

**Public Health Data Systems Task Force 2021**  
**Crosswalk of Topics by Target Area**

**Target Area: Surveillance**

(Can be Cross-Cutting with Other Target Areas)

Topic	Gap	Opportunity	Recommendation <sup>(1)</sup>	Priority <sup>(2)</sup>
Syndromic Surveillance (ILI)	There is availability of rich data that is not tapped into to support syndromic surveillance.	Consider better use of surrogate markers (e.g. employee absenteeism) to identify early clusters/outbreaks.	Rec 1: CDC should explore non-traditional data sources and surrogate markers (e.g., employee absenteeism, etc.) that could be leveraged to identify early clusters/outbreaks of disease incidence.	
ELR (Adoption of IG)	Incentives in Meaningful Use were minimal and directed at providers. Some states have still not onboarded.	ELR could be improved through lab and PH agency adoption of IGs.	Rec 1: ONC, CMS, CDC to explore providing incentives for labs and public health agencies to adopt and use ELR implementation guide.	
Improve funding	There is insufficient funding in public health, and funding structures are too rigid when responding to emergencies.	Funding for public health across states will ensure necessary shared resources are available	Rec 1: CDC should investigate how current funding streams may impede data sharing.	
Formation of a standing PH group	Many important topics out of scope for this task force.		Rec 1: CDC and ONC should explore creation of ongoing public health task force or workgroup to address topics out of scope for HITAC PHDS TF to ensure preparedness for future high consequence public health emergencies.	
Major gaps in standards adoption for key surveillance use cases	<ol style="list-style-type: none"> <li>1. Lack of adherence to existing standards (eLR, SyS, IIS).</li> <li>2. Low uptake of newer standards (eCR), lack of certification requirements for eCR</li> <li>3. Missing data due to lack of, or variance in, reporting standards across jurisdictions.</li> <li>4. Duplicative/misaligned reporting requests add to provider administrative burden.</li> </ol>	<p>Think differently about the intent and use of data to and from laboratories so that not only billing data is captured, but demographic/SDOH.</p> <p>There is a need for case data to go to PH agencies, but also a great opportunity for bidirectional data flow from PH to providers.</p>	<p>Rec 1: ONC should support the development of IGs clarifying and specifying standard datasets and mnemonics for reporting public health data.</p> <p>Rec 2: ONC and CDC should work with provider and standards community to standardize what demographic elements are required in reporting (e.g. race/ethnicity, contact info).</p> <p>Rec 3: ONC should require eCR and eCR Now within certification program.</p> <p>Rec 4: CDC should develop process for standardizing reporting asks at federal and state level to avoid duplicative asks.</p>	

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	5. Lack of incentives for standards adoption. 6. Providers struggle to send information, even thru the Immunization Gateway, as there are variations in the data sent in each state. 7. ADT-based surveillance is not fully leveraged due to lack of standards adoption. 8. Demographic/SDOH data comes from EHR, however this is often not included in what is sent to labs. 9. There is not a seamless way for providers to report to PH agencies and missed opportunities for PH to provide clinical decision support (CDS) to frontline providers. And there are often missing data points		Rec 5: ONC and CMS should explore incentives for adoption of ADT-based surveillance standard	
Technology and infrastructure factors affecting key surveillance use cases	1. Lack of central patient identifiers and ability to link patients across care settings/public health 2. Current processes to set-up data exchanges places burden on providers/public health to test new interfaces. Lack of centralized national infrastructure leads to duplicative and burdensome reporting data flows. 3. Lack of clarity on how to protect patient privacy while promoting interoperability. 4. Lack of infrastructure funding across PH leading to data silos. 5. Provider administrative overload/perceived lack of value in data reporting. 6. Lack of consistent HIEs and capabilities		Rec 1: CDC and ONC should incentivize implementation of FHIR request/retrieve standards within public health departments. Rec 2: CDC and ONC should explore the development of centralized reporting gateways to avoid duplicative reporting workflows for providers. Rec 3: CDC should investigate how current funding streams may impede data sharing.	

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	for PH reporting. 7. Lack of standards on describing SDOH and where SDOH data should be collected. 8. Differences in social service data systems will create difficulty in connecting to PH and clinical.			
Patient privacy, digital access, and social justice factors affectign key surveillance use cases	1.Lack of alignment in jurisdiction vs. state vs. federal privacy and security laws. Lack of clarity within HIPAA on data sharing for PH purposes (ie minimum necessary)leads to differing interpretations from each state/local jurisdiction. 2. Lack of interoperability adoption incentives for PH data sharing across states, lack of funding overall. 3. Lack of federal guidance, and restrictive state laws on data sharing from public health to external entities(i.e. PH requests for PHI, HIEs, research)		ONC and CDC should work with OCR to develop and release best practices/guidance for how HIPAA impacts reporting to public health agencies.	
Policy, licensing, and legal factors affecting key surveillance use cases	1. Lack of alignment of HIPAA with current use cases (population based data sharing, data sharing with non-HIPAA covered entities) 2. FQHC and individual providers lack resources to establish connections with public health.		ONC and CDC should work with OCR to develop a national framework for the collection and meaningful use of SDOH data. Enforcement, incentives, and linkage strategies to cross-fertilize key data sets (and reduce collection burdens)	
Federal/state/local factors affecting key surveillance use cases	1. Variability in local jurisdictions' and states' data reporting requirements and capabilities. 2. Lack of standardized patient identifiers. 3. Not leveraging federal funding of social service programs to push states to adopt standards and technology compatible with PH.		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.  CDC and ONC should explore policy levers to require state use of federal systems when states are receiving federal funds.	
Health equity in surveillance systems	1. Lack of standards to describe SDOH data and, collection not compulsory (e.g.	Integration of PH and Healthcare (HC) systems is needed.	Rec 1: ONC should work to ensure consistent collection of agreed upon standards for race, ethnicity, disability status,	

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	<p>disability, race/ethnicity).</p> <p>2. Ineffective process and culture for collecting SDOH data (e.g. rigid categorization of 5 races and 2 ethnicities).</p> <p>3. Lack of funding for underserved areas and inability to consistently include those with poor access to healthcare in surveillance.</p> <p>4. Information transmitted from labs (especially commercial labs) often lack demographic information as the focus is on billing requirements.</p> <p>5. Demographic data needed by PH is often omitted in case reporting.</p>	<p>Emerging standards like FHIR allow for integration of PH and HC systems. This would result in improvements in patient identifiers and linking patients across care settings/public health. Missing data due to lack of, or variance in, reporting standards across jurisdictions.</p>	<p>sexual orientation, gender identity and data for social determinants of health, through USCDI or other mechanisms.</p> <p>Rec 2: ONC should work with the community and OMB to explore expansion of existing categories of race and ethnicity within the OMB standard. Consider adopting definitions in USCDI. Consistency in standards, specification in reporting requirements, and enforcement and compliance to these is the foundation. Transparency in methods for analyzing and validating the data is also essential.</p> <p>Rec 3: CDC should work with state and local public health agencies to align requirements and reduce variation across states for collection of race and ethnicity data.</p>	
<p>Enhancing data sharing between public health and social services</p>	<p>1. Lack of privacy regulations that promote data sharing between social service and public health.</p> <p>2. In the absence of regulations that promote data sharing between PH and social services, there needs to be a electronic consent to allow data sharing.</p> <p>3. PH not currently tapping into GIS data (e.g. transit) to determine where service gaps may exist.</p> <p>4. Lack of standards to link PH to social service data.</p>		<p>Rec 1: ONC should work with OCR and others to explore changes to privacy regulations (HIPAA, 42 CFR Part 2, etc) and promote partnerships and data sharing agreements between public health agencies and social services to allow for the sharing of necessary data in a public health emergency.</p> <p>Rec 2: ONC should work to expand standardized electronic consent capabilities, to ensure consent to share relevant information between public health and social services is easy to obtain and document, absent changes to privacy regulations.</p> <p>Rec 3: CDC should encourage public health agencies to work with local social service organizations (e.g., transit agencies, housing authorities, etc) and leverage GIS data to better plan and target response efforts during public health emergencies.</p> <p>Rec 4: ONC should work with standards development</p>	

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			organizations to develop and advance FHIR standards better linking public health to social service data.	
Streamline data sharing from large hospitals/provider networks	1. Lack of EHR vendor adoption of standards that promote interoperability for public health.		<p>Rec 1: ONC should require certified health IT products to support standardized eCR. CMS should require providers to utilize eCR through Promoting Interoperability program and CMS conditions of participation.</p> <p>Rec 2: ONC should work with standards development organizations to develop a FHIR-based automated case investigation standard that supports a future state of ongoing synchronization of clinical and public health data, as one-time push operations (reporting) is not as useful.</p>	
Long-term and Post acute care	<p>1. Lack of funding for EHR adoption for long term care and support services.</p> <p>2. Lack of incentives for standards adoption (eLR, eCR, SyS, IIS).</p>		<p>Rec 1: ONC and CMS should invest in long term care and support services to incentivize EHR and health IT standards adoption to to be equipped for data exchange and reporting similar to health systems (e.g. expand Meaningful Use / Promoting Interoperability program). eCR should be explicitly included as a standard for use.</p>	
Engaging community providers in public health reporting	1. Lack of incentives/funding for standards adoption.		<p>Rec 1: ONC should work with CMS to require providers to utilize eCR as a component of the Promoting Interoperability program, and subsequently for reimbursement by public benefit programs.</p> <p>Rec 2: ONC should explore the expanded use of APIs for data sharing between social services and public health agencies.</p>	

**Target Area: Infrastructure**

Landscape Analysis Topic	Gap	Opportunity	Recommendation	Priority

**Target Area: Privacy and Security**

Landscape Analysis Topic	Gap	Opportunity	Recommendation	Priority

**Target Area: Research and Innovation**

Landscape Analysis Topic	Gap	Opportunity	Recommendation	Priority

Notes:

- (1) Implementation of proposed recommendations subject to ONC’s available resources.
- (2) The proposed tiers in this table reflect the timing of the opportunities.

Legend for priorities:

Low  
Medium  
High

Or

Immediate (calendar years 2022-2023)  
Longer-Term (calendar years 2024-2027 and beyond)