Meaningful Use Workgroup
Subgroup #4 – Population and Public Health
Draft Transcript
May 16, 2012

Roll Call

MacKenzie Robertson – Office of the National Coordinator

Good morning everyone, this is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup, subgroup #4, improved Population and Public Health. This is a public call and there will be time for public comment at the end. The call is also being transcribed so please be sure to identify yourself before speaking. I'll now quickly go through roll and at the end, ask any staff members to also identify themselves. Art Davidson?

Arthur Davidson - Denver Public Health Department - Director

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Art. Charlene Underwood? Charlene, I believe you're on the line.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes, I'm here, unmuting.

MacKenzie Robertson – Office of the National Coordinator

Unmuting, thank you. Amy Zimmerman? Marty Fattig?

Marty Fattig - Nemaha County Hospital (NCHNET)

Here.

MacKenzie Robertson – Office of the National Coordinator

Hi Marty. Yael Harris? George Hripcsak?

George Hripcsak – Columbia University

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks George. And if there's any Meaningful Use Workgroup members on the line, if they also just want to identify themselves.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

This is Leslie Kelly Hall.

MacKenzie Robertson – Office of the National Coordinator

Thanks Leslie.

MacKenzie Robertson – Office of the National Coordinator

And are there any ONC staff on the line?

Michelle Nelson- Office of the National Coordinator

Michelle Nelson.

MacKenzie Robertson – Office of the National Coordinator

Okay, thanks Michelle.

James Daniel – Public Health Coordinator – Office of the National Coordinator

Jim Daniel, too.

MacKenzie Robertson – Office of the National Coordinator

Oh Jim, hi.

Arthur Davidson – Denver Public Health Department – Director

Okay, great. Well thank you…

Amy Zimmerman – Rhode Island Department of Health & Human Services

Art, I'm here also, Amy Zimmerman.

Arthur Davidson – Denver Public Health Department – Director

Okay, welcome Amy, and thank you MacKenzie. I want to first start out by thanking Jim Daniel and Michelle Nelson for carrying on in my absence in organizing this session, the first of the listening sessions for Subgroup 4, Population and Public Health, and we're pleased to have five expert speakers today, who have joined us, and we'll have two other listening sessions on the 22nd and the 29th at the same time, from 10-11:30 in the morning, Eastern time, with additional speakers at the next two sessions. The purpose of these listening sessions is to inform the Meaningful Use Workgroup on opportunities for us to advance in Stage 3 from where we have started in Stage 1 and the proposed efforts in Stage 2. Our efforts are focused on trying to address certain functions; how to improve real-time impact of the information at the point of care, how to reinforce and empower the patient partnership, how to leverage emerging data sources that we see coming, how to compliment the efforts of clinical decision support and then finally, how to use the data for population health assessment analysis and surveillance.

Our invited guests today were asked to address several questions, and I'll just read those to you. What are you working on that can help inform Stage 3? What barriers have you faced? What infrastructure, policies, tools, training, communication is needed to make this successful? And what strategy would you recommend for us to get there? And finally, sorry, one more is, what is the impact of these activities in the cost economic savings? So we have five invited guests, not all of them are present at this time, but we expect the last one will arrive before her talk.

Eileen Storey – National Institute for Occupational Safety and Health

Art, I'm here. It's Eileen Storey.

Arthur Davidson – Denver Public Health Department – Director

Oh hi Eileen, thank you for joining us.

Eileen Storey – National Institute for Occupational Safety and Health

Okay.

Arthur Davidson – Denver Public Health Department – Director

So, I'm going to read the bios in alphabetic order, that's not the order that Jim will introduce them. John Eichwald. John Eichwald is the Team Lead for the Early Hearing Detection and Intervention Program within the National Center on Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention (CDC), in Atlanta. He oversees the EHDI activities including collaboration across government jurisdictions and organizations to develop standardized procedures for newborn screening, tracking, surveillance, data collection and management. John has more than 30 years' experience in the field of pediatric audiology from his early career at the Utah Department of Health to endeavors with the Academy of Pediatrics and the American Health Information community. More recently, his work with the quality research and public health domain planning and technical committees of the Integrating the Health Care Enterprise and the S&I framework Public Health Reporting Initiative Workgroup.

Next is Seth Foldy. Seth Foldy is also from the CDC. He is a senior advisor for Public Health Practice and the Public Health Surveillance and Informatics Program Office. Dr. Foldy joined the CDC after many years as a family physician, medical educator, local and state health official. He has led electronic health surveillance and communication initiatives at the local, state and national levels, and co-founded the

Wisconsin Health Information Exchange and has advised several other e-health plans and HIE business plans and co-authored the e-health initiative study on HIE Sustainability. At CDC he helps local, state and federal agencies adapt to the opportunities and challenges of the HITECH Act Meaningful Use EHR Incentives Program and supports Public Health Informatics standardization shared services, research and development and evaluation.

Next we have Jim Kirkwood, who is a Senior Director of e-Health at the Association of State and Territorial Health Officials, ASTHO, where he oversees work on Public Health Informatics activities supporting state and territorial Public Health Agencies. He has been involved in the BioSense re-design and provides guidance to states on federal Health IT activities and assesses state readiness to accept data from Meaningful Use certified Electronic Health Records. Prior to ASTHO, he worked at New York state government for 10 years in the State Legislature, Public Health Lab and the Health Department's Bureau of Communicable Disease Control.

Next we have Rebecca Kush, who is a founding president and CEO of the Clinical Data Interchange Standards Consortium, CDISC. Dr. Kush has over 30 years' experience in the area of clinical research, including physicians with NIH, academia and global biopharmaceutical companies. She earned a doctorate in physiology and pharmacology from University of California, San Diego School of Medicine. She currently serves on the NCI advisory board and represents research on the HIT Standards Committee.

And lastly we have Eileen Storey, who's also with CDC and Chief of the Surveillance Branch, Division of Respiratory Disease Studies at the National Institute for Occupational Safety and Health, NIOSH, at CDC. She leads NIOSH's efforts to ensure the integration of information regarding patient work history and the EHR, to improve patient care and to support public health surveillance efforts. Prior to joining NIOSH, Dr. Storey was on the faculty of the University of Connecticut where she was a professor of Medicine and Chief of the Division of Public Health and Population Sciences. She is board certified in internal medicine and occupational medicine.

So with that, once again I want to thank Jim Daniel and Michelle Nelson for putting this panel together and I'm going to turn it over to Jim to help us moderate through the session. Each of the speakers has been informed that they will have ten minutes to present, so that we'll have time for questions. At the end of this presentation, this listening session, there will be an opportunity for public comment. So with that, Jim, I'll pass the baton to you.

James Daniel – Public Health Coordinator – Office of the National Coordinator

Thanks Art, and my job today is mainly to make sure that we stay on time and remind the speakers that they each have ten minutes, so, I will be giving you a warning if it looks like you'll be going over, and we'll go ahead and get started with Seth Foldy, who's going to be talking about Public Health Informatics and the Public Health Reporting Initiative.

Seth Foldy – Center for Disease Control & Prevention

Thank you very much. Can everyone hear me?

James Daniel – Public Health Coordinator – Office of the National Coordinator

Yes Seth.

Seth Foldy – Center for Disease Control & Prevention

Alrighty. So I was asked to take a slightly different tack from the other speakers in that people were interested in hearing some summary of lessons learned so far, as well as some of the activities that CDC has been engaged in. I thank the workgroup for their invitation and I especially thank the workgroup for your commitment to building disease and injury prevention into the three stages of the EHR incentive program. Centers for Disease Control and Prevention is pleased to participate by identifying major health problems and evidence-based interventions that would be applicable to the program, by aligning the objectives and specifications to the practical realities of both state and local health departments which they most often impact, and finally to offer practical support to those health departments at problem solving in Public Health and Population objectives.

I'm going to review very quickly why Public Health is important, why Public Health and Population objectives are important, lessons from the first year of Stage 1, although I will largely leave that aside, I've submitted written materials that can be referred to by the committee, discuss very quickly four domains of

interaction between health departments electronic health record, talk briefly about the Public Health Reporting Initiative and what it may produce in time for Stage 3 of Meaningful Use and to help set the stage for some of the other speakers and innovators who will be talking after me.

Just a few words about, is Meaningful Use for Population and Public Health important? Many of the items that were used in Stage 1 of the Meaningful Use regulations have been deployed very successfully and used to great effect in public health agencies, for example, in my own last state of Wisconsin, we relied very heavily on syndromic surveillance to give us some assessment of what was going on during the H1N1 flu epidemic. We had thousands of laboratory reports coming to us from electronic reporting. The fact that they were electronically reported allowed them to be pressed into immediate use by epidemiologists and public health nurses, allowing those professionals to do what they do best, intervene and perform studies.

We used the immunization registry to get a sense of who had been vaccinated and who had not and in a state like Wisconsin, where there is a lot of contributions to the immunization registry by providers across the state for all vaccinations, we've seen the rise in provider contributions to the registry be paralleled by an increasing number of children vaccinated statewide. In other words, people are using the information and moving our vaccination adequacy up rapidly as a state, in my former state of Wisconsin. So, that is to say, what we have done has effect. What remains to be done are a few things. The first is closing the loop from information collection to public health to sending information in a useful form back to the clinicians through the electronic health record. Perhaps the most important example of this might be to make a . . . to have the electronic health record be able to access the lifetime vaccination history for an individual and to make clear to the healthcare provider what vaccines may be lacking for that person.

Other promises that we might want to see in Stage 3 is potentially adding additional types of public health reporting so as to further increase the cost savings that result from changing manual reporting practices by healthcare providers to automated practices, thus reducing long term cost. It is important to realize that the impact of these activities often fall on state and local health departments and that the HITECH Act, as people know, provided only very slight funding for statewide and local public health systems to consume, standardize reports. What this means is, the savings and benefits from electronic information exchange with public health might be delayed somewhat, to the extent to which the Health Departments are slow to transform this reusable electronic information into faster public health benefits.

As we've heard one state health official say about the last few years, the Meaningful Use Program was the best possible event at the worst possible time, given the fact that so many local and state health departments have suffered budget and personnel reductions; however, this does not change our understanding that over the long run, efficient transmission of structured electronic information between public health and healthcare as fueled by the electronic health record incentive program, is a very important, long term tool for improving the nation's health and reducing costs.

Some of the things we've learned from Stage 1, public health objectives have actually involved some of the most challenging and advanced levels of information exchange of any of the objectives in the Meaningful Use Rule. Thus, in fact, some of the lessons learned by Public Health in Stage 1 will be very important for others, as in Stage 2 and 3 of the Meaningful Use Rules, more and more activities are performed using information exchange, such as the transfer of care. It was necessary for us to have a concerted campaign with CDC and professional organizations to offer education, to allowing grant programs, to deploy tools and to deploy technical assistance to help state health and metropolitan health jurisdictions develop the capacity to consume standardized messages from meaningful use. We've seen considerable uptake in the first year and we are confident that this will continue. Virtually every jurisdiction offers one or multiple options to healthcare providers to submit electronic information and we have also initiated a technical assistance team, with the assistance of CMS and ONC, to help learn about situations where providers are having trouble making the connection to public health. What we've learned there is that many such situations can be resolved using existing solutions that have been already developed elsewhere, or, with the correct interpretation of policy, some of the other problems are being logged and addressed in suggested changes to regulation or technical solutions.

One thing that is important for the Meaningful Use Workgroup to consider over time is that onboarding providers for public health reporting, is a fairly labor intensive activity and thus it may be important in Stage 3 to try to minimize disruption to existing, successful ongoing submission of information by introducing new specifications down the road that might cause a need for re-onboarding of existing public health submitters. Many of the issues confronted by health departments in terms of receiving meaningful use information in Stage 1 do not relate to the actual use cases of electronic laboratory reporting or

immunization information system reporting, but to uncertainties about health information exchange strategies many states were expecting to rely fairly heavily on their state or regional health information exchange organizations to provide the necessary connectivity with healthcare providers. Others are adapting to the more point-to-point solutions . . .

James Daniel – Public Health Coordinator – Office of the National Coordinator

Just a two minute warning Seth.

Seth Foldy – Center for Disease Control & Prevention

Two minute warning. And then a third possibility, of course, is to develop national receiving systems like the BioSense 2.0 syndromic surveillance system to simplify receipt. The ongoing uncertainty about which of these solutions is sustainable and scalable in the long run for public health has impeded public health uptake of electronic exchange with health records.

The Public Health Reporting Initiative is focused on trying to see if it is possible to take multiple types of public health reports, that is to say, reports initiated from the healthcare provider and sent to a health department to see if they could potentially be merged into a single specification. It has been a community driven initiative, more than 34 different user stories across multiple domains have been submitted and what we have learned is that a single public health button, or a single push of all information needed to public health through a single specification is unlikely to come about, that the most likely possibility for the future is to iteratively develop specifications for a modest number of public health report types, that could then be expanded over time. At this point, it is too early to predict how many types of public health reports might be consolidated into a Stage 3 ready specification and also whether or not clinical document architecture or HL7 message specification would be more feasible or whether, in fact, we might need to develop specifications for different reports using each of those methods.

Candidates under consideration include several of the report types you'll hear about from other speakers today and in your next two listening sessions. I think as this group sets it goals, looking ahead to Stage 3, the workgroup, you can certainly feel very proud if you are able to accomplish many of the following. The first of which, to close the loop of immunization information system reporting to include communication back from immunization information systems to the electronic health record, including providing a patient sectorate view of immunization history and clinical guidance about missing vaccinations.

Second of all, to supplement the Stage 1 and Stage 2 public health reporting objectives with new reporting specifications that are practical and efficient for both providers and public health agencies to provide. A third is to advance the capability of public health agencies to query electronic health records for aggregate, de-identified information about communities and potentially for the retrieval of information about individuals, such as in case reporting, when authorized by public health law. Of course that will depend on the advance of the health query specification and the practicality of the use of that specification. A fourth is to improve the capture of health information in the electronic health record issues like family health history, occupational history, environmental history, sexual history and pregnancy status, are critical both for public health and for good medical care; they've been problematic even in the paper record, and considering creative uses for how that information can be captured in the electronic health record, both for public health and clinical use, would be a worthy goal. And finally, to keep our eyes on the long term, on whether or not patient health records or other modalities of patient information actually might be able to be a partner in some of this data capture.

James Daniel – Public Health Coordinator – Office of the National Coordinator

Okay…

Seth Foldy – Center for Disease Control & Prevention

Thank you very much.

James Daniel – Public Health Coordinator – Office of the National Coordinator

Oh great, I was just about to stop. Okay thanks Seth for that great presentation and we'll move right along with Jim Kirkwood, who's going to be talking about health department readiness.

Jim Kirkwood - Senior Director e-Health at the Association of State and Territorial Health Officials

Thanks Jim. This is Jim Kirkwood, I'm Senior Director e-Health at ASTHO, and I'd like to thank the workgroup for inviting us for the series of listening sessions on public health and public health data exchange. So, one of the things I was asked to talk about was the current readiness and capacity for public health agencies to receive data for meaningful use transactions. I think, as Seth said, this number… the number of states able to receive data and start pregame testing and put into production data exchange with providers and hospitals has increased dramatically since about two years ago, when CDC associations such ASTHO, NACCHO, CSTE, APHL and International Society for Disease Surveillances began the process of getting their members and state ready for meaningful use.

For immunization, this data coming from December from one of the reports for cooperative agreement recipients from the CDC, 43 states are testing for meaningful use in either HL7 format and that data, going back, currently about half that number can receive in only HL7 2.3.1. As for electronic lab reporting, and this is information from another cooperative agreement reporting process, was that about 28 states are testing with hospital labs in HL7 2.5.1. So, as Seth said, this is a really great increase and I think in no small case due to, I think, the work of communications from the CDC, ONC, others and the coordination among states and their associations. Fewer states are testing for meaningful use in syndromic surveillance, but there is as Seth said, a BioSense 2.0 system that's available for public health agencies to use as their own system. I think one of the reasons for that is that as syndromic surveillance systems were developed, they had been less standardized and they are much younger I think and there are fewer implementations in more standardized way among the states and local health departments.

Going on to the next slide, I think one of the barriers is, some of the big barriers are funding obviously, budget cuts have been a real issue for states and I'll get into a little bit of that, for states and local health departments later, but, another barrier has been sort of message quality. So, as Seth said, that the onboarding process is a relatively long process for bringing on a hospital or provider to send data to the health department to ensure that the data has high quality and are ready essentially to be used. There is an implicit assumption that when data… when a message came from certified technology, that they would be sort of, more ready to go, but I think there's a lot more… people are seeing a lot more work to get providers and the hospitals sort of ready to send that data, to a proper format.

I think another barrier has been accessing 90/10 matching funding from CMS. CMS put that funding out as part of its work to accelerate meaningful use data exchange. I think that one of the things that has been a result of the budget cuts for people has been the lack of state matching funds to support that activity. So, even if the coming up with the 10% to match the 90% is difficult right now in a lot of state and a lot of local health departments. I think as this moves on, I think if there is an appropriate consideration of in-kind funding that states already provide, whether it's not just cash up front, but work that's already going on with the states that's paid for under state budgets and that would be greatly helpful, I think, for a lot of state health departments.

I think also, and it's not only a barrier so much as the interest of public health agencies in Stage 1 and bidirectional exchange, I think a lot of health departments want to increase bidirectional exchange because, for things like the Vaccine for Children Program, people want to get information so there's going to be more provider ordering and more back and forth with the immunization registries. So, as a provider comes on, the health department wants to do more bidirectional exchange, but of course, the requirements for Stage 1 of Meaningful Use don't really require that, so, it's a slight barrier, but I think it's just getting on the same page and as Meaningful Use goes on, hopefully that will be, sort of rectified.

Strategies to overcome barriers. I think that a lot of states we've heard from are looking to implement one gateway for public health reporting. There have been concerns from provider communities and hospitals that they see a health department as a health department, not a series of federally-funded programs that each implement their own system. So, a few states like New York, Illinois and Michigan are looking to do sort of this one gateway to bring in data and then parse it themselves and send it on to the appropriate programs. I think using a tool such as CDCs MQF to alleviate… this is a Message Quality Framework where a provider or hospital can paste in an HL7 message and parse what the message looks like and to sort of do some of the quality control themselves before they go to the health department; states like Washington have implemented that, has required that for some of their providers and it's helped greatly to decrease the amount of time it takes to bring somebody on board.

I think more specificity and text scripts for electronic health record technology, certification related to public health reporting would be helpful. And I think that something like BioSense 2.0, where it's a shared service among states for where they don't have a system itself can be greatly helpful. I think generally,

data exchange will be helped by states and locals banding together to collaborate and work on these activities that are, essentially might be duplicative across states, but can really be helped by collaboration. I think as it goes to infrastructure needs, the question that we were asked on the next slide is that, workforce I think, at state health departments, 18,000 jobs have been cut since 2008 with data from NACCHO too, local health departments have cut another about 44,000 jobs, too. So, I mean, I'm sorry, 34,000 jobs. So, I think these are very large numbers, so what public health has done in the context of those budget cuts and job cuts, I think has been actually pretty, I think, amazing quite frankly.
I think there's also going to be greater reliance on HIEs to assess data. I think that some states are realizing that more providers and hospitals want to exchange data with the health department, the ability to do point-to-point transactions are going to… and sustain them over time is going to be very difficult, so states are relying on HIEs, or will be relying on HIEs to do some of that work. I think with communication, I think what we've seen since about two years ago, the communication across CDC, CMS and ONC have been great and greatly increased and everybody's on the same page, I meant it's evidenced by some of the work where ONC, CDC and CMS are doing joint calls with public health on a monthly basis, on meaningful use and HIEs. But I think also coordination of funding too will be very, very important; whether it's coordination between HIE funding for states and other programs within other federal agencies.
As we look towards Stage 3, I think there's a significant interest, as Seth said, in defining bidirectional communication for immunization data. I think there's evidence out there and literature saying that bring information back from immunization registries to physicians does help increase immunization uptake, vaccination uptake; the more we can do that, we've seen increases in other vaccine-preventable diseases going on over the past few years. I think this work will greatly help that. I think also, looking at the Public Health Reporting Initiative and the results of that will be very important for public health agencies to see what is feasible out there for reporting in sort of a standardized way across programs, and I think we're sort of waiting to see what happens there. And then finally, with healthcare associated infections, there's a system that a lot of states are relying on, the National Healthcare Safety Network, which could be, I think, might be useful for reporting for healthcare associated infections and it's already a requirement for many states and for, I believe, for other CMS programs related to that. I think with that, I will end and hopefully I'm under the ten minutes.

James Daniel – Public Health Coordinator – Office of the National Coordinator

Thanks Jim, you were a minute and a half under, so we appreciate that and we're starting to get back on schedule. So we'll move right along with Rebecca Kush, who's going to be discussing clinical data interchange standards.

Rebecca Kush - President and CEO of the Clinical Data Interchange Standards Consortium

Thank you and I really appreciate your inviting me to speak today. I apologize in advance if you hear background noise, but I have a flight to catch in a half an hour, so I'm at an airport. But, I'd just like to show the first slide, which is… the next one then, as you all know, it's a very inefficient process right now to have research findings and have them inform clinical decisions and some say this actually takes about 17 years, so, this is the vision that we had when we started CDISC 15 years ago, and the next slide is just a snapshot of what CDISC is.
If you'll show the next slide please, this is… I'm not going to go through all this with you today, but I primarily wanted to explain what CDISC is and establish our standing as a global standards developing organization. So, we are global, open and multi-disciplinary, vendor neutral, non-profit, 501c-3, standards developing organization that's been around for 15 years, primarily focusing on clinical research standards and also how they connect with healthcare standards, and we do have a Liaison A Status with ISO Healthcare Standards Technical Committee 215 and a number of other relationships. We established CDISC to put together global standards because clinical research is really a global activity. So, that's how we started it and, it is becoming a common language for clinical research in the world and also, we support a number of things that the FDA does as a public health and safety agency for protecting and monitoring drug use around the world actually.
The next slide shows you the products that we have produced over the last 15 years and these are the blue circles and these are shown in the context of how they support a clinical research study of any sort; it could be outcomes research or whatever, but, from the planning through the data collection, through data tabulations and statistical analyses and we have several different standards and an XML transport

method, as well as semantics a glossary controlled terminology that is actually housed at the NCI and a bridge model. The purpose of the bridge model is to create a domain for clinical research that also links with healthcare and it makes sure that all the standards that you see on this page are harmonized together and one of them doesn't break another. We are getting into implementations around certain therapeutic area standards such as tuberculosis, cardiovascular, a number of areas that we're working in, and we have something called our Healthcare Link, which I'll talk about in a few minutes; but that's how we link between the research and the healthcare. So, these standards are all ready and in production mode, all the ones in the top three bars and the one in the therapeutic area standards, we have published out an Alzheimer Disease standard.

The next slide will also show you some of the activities. I should say that all the standards that we produce are open and free, and they're through our website. The activities that I think most relate to what we're talking about today, is a number of things that we've been doing with IHE for the last several years, in a group called Quality Research and Public Health and we have put together several different integration profiles to improve workflow and they are standards based and used to SETA standards as well as some of the other standards. One of them, called Retrieve Form for Data Capture, is in trial implementation status. It has use cases and it has been used, and I'll show you a picture of it on the next slide. It'll make it a little easier to explain, and we use that to create what's called a Clinical Research Document. Can you go back, I'm not quite ready to go on to the next slide yet.

The IHE profiles are several, but the ones I'm mentioning here are the RFD, Retrieve Form for Data Capture and then I'd just like to talk a minute about one called RPE, which is Retrieve Process for Execution, and this actually started with a research protocol, but because they wanted to use it in public health and quality and other purposes, it's been changed to say Retrieve Process for Execution, so it enables a healthcare provider to take a process definition and automate an EHR setting to simplify workflow and to enact quality research or public health activities.

So, if you look on the next slide, this is just an example of what we have done with RFD. This was done with the HITSP group, which is the last interoperability specification that went through that process and the use case that was defined through HHS and ONC and about 20 different organizations including… and others, was how to collect a high quality core set of research data from EHRs with as little impact as possible. So, as you see here, you can take an electronic health record and it actually pulls an externally managed form into the screen of the EHR, it can prepopulate certain fields and send the forms to the manager of the form, or whoever is the owner of the form and, this particular scenario and use case uses the CCDA and creates a clinical research document from that, and then populates the core data set standard that CDISC has developed, which represents a core set of information that's collected on any regulated research study around the world, and it's called CDASH. So, this is an interoperability specification, number 158, that produces the standard core set of research data that's high quality, it can go through edit checks and do what's needed to support regulated research and it enables what's called 21CFR11 compliant interoperability or basically the research form of HIPAA, and this is what we need to do for a regulated research study.

So, that's an example. It is in use by actually a number of parties. It's been used for reporting safety from Harvard Partners, and there's a slide at the end about that research study. It's been used by the CDC for reporting of H1N1, during that outbreak. It's being used for phase 4 studies. Unfortunately, I think people are still afraid to use it for an actual regulated research study, so if you go to the next slide you can see some of the capabilities that this provides. It provides a dramatic reduction in time; it took the safety reporting from paper-based 35 minutes when doctors would not do it because its elective and it took too much time, to less than a minute and there was significant reporting. It can accommodate eDiaries or patient-entered data, it improves data quality and allows the data that's collected to be more readily aggregated or analyzed because it's collected in a standard format, although it does not make the EHR vendor have a standard format within the EHR, so, it's been endorsed by EHRA and its readily implemented by EHR vendors and it could increase the capacity for research in the US by making it much easier for clinicians to do research.

So, the next slide, I have put my open and honest opinions of the barriers and challenges and these are really my opinions. But, I think there's still a lack of understanding that this simple integration profile that's readily implementable can actually be so powerful and provide the data that we need from EHR in a simple way, and in a format that's easily analyzed. I think that we need to appreciate varying use cases, a lot of people think if you just have enough data then you can find your answer, so, there is certainly a use case for that. But, I think there's also a use case for obtaining smaller amounts of high quality data in

some cases, where we really need a different method, and that would provide this method. I do think patient privacy and protection is an issue and that providing some more universal consent opportunities would be helpful.
Biopharma has a business model of being pretty slow adopters and slow to change, it's taken 20 years for them to adopt EDC, but this is an opportunity to leverage that and connect their EDC methods with EHRs. There's still a fear of regulatory repercussions if the data may not be accepted for a regulated study by FDA. The academic model isn't so conducive to data sharing although there are lots more data sharing meetings now on how to make this happen and I think there's a need to communicate this value more broadly and influence the future research for population and public health. And I think that, I'm not sure if there's one more slide or not.
The last two slides that I put in here are just to give you a few more figures and some references and they're kind of back up and I don't need to go through them today. But, there's one on the ASTER study AE reporting that has publications that are available on this study and then I'd just like to recognize the fact that a lot of patients are now entering data, on the next slide there's an article sited by Sharon Terry about… that's a build slide, so if you could build it please. The last build is an article by Sharon Terry about participant ownership of clinical trial data, and I think this is a really important thing to recognize, that patients are entering more and more data themselves and if we can collect it in the right formats, and the right ways, we can really leverage that information. So, that was my presentation and I will not be around probably when you go into the Q&A, and so, I don't know if there's time for a Q&A now, or do you just want to collect those and I can respond to them later. But, that was then end. Thank you.

James Daniel – Public Health Coordinator – Office of the National Coordinator

Thank you very much Rebecca. Art, did you want to stop and ask Rebecca any questions before we move on? We are pretty much on schedule if you wanted to stop and ask her a couple of questions.

Arthur Davidson – Denver Public Health Department – Director

Becky, let me just ask you quick question, since you will be gone and we will collect some questions and then pass them along to you afterwards. Thank you for your presentation. Has the… since you are representing research in the HIT Standards Committee, have there been discussions there about how this might apply beyond this Biopharmaceutical approach to research, but using CDISC more broadly in the EHR? I mean, has that come up in the discussions there?

Rebecca Kush – President and CEO of the Clinical Data Interchange Standards Consortium

It hasn't really come up in the HIT Standards Committee discussions, because we haven't talked about Meaningful Use 3 yet. But, it is coming up and it came up at an IOM meeting a couple of weeks ago where ONC sponsored that, and there were some suggestions on how to take it forward, and there's a very big interest in actually doing and having ONC stand behind doing some studies using EHRs. And I think the fact that this method has been used by CDC and others, and we're talking about using it for quality reporting and other information that they want to collect, I believe ONC has some interest in finding a way to do some testing of it with some ideas they have on how to collect some of the quality data and such.

Arthur Davidson – Denver Public Health Department – Director

Great. Thank you. Maybe I'll ask… any of the other members of the subcommittee or the workgroup interested in asking a question of Becky before she may have to leave? Okay, well, we'll send…

Rebecca Kush – President and CEO of the Clinical Data Interchange Standards Consortium

I'm happy to respond by email or however you want later, and I apologize that I can't stay on longer. Thank you.

Arthur Davidson – Denver Public Health Department – Director

Thank you for joining us and for your presentation. I did enjoy that. Thank you.

James Daniel – Public Health Coordinator – Office of the National Coordinator

Yes, than you very much Rebecca, that was an excellent presentation. We'll move on then to John Eichwald, who's going to be talking about Early Hearing Detection and Intervention.

John Eichwald – Centers For Disease Control and Prevention – Team Lead for Early Hearing Detection and Intervention (EHDI)

Great. Thank you. First of all I want to thank the workgroup for the invitation to speak today. I am the Team Lead for Early Hearing Detection and Intervention at CDC. We affectionately refer to this as EHDI. What I thought I would do first of all is provide some background on EHDI. I know there are members of the workgroup that are very familiar with it, but, there may be other members and members of the public that are not as familiar with the program.

So, EHDI is a condition being… hearing loss is one of the conditions that's presently being recommended for scrutiny in the newborn period by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. It's also recommended for screening by the U. S. Preventive Services Task Force. Next slide. It is a condition that although it's not consider high incidence, if you look at this slide, this points out that hearing loss certainly has a high prevalence compared to other conditions that are being currently screened within the newborn period. The next slide. There are significant health and economic impacts with congenital hearing loss. The negative impacts are basically on the child's ability to develop communication, language, social skills and educational achievement. In educational costs alone, there is an incremental cost in special education of $115,600 dollars per child, based on 2007 values, and we feel that with newborn hearing screening, EDHI reduces the educational cost by about $44,000 dollars, or about 2 million dollars per year.

The next slide. The foundation for EDHI is what we call our 1 – 3 – 6 plan and that is, that every newborn should be screened for hearing loss prior to one month of age, preferably before hospital discharge. Any child that does not pass their hearing screening should be diagnosed no later than three months of age and any child identified with a hearing loss, should receive appropriate intervention services no later than six months of age. Next slide. We've been doing a… EDHI is a Public Health success story. You can see on this slide that over the last decade, we have increased from less the children in the United States being screened for hearing loss, the latest data reported to CDC suggests that nearly 98% of the newborns in the United States are now being screened. Again, a very good Public Health success story. Next slide. In calendar year 2010, we diagnosed… we have confirmed a documented diagnosis of over 5,000 infants, documented with a hearing loss and we know that 70% of those diagnosed before three months of age, which is actually meeting our healthy people 2010 target. Although if you look at where we do feel we have significant success, if you look at the chart, you can see this big red piece of the pie where nearly… a little over one third of the children that do not pass their hearing screening, we cannot document that these children have received diagnostic evaluation, and we do believe that electronic data exchange among clinical care providers and public health can have a meaningful impact on this issue. There's very few primary care providers currently have ready access to screening results or to clinical guidance for assisting care coordinators with infants suspected to have hearing loss, and so we are looking at electronic health records as one of the ways of making an impact.

Next slide. To try to start answering some of the questions, in terms of what we were asked for today's presentation, EDHI… newborn hearing screening is really one of the first domains in an individual's lifetime that requires information exchanges between clinical care and public health and a newborn electronic health record creating at birthing facility, that would be interoperable with an EDHI information system, could lay the foundation for population based surveillance and meaningful coordinated care among primary care providers and public health programs. EDHI information systems are relatively simple, or not too complex, that we have actually a fairly small number of data items, particularly compared to other public health programs such as immunizations, reportable and notifiable diseases and other newborn screening programs.

It's relatively new, as you saw by one of the slides, we've been in existence for just about a decade, so many of these information systems have been developed just during the last decade. Even though we have this, we're sort of narrow, we have this very broad impact and that is, that every occurrent birth is being followed with an information systems. We are advancing both public health and clinical quality measures, we're promoting clinical decision support and we're trying to align, whenever possible, with public health vital records, so that we can improve our demographics to identify health disparities.

Next slide. We've been moving along, in terms of interoperability, and we've been looking at this both from areas of process, semantics and technical interoperabilities. Next slide. From processing interoperability, back in 2008, we worked with the American Health Information community in developing a newborn screening use case. In 2012, we worked with the ONC S&I framework to work on use case for hearing screening, in terms of harmonization. In 2009 we did interoperability specifications with HITSP

and again, we've done work on implementation guide, with S&I framework. Implementation specifications between 2010 and 2012, we've been developing IHE content for health, specifically for EDHI and for reference implementation, we've been doing connective testing through IHE, both in 2011 and 2012.
Next slide. In terms of semantic interoperability, the National Library of Medicine has developed National Newborn Screening Codes and Terminology Guidelines. I believe this was launched in the fall of 2009 and EDHI is moving towards a national consensus around the data elements, the vocabulary, value sets and messaging document specifications nationally. Next slide. We also have been working in the area of technical interoperability. We're definitely supporting clinical document architecture and much of that is about our quality measures that we're currently developing. Next slide. And speaking of some of those quality measures, in August of last year we submitted several quality measures to the National Quality Forum. You can see that we also had one that was also submitted and endorsed last year by NCQA and we're continuing to push these forward and I'll talk a little bit more about those briefly.
Next slide. One of those measures, NQF #1354, which is hearing screening prior to hospital discharge, has been proposed for Stage 2 of Meaningful Use, for hospital reporting for clinical quality measure, beginning in fiscal year 2014.

James Daniel – Public Health Coordinator – Office of the National Coordinator

Just a two minute warning.

John Eichwald – Centers For Disease Control and Prevention – Team Lead for Early Hearing Detection and Intervention (EHDI)

Thank you. Next slide. We're also pushing forward an early hearing care plan for clinical decision support and that contains many of the codes that we're trying to push forward and so this really is a support of clinical decision support. Next slide. We've demonstrated this over the last two years, at the HIMSS interoperability showcase and at the Public Health Information showcase in Atlanta in 2011. Next slide shows the use case that we presented in Orlando in 2011, where we were capturing data from Labor and Delivery, combining that with the screening results in the nursery, turning that into the early hearing care plan that we could then move forward into a medical home. This slide does show that we use that hearing care plan to develop personal health records, but that was not tested or demonstrated. Next slide down shows the use case that we demonstrated in Las Vegas this year at HIMSS, and this really was aligning much more with the vital records, where we were actually combining information, capturing information one time, at Labor and Delivery, moving that data forward to public health, both for national recording for NCHS, but also taking that information and using it for EHDI and providing that EHDI into primary care for the pediatrician to reuse that early hearing care plan.
Next slide. Our next steps is that we're moving Quality Measure Execution through IHE Quality Research Public Health, that will be in public comments coming up next month and this content profile is going to demonstrate how the HL7 QRDA Standard to collect newborn hearing screening measurement data in a clinical document architecture, CDA document, will allow computer systems to calculate our newborn hearing screening care measures that are defined electronically, using EHL7 H2MF, human and machine-readable standards. We're going to continue to move forward moving our quality measures forward, we're going to be field testing. One of our measures that has time-limited endorsement, we're going to retool to – and demonstrate at the HIMSS interoperability showcase. And with that, I'll finish up with my last slide, and I want to thank everybody again, the workgroup again. Thank you

James Daniel – Public Health Coordinator – Office of the National Coordinator

All right, thanks very much John, and we'll move right on to Eileen Storey, who's going to be talking about the National Institute for Occupational Safety and Health.

Eileen Storey – National Institute for Occupational Safety and Health

Thank you. Can you hear me?

Arthur Davidson – Denver Public Health Department – Director

Yes.

Eileen Storey – National Institute for Occupational Safety and Health

So, thank you for this opportunity to speak with you again about incorporating occupational information into electronic health records, and the opportunities that this raises for Meaningful Use of electronic health record systems. I'm here on behalf of Dr. John Howard, whom you invited, the Director of NIOSH, and with me on the phone in Cincinnati is Dr. Terry Schnorr, Director of the Division of Surveillance Hazard Evaluation and Field Studies, and here in Morgantown with me is Captain Margaret Filios, who co-leads this effort across NIOSH for electronic health records.

When this committee considered this issue back in 2010, you commented on the evident importance of work in health, and you challenged us to demonstrate that the collection of work information was feasible and could be made useful in the electronic health record. We have been working hard to meet this challenge and hope that occupational information will be incorporated as essential data in Stage 3 of Meaningful Use. Next slide. I need to have a disclaimer that if I note any specific products, which I'll try not to do, or cite some websites, which I will do, that we don't take responsibility for those. And I have one more disclaimer, just press, yup, and despite the fact that I'm representing the Institute today, I am speaking for myself. Next slide.

What I'd like to do is just briefly review the desired outcomes that we hope to see with successful incorporation of occupational information into the electronic health record. Major findings of an Institute of Medicine Committee report that we have found extremely helpful, that came to us in 2011, and then to specifically address the questions that you posed to us today. Next slide. So, we have two major domains where we're looking for changes by incorporating occupational information. One is to, in the clinical domain, which is to directly improve clinical care. Having occupational information visible to clinicians will improve recognition of links between work and health. It will support correct diagnoses that are currently being missed. It will support appropriate treatment and care management when work is playing a role in health, or lack of health. It will support disability management and improve matching patients back to work that they can, in fact, accomplish, and it will support intervention on risks at work. In addition, there is a major public health role, which is to support sentinel case identification and reporting. Currently many states have required reporting to state Health Departments or Labor Departments with occupational injury and illness cases, but that is happening rarely, and only with specific interested providers. Such sentinel case recognition supports co-worker protection. Next slide. In addition, with occupational information, we would be allowed to track trends both within clinical populations cared for by clinical groups and within occupational groups by aggregating data across clinical groups. This will provide opportunities for intervention at a population level, identify old and new risks and also track patterns of disease and transmission, infectious diseases as they move through work places.

Next slide. Since our meeting with you in 2010, we asked the Institute of Medicine to study the question, and they provided us with a letter report in September of 2011. The charge to the committee was to evaluate the significance, whether or not there were potential benefits to individual and public health by incorporating occupational information, to look at the current environment and see whether it was supportive of this effort to address technical issues and to suggest next steps for NIOSH. Next slide. This committee was a mix of occupational health professionals, but importantly, included people with extensive experience and expertise in health systems and health IT, who did not come with a background in occupational health, and it's of great significance to us that they found that incorporation of occupational information in the electronic health record could contribute to fully implementing Meaningful Use of electronic health records, both through improving individual care and through improving population health.

And the next slide, of great importance to us as well, is that they found this to be entirely feasible and they suggested four data elements that could be incorporated right now which include occupation, industry, work-relatedness and employer information, and they suggested that we work on developing approaches to incorporate more detailed exposure information as time moved on.

Next slide. So the questions that you have posed to all of us today, we've been reviewing. Next slide. And the first question, what are we working on that can help inform Stage 3? There are four major areas of work in which we're participating now. The first is participating in the development of standards related to work information. The second is demonstrating how to collect and structure work information in the record, developing tools to enhance the value of that work information once it's collected and working with stakeholders who are very interested in this, independent of us, to clarify what the goals should be and what the message should be.

Next. With regard to standards development, we're working with the CDC to make sure that the PHIN VADS coding systems reflect the dominant coding schemes in use in the United States. We have participated in developing an occupational health domain in the HL7 public health functional profile release 1.1. We are now working on the functional model release 2. We're developing public health case reporting standards with a variety of groups, and we have established a cooperative agreement with the public health data standards consortium to update and establish implementation standards for work information with the IHE profiles. And we continue to find ways to relate occupational factors to other public health domains.

Next. In terms of demonstrating how to collect and structure work information, there's two major areas of work. One is, finding ways that are feasible and not burdensome, to be able to code collected data. The method of collection will always be a text field, and it's basically a narrative discussion between a patient and somebody; it can be administrative staff, it can be clinical staff; but once that is collected, being able to structure the data is going to be extremely important to make it useful. And the National Institute for Occupational Safety and Health has long had a project to develop an auto-coding process for these text fields, and the context for this work in the past has been population surveys such as the National Health Interview Survey and vital records such as death certificates. But the experience was that coding scheme as a manual function is deep and it's a very robust system.

In development now, and we believe it will be available within calendar year 12 for public use, is an auto-coding scheme that has been demonstrated to be useful and viable and the investigators working on this in Cincinnati just recently secured a CDC innovation award to develop methods to link this to electronic health records, and we're very excited about this development, as it will move this entire field forward. In addition, a primary care network in Massachusetts initiated its own pilot work in conjunction with Massachusetts Department of Health, to collect occupational data, and that's given us some information which I'll share with you in a bit. We've also submitted an internal funding request at NIOSH to support pilot work with our partners. We will be putting out a request for information broadly to health systems and to vendors to find out more about the current state of the art of collecting occupational information, and we're working on an information model to guide the work. Next.

James Daniel – Public Health Coordinator – Office of the National Coordinator

The two minute warning.

Eileen Storey – National Institute for Occupational Safety and Health

Okay. In developing tools to enhance the value of work information, there's two pieces to this; one is that the structured work information needs to translate to exposure information and then the exposure information needs to translate to intervention strategies on the part of clinicians and public health authorities. We've had recent work has demonstrated that a database maintained by the Department of Labor, called the occupational information network, or O*NET, can be successfully used to link occupations directly to health risks such as hearing loss. In addition, we've developed a job exposure matrix for chronic obstructive lung disease which is successfully predicting outcomes in pulmonary function.

Next. We've been working with our stakeholders to clarify goals and methods, and they're listed here. I won't go through the list, but there's a broad group of public health and clinical groups, as well as labor and regulatory agencies, who are very eager to see occupational information in the record. Next. Barriers are considerable. The fact that occupational information is not currently considered a core demographic variable is leading us to considerable other barriers. But, that's the first barrier. A consequence is that there's poor visibility of work information during a clinical visit, even in records where their information is collected. It's usually buried in the social history and a physician really needs to search if they want to find this. There's an ongoing perception of the difficulty obtaining work information and there's a failure to preserve data over time so that one's occupation is overwritten if they change jobs.

Next. There are also significant concerns regarding privacy and security that are particular to occupational information and there's limited public health capacity to receive reports, as was described by earlier speakers. Next. The infrastructure and tools that we need; we need specific policies regarding protection of the privacy of data, we need to implement the auto-coding logic in electronic health records. We need to develop clinical decision support tools, we need personal health records tools to collect more

detailed information from patients who know in detail what they work with and what their working conditions are like, and we need to train providers and patients to both collect and use the data.
Next. So our strategies that we recommend are to conduct pilot projects that demonstrate data collection, document best workflow, develop these tools. Next, I want to get to this interesting one. Next. Okay, potential impact. The potential impact on patients and populations is enormous. There's the opportunity to reduce the burden of occupational illness and injury and to improve care management. Next. I want to tell you about this one particular project, because it's very, very telling. The primary care network in Massachusetts, in conjunction with the Department of Public Health, documented occupation at the time of registration; this was by phone, of their patients in the whole year of 2010. 27,000 patients provided current or former occupation and the NIOCCS coding is in process and the reason it's been slow is that they did not collect industry and the algorithm has to be adjusted. But, we do have preliminary data which show links between demographics and occupation.
Next. In this particular community, Portuguese is the most common preferred language, other than English. Next slide please. And among the Portuguese speaking patients, a cleaning maid or housekeeper is the most common occupation among the women, and a construction and maintenance painter is the most common occupation among men. This is very, very interesting. Maids and housekeepers are exposed to a variety of factors that can affect their health, among them, asthmagens commonly used in cleaning products and ergonomic risk factors. A recent NIOSH analysis found that housekeeping is one of the occupations with an injury rate that doubles the national average, and this is with lost work time. So being able to reduce risk in this population would significantly improve their productivity, their income and their health.

James Daniel – Public Health Coordinator – Office of the National Coordinator

We are two minutes over.

Eileen Storey – National Institute for Occupational Safety and Health

Okay. I will simply say that the primary care network does now screen for lead poisoning among its painters. Next slide. And in terms of, next, in terms of the other interventions the Health Department developed specific worker education materials. And the next slide is simply a summary of the burden, and we don't have to go through that, and I'll stop. Thank you.

James Daniel – Public Health Coordinator – Office of the National Coordinator

Thank you so much, I'm sorry that I had to cut you off, I was so interested.

Eileen Storey – National Institute for Occupational Safety and Health

Thank you.

James Daniel – Public Health Coordinator – Office of the National Coordinator

I didn't want to do that, but I did have to save time for questions. So Art, I will turn it over to you to start off our questions for our panelists.

Arthur Davidson – Denver Public Health Department – Director

Thank you everyone who has presented and I'm sorry that Becky can't join us for this part, but, maybe I'll open this up to the subcommittee or any other members from the Meaningful Use Workgroup that may have joined us. Are there any questions in particular for our panelists today?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

This is Leslie Kelly Hall. I have some questions.

Arthur Davidson – Denver Public Health Department – Director

Yes Leslie, please proceed.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yes. You know, one of the things I was very interested to hear about the occupational health and the importance of that information, and something that I did not see in your presentation, and would hope to

learn more about, is occupational health in general has demonstrated for years coordination of care, where assistance didn't exist and there's still disjointed care delivery mechanisms, complicated by the employer participation potentially as well as more patient interaction, primary care and specialists, and I wonder if there are any learning that we could have in Meaningful Use that occupational health in specifically could bring about care coordination.

Eileen Storey – National Institute for Occupational Safety and Health

Thank you for that question. Yes, I think that that's a major piece that occupational health can bring to the table, because there is considerable experience, particularly in the worker's compensation domain. When claims are approved, then that care becomes highly coordinated indeed…

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Not only highly coordinated, but one of the only places where we actually have some sort of required intervention and oversight, so, I would be curious, perhaps in another offline discussion, or to have a specific response on care coordination, as we look towards Meaningful Use 3, and how that could help us.

Eileen Storey – National Institute for Occupational Safety and Health

Okay. Thank you.

Arthur Davidson – Denver Public Health Department – Director

Thank you Leslie and thank you Eileen. Any other questions from this subcommittee or the workgroup?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, this is Amy. And this is actually for… it's based on the ASTHO presentation. If I recall, I remember you mentioning that a number of states are implementing one gateway for public health reporting, and I was curious to know if, I also heard completely separately that there is some work at CDC being done, Seth, maybe you can answer this, by a company named O'Neal, that has been doing something on behalf of CDC around one gateway for data coming in to public health for Meaningful Use? Is there . . . does that make sense at all and is there any elaboration on that?

Seth Foldy – Center for Disease Control & Prevention

This is Seth Foldy. I'm going to have to investigate what you're asking, the particular name is not known to me.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Okay, it wasn't known to me either when someone recently asked me about that, so I just wanted to double check.

Seth Foldy – Center for Disease Control & Prevention

I think what is safe to say is, we at CDC have been figuring out how with very modest resources to address the complexity of multiple types of messages having to be received and managed at the state level, and systems that were developed for CDC to do that some years ago are too cumbersome, we think, for most state efforts. But, I think it's safe to say that with new leadership in our informatics solutions office and operations office, that people are taking a hard look at some of the best ways to try and develop systems that could be either developed on a shared basis by multiple states and stakeholders or produced here at CDC that could then be used by states. But, it's probably a little early to know the direction that will be taken.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Thank you.

Arthur Davidson – Denver Public Health Department – Director

Other questions from, or Jim, do you have a comment regarding Amy's question?

Jim Kirkwood – Senior Director e-Health at the Association of State and Territorial Health Officials

No, I don't think… I hadn't heard about that project at CDC either, but, I think we are hearing that, like I said in the presentation, we are hearing a lot of states are looking to decrease the provider reporting burden. So, that's why they're moving that way. And also, to sort of coordinate among their programs better to essentially share services, use the same sort of services, informatics services, that are bringing data in.

Seth Foldy – Center for Disease Control & Prevention

Yeah I think, it's Seth Foldy again, the burden certainly is on states as well as provider systems to maintain multiple receiving and routing systems within a state.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Thank you. I mean, I fully agree and we're wrestling with the same issue in Rhode Island, but I just wanted to clarify. Thank you.

Arthur Davidson – Denver Public Health Department – Director

Other questions from the committee?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, Art, this is Charlene Underwood.

Arthur Davidson – Denver Public Health Department – Director

Yes Charlene.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I just, and this could go… first of all, thank you for the excellent presentations, I think there's some excellent work that's going on by each of the speakers in terms of your area and moving them to a more standards-based approach. But speaking of that, and this goes from years back, again, one of the experiences that as a vendor we've had in this space, is that you go to the state and for each type of reporting, there's a separate system that you've got to report to and again, you've got to learn the people and the system and that uptake is challenging in some cases, and we actually hear that from our customers that, they're like, get 25 states ready to go, and this is in one of their states that wasn't ready to go, blah, blah, blah.

But looking at the broader picture of public health, is there a vision, kind of how this stuff, all these different piece parts come together; and I know Art always talks about kind of this harmonizing standard and you've made the statement, there can't be one, there can be a couple. But, they're still a lot of piece parts here to sort out. So as a Meaningful Use Workgroup, do we take the one that's most ready, do we prioritize and say, okay, because the newborn one might get us going and establish a record that we can move forward on, yet occupational health might give us the most immediate term impact, which, and it doesn't seem quite as far along as some of the newborn screening work, so how do we think about this in a framework. Some of our customers just say, well, why don't we just kind of blow up the current system and report everything nationally. I can't answer those questions and you guys think about this all the time, so I don't know, I'll kind of class it to all of you. Can you kind of frame, in terms of how we have a vision of how we want to do everything that you're talking about in some sort of sequence and order. Or maybe that's too hard of a question.

Seth Foldy – Center for Disease Control & Prevention

Well, Seth Foldy here, it is the big question and, as members of the panel know, the incentive program and HITECH funding has largely bypassed public health so, what public health is forced to do is figure out what it can offer, largely within existing resources. I think the success of BioSense 2.0 clearly raises the possibility of the concept of cloud-based applications that could redistribute data from a national platform. But that, of course, took two to three years to develop and some of the other use cases, like disease reporting, case reporting are more complex, and so it may take time, and whether it'll be ready in time for Stage 3, is a little uncertain.

We are also working iteratively, so for example, in Stage 2, we do hope to make it more transparent to providers and vendors, what our local constraints in different implementation guides, to make that information readily accessible, accessible in advance so that we can minimize some of, kind of the friction, created by what is unfortunately necessary local variation based upon regulation. So, we can't think… without a major funding program, we don't have a major fix. We're kind of working on modest improvements for Stage 2, and I guess, I'll have to leave it there.

Jim Kirkwood – Senior Director e-Health at the Association of State and Territorial Health Officials

And this is Jim Kirkwood. I think one of the things that people talk… and I've heard this too from vendors, I think we had a discussion or sort of a meeting at HIMSS with Seth and some of the EHR vendors on that, talking a little bit about unnecessary versus necessary variability across dates and programs for public health reporting. I think one of the things that we probably do need to do, and I think that quite a few people are actually interested in, is sort of examining what is this, what is the variability out there, what is the specific variability out there. We hear it a lot, but there aren't a lot of times where we get specific examples.
So, as more and more we get specific examples from folks like you, and we can start to sort of investigate, and then also figure out what is the process going forward, long term, to reduce that unnecessary variability and I think that everybody across public health would be interested in that. But, on the other hand, you also have to remember too that when it comes to public health reporting, state legislatures are involved, rule-making is involved across the fifty states, so there is a lot of variability that can be put in there by law, too.

Arthur Davidson – Denver Public Health Department – Director

Yeah but I think, this is Art, and I'm just wondering whether there's a need for us to revisit this as indeed, states have their individual rights and requirements, but are there some stepping stones that we could take nationally, as Seth pointed out, the BioSense approach; is there something we could do in Stage 3 that would move us toward a transforming process that allows us to make progress without forcing every state to revisit all its laws.

James Daniel – Public Health Coordinator – Office of the National Coordinator

This is Jim Daniel and I just wanted to suggest that maybe we could look to the immunization registries as an example of what should be done. They're doing a great job of working with the vendor community to identify variability across states and to reduce that variability.

Arthur Davidson – Denver Public Health Department – Director

Yeah, right. That's a good example Jim. Thank you.

M

But to some extent that's a slog, it's people working hard to identify what's happening in the current environment. It's not exactly a transformation, I suspect there's going to be a lot of slogging, the question is, is there a transformative option that could be somehow built into Stage 3? I must admit, I am uncertain as to the answer to that

James Daniel – Public Health Coordinator – Office of the National Coordinator

So Art, I wanted to do a time check with you as well. We…

Arthur Davidson – Denver Public Health Department – Director

We have about four minutes left, I think, according to our schedule, right?

James Daniel – Public Health Coordinator – Office of the National Coordinator

Correct. And we do need public comment.

Arthur Davidson – Denver Public Health Department – Director

Right. So, are there any other questions from our committee members or workgroup members?

George Hripcsak – Columbia University

This is George Hripcsak, I just, since we don't have time, the comment is just I don't know how we're going to end up prioritizing, there are just so many individual things we need to address and each of them has their burden that we could solve, but they'd carry on burden of reporting, even if we reduced all the duplicate reporting, and so, I think the challenge is how do we do this in a way that we can address all the different diseases and all the different things we need to do without overburdening the dentist, the chiropractors, the neurosurgeons and the primary care providers in the data collection task. So, that's a challenge. I don't think there's a specific answer, but that's the challenge.

Seth Foldy – Center for Disease Control & Prevention

This is Seth Foldy. Hopefully the public… the S&I process is not an easy one. We hope that the Public Health Reporting Initiative may develop a specification that will be practical to manage a few more reports, and take some of the costs of that manual reporting off the table for future providers and not overly burden them. A big discussion in our community is whether or not we try and incorporate some of the existing reporting streams, like electronic laboratory reporting, like immunization reporting, and integrate it all in one new specification. There, of course, we are fearful that that will create new requirements once again on both vendors and providers and Health Departments, so, there are some discussion areas.

So, I think incremental change, the addition of some more simplified reporting schema, on top of those that were already adopted in Stage 1 and Stage 2, seems to me to be what is realistic for public health reporting, push reporting, in Stage 3. It's going to be less than transformation, but, it'll set a pathway for iterative improvement over time. I think also, in areas like occupational health, that's less a matter of reporting and more a matter of will the EHR record structured data that is useful for both clinical use and public health, and that's a separate area that I hope the workgroup will address.

Arthur Davidson – Denver Public Health Department – Director

Thank you. Thank you George and thank you Seth for your comments. I think we do need to leave a few minutes here for public comment. Is it MacKenzie who's going to speak back with the operator or do I do that directly?

Michelle Nelson- Office of the National Coordinator

Can I just make one quick suggestion, sorry.

Arthur Davidson – Denver Public Health Department – Director

Yes.

Michelle Nelson- Office of the National Coordinator

If there are workgroup members that have questions that they weren't able to ask, perhaps they could send them to me, this is Michelle Nelson, and I could reach out to the participants in attendance and see if we could get an answer.

Arthur Davidson – Denver Public Health Department – Director

Thank you. Thank you Michelle.

Michelle Nelson- Office of the National Coordinator

Okay. Sorry.

Arthur Davidson – Denver Public Health Department – Director

Sure, that's very reasonable. So…

Public Comment

MacKenzie Robertson – Office of the National Coordinator

We can open the line now for public comment.

Caitlin Collins – Altarum Institute

Yes. If you are on the phone and would like to make a public comment, please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comment at this time.

Arthur Davidson – Denver Public Health Department – Director

So, on behalf of the subcommittee and the workgroup, I want to thank once again the panelists who presented and testified today. Our next listening session for this Population and Public Health workgroup will be on May 22nd, once again at 10 o'clock Eastern time. Look forward to speaking with you all then.

James Daniel – Public Health Coordinator – Office of the National Coordinator

Is it at 10 or is it at 9?

Arthur Davidson – Denver Public Health Department – Director

Did I get that wrong? I'm sorry.

Michelle Nelson- Office of the National Coordinator

It's at 10.

James Daniel – Public Health Coordinator – Office of the National Coordinator

Oh.

Arthur Davidson – Denver Public Health Department – Director

Yeah, I think it's at 10.

James Daniel – Public Health Coordinator – Office of the National Coordinator

I had it at a different time.

Arthur Davidson – Denver Public Health Department – Director

Okay, good. We'll speak to you all then. Thank you all.

Michelle Nelson- Office of the National Coordinator

Thank you.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Bye.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Thanks to everyone again.

Eileen Storey – National Institute for Occupational Safety and Health

Thank you.