always align with the nomenclature used at urgent care clinic based on what we have experienced (e.g. discharge diagnoses, admission and discharge, discharge disposition, etc. mean different things to urgent cares). USCDI may help with this over time.

Noam Arzt: @Steve Lane - remember, the RR comes from RCKMS, not the PH agency itself...

Gillian Haney: I believe the RR is authored by each jurisdiction via RCKMS

Steven Lane: That is my understanding as well, Gillian.

Leslie Lenert: Situation awareness needs data on surge capacity and, for many emergencies, data on CT/MRI and OR availability, blood supply, etc.

Steven (Ike) Eichner: @jirgis, Limiting syndromic reporting to particular diagnoses makes it much closer to eCR. A major purpose or syndromic surveillance is to collect information for symptoms that are emerging or do NOT have a immediate diagnosis/suspected diagnosis.

Erin Holt: aggregate data, like for communicating metrics on resource availability is able to be supported via the SANER FHIR IG that was recently published.

Steven (Ike) Eichner: One of the challenges for situational awareness is data that may be sourced from systems other than EHRs and/or don't have standards both for extracting data and a common vocabularly/standards of measures for some resources (e.g., do all hospitals track gowns at the individual gown level or do some track/inventory boxes (or vice-versa, and is there a standard number of gowns in a box)?

Steven Lane: One of the challenges of extending SyS from the ED to Urgent Care, to ambulatory and inpatient care more generally, is understandable concerns on the part of providers that excessive/unnecessary information will be sent to PH and that PH could be overwhelmed by the volume of data received ("needle in a haystack" problem). If SyS were redesigned to function more like eCR (with triggers based on Chief Complaint, Orders, Dx, etc.) as opposed to an ADT feed, providers would likely be more willing to contribute and PH would be more able to mange the resultant data.

Erin Holt: Ask at order entry is usually used to document additional information the lab needs in order to make their observation. It was used for COVID to push through additional information to public health.

AoE is communicated in a lab order to the lab and can be communicated in a result message.

Noam Arzt: On RR, you are correct: PHA can customize what gets sent back on a condition by condition level in RCKMS.

Steven (Ike) Eichner: And to add- for drive-through testing situations, there should be a way of routing sults back to the patient's PCP or regular cae provide. This could also be collected through AOE, in certain enviroments/

Erin Holt: Might be helpful to reference https://www.hl7.org/fhir/us/ecr/index.html and the 3.3 Electronic Reporting and Surveillance Distribution (eRSD) Transaction and Profiles for the trigger code distribution

Steven (Ike) Eichner: There needs to be recognition of the different needs across public health agencies

Erin Holt: I think modular certification should also extend to PH as well.

Arien Malec: @erin -- agree…

Steven (Ike) Eichner: erin- areed

Bryant T Karras (WA State): Back to ELR: I really think there are miss understandings from Providers on the importance of some of the "optional or RE" elements in PH response. AOE and key fields like Phone and address were often skipped or filled in with the facility address rather than the patients. Race Eth, and Language are also critical in making sure we are sensitive and equitable in our response

Steven (Ike) Eichner: erin-agreed. Sorry for the typo!

Erin Holt: Bryant, I agree that looking at conformance in the various IGs is probably worth doing, and commenting on during ballots and STU commenting periods. Particularly in situations where RE is regularly interpreted as O, which does happen, often.

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

There were no public comments received via email.

Resources

PHDS TF 2022 Webpage
PHDS TF – September 21, 2022 Meeting Webpage
PHDS TF – September 21, 2022 Meeting Agenda
PHDS TF – September 21, 2022 Meeting Slides
HITAC Calendar Webpage

Meeting Schedule and Adjournment

Arien and Gillian thanked everyone for their participation. The co-chairs summarized key achievements from the current meeting and encouraged TF members to continue to use the Tracking Document spreadsheet to capture comments. The co-chairs briefly summarized the final (f) Criteria the TF is scheduled to review. Arien described how the recommendations in the spreadsheet would be turned into a recommendations report. They shared a list of upcoming PHDS TF 2022 meetings, including dates the TF will present to the HITAC.

The next meeting of the TF will be held on September 28, 2022. The meeting was adjourned at 11:59 a.m. E.T.