

Comments by David Ross
HIT Policy Committee Meaningful Use Workgroup

I would like to address the specific questions asked by this Workgroup within a general context of a “new public health” functioning to drive continued improvements in the population’s health by using personal health care services optimally and also addressing the other determinants of health. I consider Meaningful Use to be a game-changing concept. It speaks to achieving the important – that is, using technology to make care safer, to assure quality through evidence-based practice and to enable interventions that are proven cost-effective. Meaningful Use is the right concept because it points us at the right targets. The HIT Policy Committee has asked this Workgroup to consider how these important concepts also enable improved population health. Addressing these questions requires that we consider carefully what we mean by population health.

- What policy, legal and/or technical issues do you perceive as barriers to getting to improved population health outcomes?

Policy barriers

1. Funding the individual health care delivery sector to have a role in Population Health
The notion of population health in the U.S. has been assigned fully to government. Should this be the case in a reformed health system? Should the “New Public Health” be a partnership among the many parties that influence the determinants of health? The United States organizes health activities in a manner that is different from most other parts of the world. We choose to assign those services provided to an individual as belonging to the private practice of medicine and only for those who cannot pay to a publically or charitably provided source of care. Thus, charity care or low income care gets assigned to government by default and is sometimes referred to as public health. A consequence of the strong attention to individual health as a commercial exercise, we have segregated the notion of activities that advance the health of all people to government, which we also call public health. And, in many places we have left the charity care burden to the public sector, so that has implicitly folded into the meaning of public health, even though it is merely individual health provided by or through government payments. As a country, we have not grappled sufficiently with what we mean by population health and how we finance it. We finance an elaborate array of categorical programs that attend to specific health problems, conditions and diseases that have population impact. For example, we address sexually transmitted infections through this kind of funding, and this funding goes to public health agencies to support their case investigation, patient follow-up, epidemiologic analysis and reporting. We treat the private care provider’s role – the responsibility to notify public health that a case has been found -- as a legal mandate not as a reimbursable service. The consequence of this approach is that many conditions of population health importance never get reported. As we move into an e-health enable health care system, we must

recognize that the costs of interoperability among provider EHRs and public health surveillance systems in a way that current financing does not respect. The categorical disease program funds public health receives tend to hamstring public health agency flexibility in building an integrated information infrastructure. On the private provider side, failure to reimburse for their role in population health forces attention to diseases of population significance to the bottom of the list of their priorities.

In my view, we need to find ways that incentivize the broader health system to pay attention to the population health implications of their actions and even to participate in population health activities. Policy barrier number one is this bifurcated thinking and the consequential approach to financing that inhibits health care providers from becoming actively involved in population health strategies.

2. Public health agency information infrastructure is not population-centered

The Nation's information infrastructure for population health is actually a patchwork quilt of pieces and parts assembled through the efforts of literally hundreds of categorical programs. It is hard in many states to see an integrated information infrastructure where data warehouses support multiple programs, where business processes are automated efficiently to support multiple programs and where the business purpose of the automation focuses on the patient and/or the population. Through Meaningful Use we seek to make patient care more patient-centered. Through Meaningful Use we should also seek to create a population-centered approach to information use.

For example, HRSA's MCHB has provided grants for more than a decade that promote the notion of a "child health profile." This concept is essentially a concept of patient-centered care whereby all information relevant to an authorized provider caring for a child will be available when he/she needs it in a form most useful. The EHR should make this available to the provider. To allow this to happen public health agencies need to integrate the data presently held in multiple population-based information systems and be able to push it to the provider's system in a manner that most helps the child's provider give maximum care. From the provider's point of view, we merely ask "why can't public health tell me everything I need to know about this child in one single, consolidated record?"

This example tells us that achieving the population health impact of Meaningful Use means we must put attention to the challenge of integrating information within the walls of public health agencies such that your public health agencies functions as a singular, standards-based node on the NHIN.

3. The business of population health has not been adequately specified.

Much of public health work is population-based work. Most of this work has never been understood in terms of business process. That is, the work of public health needs to be documented formally in business process terms, modeled and published to enable developers to build into EHRs and other applications the capabilities that will yield that data needed for population health analysis. The HIT Policy Committee needs to state explicitly that population health goals under Meaningful Use will not be attained until we are clearer in stating what the work of population health looks like, who does it, what business rules govern the doing of it, what triggers it and what results when the work is done well.

Newborn screening is an example of where population health progress will require the joint, coordinated efforts of public health and health care. HRSA/MCHB sponsored a national workgroup study that produced a rigorous analysis of the business processes involved in screening, diagnosing and coordinating the care of infants identified to have metabolic disorders, birth defects and other conditions that require immediate treatment and usually life-long care. This business process analysis reveals the intricate and complex nature of care coordination, as well as the ways public health agency programs, social support programs, educational programs and medical care providers must interrelate to produce optimal health for these kids. More attention to these kinds of problems will be essential if we are to realize the promise of meaningful use.

- Are there any specific approaches to data standards, aggregation and/or infrastructure that would help achieve better population health outcomes?

1. HIT Policy Committee should support and encourage public health inter-sectoral collaboration.

Several years ago the public health community formed the Joint Public Health Informatics Taskforce (JPHIT) to provide an ongoing mechanism for identifying informatics issues that would require uniform action, such as adoption of a specific data or system standard, across all professional domains of public health. Our Nation's federated approach to public health means that states and localities can choose to do whatever they feel is in their local interest to do when it comes to public health. Consequently, we must place a high value on effective collaboration if we expect to see population health gains made on a national basis. JPHIT has shown the public health community that it can unify around important issues. JPHIT has shown that all components of the public health enterprise -- local and state, epidemiologist, laboratorians, vital registrars, and informatics specialists -- want to step up to the Meaningful Use plate.

2. Syndromic surveillance standards needed.

Public health agencies and other groups, such as the International Society for Disease Surveillance, are working closely together to understand the best ways of gathering syndromic data useful to response at all levels of the public health system. The HIT Policy Committee should request regular briefings on progress being made to resolve important issues, such as whether a standard message for syndromic data can be found and what it will take to implement it throughout the public health system.

3. Certification of public health systems.

Public health systems, such as immunization registries or cancer registries, may need to be certified in line with EHR and HIE certification. The HIT Policy Committee should address this issue directly, possibly by requesting that the CDC through its Public Health Informatics and Technology Program Office develop a decision white paper on the subject and make recommendations. Because of the decentralized nature of public health agency practice, we presently delegate to state and local agencies the challenge of remaining standards based. In the evolving world of continuous upgrades to e-health infrastructure the public sector will be challenged to remain in compliance with national standards. Certifying systems is one way to bring essential public health information utilities, like immunization registries, into compliance with standards. Keeping them in compliance needs to be addressed also.

- How should PH contribute to the concept of a learning health system?

Public health is well positioned to serve as a neutral convening body to promote continuous learning. Through communities of practice, governmental public health could support the multiplicity of actors needed to improve population health. For example, public health agencies could support regional collaboratives, through a community of practice format, to promote understanding of best practices in healthcare facility acquired infections, how to integrate child health information in ways that improve hearing screening or newborn screening, or how best to expose population-based information on the impact of over prescribing antibiotics to frontline providers of care. The list can go on and on where progress in population health will result only from where public health and private healthcare delivery work jointly to advance evidence-based practices and practice-based learning.

- What future state might we envision as public health agencies gain access to population health information to drive improved health outcomes?

As health information exchanges grow in number and breadth of their population coverage, we should anticipate the need for role shifts between the HIE and public health agencies. Public Health agencies may need to shift their emphasis from data gathering to data

analytics and use of the data for population health policy purposes, while seeding the role of data gathering to the HIE.