



Leaders in Applied Public Health Epidemiology

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CSTE is an organization that supports epidemiologists practicing at the state, territorial, tribal, and local levels.

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March 10, 2014

Dr. Karen DeSalvo
Chair, Health Information Technology Policy Committee
National Coordinator for Health Information Technology, ONC, DHHS

Dear Dr. DeSalvo,

This letter contains recommendations from the Council of State and Territorial Epidemiologists (CSTE) on the Office of the National Coordinator (ONC) Health Information Technology Policy Committee (HITPC) Meaningful Use (MU) Workgroup recommendations for MU Stage 3. CSTE is an organization of member states and territories representing public health epidemiologists. CSTE and all epidemiologists at state and local public health agencies have a vested interest in the successful implementation of health information technology and electronic health records (EHR) for facilitating timely and complete transfer of information from the clinical care sector to public health for use in identifying, monitoring, and responding to events of public health importance and improving population health.

CSTE appreciates the efforts of MU Workgroup to further health information technologies that promote improvements in both personal and population health outcomes. MU must incentivize EHR technology functionalities that help healthcare professionals comply with state public health laws that require them to notify health authorities of patients with reportable health conditions.

ONC's recognition of the importance of public health and population health is clear from the inclusion of relevant, high-impact objectives in Stages 1 and 2 of MU. We feel strongly that at this critical point in time, as expectations for electronic health record functionality are being defined, it is important that public health data needs are met.

We ask the HITPC to accept recommendations for the Stage 3 public health objectives that support:

1. Immunization as a core measure for EPs, EHs, and CAHs, with EHR-Ts certified to an ability to receive external clinical decision support (CDS) data pertaining to a patient's immunization;
2. Electronic Laboratory Reporting (ELR) and Syndromic Surveillance (SS) as core measures for Eligible Hospitals (EHs) in MU Stage 3;
3. Registry report as a menu objective for EPs and EHs; and
4. Further incentivizes EHR technology functionalities that help healthcare professionals comply with state public health laws that require them to notify health authorities of patients with reportable health conditions.

The remainder of this letter is devoted to sharing our perspective on ELR, SS and the EHR functionalities for reportable conditions. MU requirements for Stages 1 and 2 are a substantial boost to the connection between clinical care and public health. These objectives provide a bridge for health agencies to work with hospitals, healthcare professionals and technologists. Prior to MU, these parties were reluctant partners in building electronic data transmissions for public health purposes. States are now making progress in implementing ELR and SS data transmissions from EHs due to MU requirements. Stage 2 incentives, in particular, make a difference in hospital willingness to constructively work with public health agencies.

Public health agencies have the ability to receive and use ELR and SS data from hospital EHRs, but are challenged to fully implement hundreds of hospital data feeds within a Stage 2 incentive window. Establishing production quality public health data transmissions from new EHR-T is a complicated and time-consuming process. It is a process that requires a prolonged period of engagement among data exchange partners. Stage 2 does not provide enough time for hospitals and public health agencies to complete this process and build sustainable connections. Progress and work that EHs make in Stage 2 need to be built on in Stage 3 to meet the public's expectation that MU investments are being used to protect and secure population health.

1. **ELR:** CSTE strongly supports the Workgroup's vote to retain the ELR Objective. Retaining the ELR Objective is paramount. ELR has become a critical part of the reportable disease data submission process. Many communicable and environmental diseases that are currently under surveillance across the country are identified and confirmed by laboratory observations. In some states, ELR now accounts for the first identification of as much as 60-70% of reportable diseases. The benefits of ELR are widely recognized. Electronic laboratory reporting provides substantial increases in efficiencies, completeness, and timeliness of reporting. Timely and complete electronic laboratory reports are an important source of information for the core public health functions of disease surveillance and responding to public health events. Reduced disease identification times as a result of ELR enables states to implement disease control measures more quickly (as in identifying outbreaks of foodborne disease, excluding ill children from daycares preventing others from getting ill; or ensuring all potentially exposed contacts of invasive meningococcal disease are identified and get their prophylactic treatment necessary to prevent life-threatening disease onset). In addition, some surveillance initiatives, such as monitoring new and reemerging antimicrobial resistance (e.g., Carbapenem-Resistant *Enterobacteriaceae*), are conducted entirely based on laboratory observation findings and are considered high priority at the national level, even considered as one of the CDC's top five health threats in 2014.

All states have prioritized ELR and implemented the ability to accept HL7 v 2.5.1 ELR messages as specified in the MU Objective. States have also built registration systems in order to track the interest and progress of participating EHs. During Stage 1, low levels of EH participation reflected hospitals selection of other public health related Objectives. With the onset of Stage 2, many hospitals are now engaged and working collaboratively with public health to implement ELR. Inclusion as a Stage 3 Objective is crucial to continue this momentum and emphasize the importance of notifiable disease surveillance for monitoring population health and the timely detection of outbreaks.

Given the large number of facilities that have not fully moved into production to date, stronger support and prioritization for inclusion of ELR in Stage 3 is needed. If ELR is removed from MU, there is a potential to waste much of the recent effort that was made by hospitals and public health to move ELR forward to its current state, to degrade the functioning of ELR systems that are in progress or recently completed, and some hospitals will never move to production ELR submissions.

2. **SS:** CSTE also supports the Workgroup's vote to include the SS Objective for **EHs**. Syndromic surveillance is a distinctly different activity from ELR. Many states have demonstrated success with hospitals implementing SS measures and utilize emergency department and inpatient hospital data to provide situational awareness, as well as to identify clusters or outbreaks. Maintaining SS as an objective for eligible hospitals in MU Stage 3 will continue to enable state and local public health agencies to monitor serious health impacts in real time to promote public awareness and to target interventions. Syndromic surveillance data from hospitals provide data to public health in near real time which makes it heavily relied on to characterize and anticipate emergent health threats such as the monitoring of the severity of influenza, large scale events (Boston Marathon, Super Bowl, large conventions), or natural disasters such as hurricanes and snowstorms. In some states, although SS was implemented following 9-11, hospitals did not re-initiate data feeds when they moved to a new medical record system. Inclusion of SS for EHs will aide many states in maintaining or developing more robust systems. Removal of this measure is premature for similar reasons as indicated for ELR (above).

While CSTE supports continued inclusion of SS for EHs, CSTE understands the Workgroup's charge and need to reduce the number of Objectives consistent to that of Stage 2. **CSTE agrees with the vote to remove the Objective for participation in SS for EPs.**

3. **Electronic Case Reporting in support of reportable disease surveillance is important to CSTE.** CSTE recommends modifying the proposed Objective of participation in one registry to participation in two registries.

Lack of physician compliance with laws that require them to notify public health authorities of patients with reportable health conditions remains a national problem. Hospital reports of ELR and SS data to public health agencies do not satisfy these laws. It is therefore crucial that the MU programs provide a framework that incentivizes the development of EHR functionalities that are necessary for case reporting.

Traditionally, public health reportable disease surveillance has depended largely on information arising from the use of healthcare services, healthcare providers, and interviews with individuals, which are then hand-keyed into our surveillance systems. These data are foundational in case and contact investigations for immediate disease control purposes, or in combination with census or other data to determine event rates or, in combination with other measures, to provide further context for understanding patterns of health or disease. This Objective would substantially improve reportable disease case ascertainment and promises significant efficiencies for data submitters and public health. For example, in the current environment, public health must complete additional follow up with EEs and EPs, often involving multiple phone calls with clinical care staff following the receipt of an ELR to obtain additional necessary case specific information, such as the medications given, relevant travel or exposure history collected during the patient encounter, and collection of information about any provider identified contacts in need of prophylactic treatment. This requires clinical care provider time and interaction that could be greatly reduced or eliminated if the information was able to be sent electronically to public health, thus allowing providers to spend more time conducting disease treatment activities and allowing more time for public health to spend on disease control activities. CSTE acknowledges that while case reporting utilizes EHR functionality required in Stage 2, additional effort would be required for implementation. Much progress has been made in this area: for example, CSTE has collaborated with the CDC and other public health stakeholders to develop the Reportable Conditions Knowledge Management System (RCKMS) to serve as a source of information on reporting criteria that can be used by an EHR system to determine when a condition should be reported to public health agencies. Additionally, case reporting models are currently in pilot in some states. Public health has a long history of protecting and handling confidential data and doing so responsibly.

In closing, CSTE wishes to acknowledge the efforts and vision of ONC, the Health IT Policy Committee, and the MU Workgroup to move Stage 3 forward. CSTE is sensitive to demands to reduce the burden of MU compliance for EEs and EPs in Stage 3. We are interested in contributing to the overall process enacted by these groups and recognize their importance to improving clinical care and population health. MU Stage 3 is an important opportunity to support the overarching goals of the Health Information Technology for Economic and Clinical Health (HITECH) Act of improving population health management to serve more than just those that seek care but make “meaningful use” of health data to improve health for all. MU Stage 3 can further the ability for states to implement strong and reliable programs that will benefit hospitals and populations, which results in timelier follow-up and identification of problems in our communities. Maintaining a focus on improving

population health is critical to transforming healthcare and achieving the highest possible value from the public investment in the HITECH Act.

Thank you for your attention to our concerns. We would be happy to address any questions or concerns and look forward to continued partnerships.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeffery P. Engel". The signature is fluid and cursive, with the first name "Jeffery" and last name "Engel" clearly distinguishable.

Jeffery P. Engel, MD
Executive Director