CSTE
Council of State and Territorial Epidemiologists
Leaders in Applied Public Health Epidemiology

National Headquarters
2872 Woodcock Boulevard | Suite 250
Atlanta, Georgia 30341
770.458.3811 | fax 770.458.8516

www.cste.org

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

March 3, 2014

Dr. Paul Tang
Chair, Meaningful Use Workgroup
Health Information Technology Policy Committee
Office of the National Coordinator (ONC)

Dear Dr. Paul Tang,

This letter contains recommendations from the Council of State and Territorial Epidemiologists (CSTE) on the February 19th Meaningful Use (MU) Workgroup vote to propose the removal of Electronic Laboratory Reporting (ELR) for eligible hospitals (EHs) and syndromic surveillance (SS) for EHs and eligible providers (EPs) from MU Stage 3. CSTE is an organization of member states and territories representing public health epidemiologists. CSTE and all epidemiologists at state and local public health agencies have a vested interest in the successful implementation of health information technology and electronic health records (EHR) for facilitating timely and complete transfer of information from the clinical care sector to public health for use in identifying, monitoring, and responding to events of public health importance and improving population health.

CSTE appreciates the efforts of the Office of the National Coordinator (ONC) Health Information Technology Policy Committee (HITPC) MU Workgroup to ensure that Stage 3 is not immoderately more burdensome on healthcare providers than previous Stages. However, CSTE is troubled that the MU Workgroup's draft recommendations for the Stage 3 public health objectives will undermine state and local efforts to better secure our nation's health. We have listened to the audio recording of the MU workgroup's February 19th meeting and concur with the decision to include Objectives supporting immunizations and registries. **We strongly urge the Workgroup to reverse its draft recommendations on the ELR and SS Public Health Objectives. CSTE is also concerned about the Workgroup's discussions around Electronic Case Reporting.** MU must incentivize EHR technology functionalities that help healthcare professionals comply with state public health laws that require them to notify health authorities of patients with reportable health conditions.

ONC's recognition of the importance of public health and population health is clear from the inclusion of relevant, high-impact objectives in Stages 1 and 2 of MU. However, we are concerned by the large proportion of public health Objectives proposed for exclusion from Stage 3. We appreciate the Workgroup's comments that exclusion as a Stage 3 Objective does not prevent or prohibit a vendor or a provider from developing functionality to submit data to public health. We also feel strongly that at this critical point in time, as expectations for electronic health record functionality are being defined, it is important that public health data needs are met. By removing these critical objectives for monitoring population health from Stage 3, the unintended message to vendors and providers may be that public health functionalities are no longer considered important or meaningful as ongoing initiatives for electronic health information exchange.

CSTE respectfully yet strongly urges the HITPC MU Workgroup to reverse its decision and include both ELR and Syndromic Surveillance Objectives in Stage 3.

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

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

   Removing this Objective would be premature for several reasons:

   i. Facilities that have established sustained transmission may redirect efforts toward implementing new required MU measures rather than maintaining ELR transmissions. Health information exchanges (often managed outside of public health) have expressed the need to redirect efforts away from ELR without the continuing support of the MU incentive program.

ii. As facilities purchase new EHRs or upgrade to new versions of EHRs, EHs must devote IT resources to reconfigure ELR and retest with public health in order to continue ongoing submission of ELRs; additional time and incentives are needed to ensure sustained engagement with public health following EHR upgrades and migrations that will occur over the next 3 years.

iii. The current Stage 2 language allows providers to remain in the testing queue as long as they are actively engaged and responsive to public health with the intention of moving to production. This means that some providers will remain in the queue and never achieve production data submission without the inclusion of this Objective in Stage 3.

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

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

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

Even in states where laws or regulations have supported electronic submission of ELR and SS data to public health, experience prior to MU was that EHs often did not devote internal IT resources to participate in the public health data submission process, often prioritizing internal resources to other projects. The MU incentive program has strongly motivated participation in ELR and SS by providers.

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

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

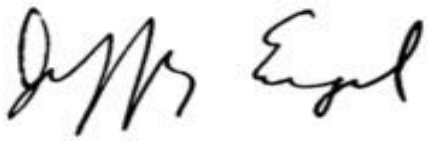
   Traditionally, public health reportable disease surveillance has depended largely on information arising from the use of healthcare services, healthcare providers, and interviews with individuals, which are then hand-keyed into our surveillance systems. These data are foundational in case and contact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

In closing, CSTE wishes to acknowledge the efforts and vision of ONC, the Health IT Policy Committee, and the MU Workgroup to move Stage 3 forward. We are interested in contributing to the overall process enacted by these groups and recognize their importance to improving clinical care and population health. MU Stage 3 is an important opportunity to support the overarching goals of the Health Information Technology for Economic and Clinical Health (HITECH) Act of improving population health management to serve more than just those that seek care but make "meaningful use" of health data to improve health for all. MU Stage 3 can further the ability for states to implement strong and reliable programs

that will benefit hospitals and populations, which results in timelier follow-up and identification of problems in our communities. Maintaining a focus on improving population health is critical to transforming healthcare and achieving the highest possible value from the public investment in the HITECH Act.

We have encouraged our member states to send their responses directly, and urge that feedback results in the Workgroup's reconsideration. Thank you for your attention to our concerns. We would be happy to address any questions or concerns.

Sincerely,



Jeffery P. Engel, MD
Executive Director