March 10, 2014

Dr. Karen DeSalvo

Chair, Health Information Technology Policy Committee

National Coordinator for Health Information Technology, ONC, DHHS

Dear Dr. DeSalvo,

We are writing behalf of the Joint Public Health Informatics Taskforce (JPHIT), a collaboration of nine national public health associations that represent a broad spectrum of public health practice and policy in the United States of America. JPHIT follows the Health IT Policy Committee's (HITPC) and its workgroup dialogues with great interest, and applauds member commitments to health information technologies that promote improvements in both personal and population health outcomes. JPHIT is grateful for the Meaningful Use (MU) workgroup's careful discussions of the Stage 3 incentives necessary for public health data reporting. The MU program must be designed to support the efforts of state and local public health agencies to better secure our nation's health with public health data from electronic health record technologies (EHR-Ts). We ask the HITPC to accept recommendations for the Stage 3 public health objectives that support:

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

We devote the remainder of this letter to sharing our perspective on ELR, SS and the EHR functionalities for reportable conditions.

JPHIT
Joint Public Health Informatics Taskforce

The U.S. public is investing over $21 billion to help eligible hospitals (EHs) and healthcare professionals (EPs) adopt EHR-Ts. From this and other investments, the public trusts that there is a public health system that ensures their safety and protects them from public health threats. This trust must be fulfilled with adequate Stage 3 incentives for EHs and EPs to fully implement health data reporting with public health agencies.

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

Public health agencies have the ability to receive and use ELR and SS data from hospital EHRs, but are challenged to fully implement hundreds of hospital data feeds within a Stage 2 incentive window. Establishing production quality public health data transmissions from new EHR-T is a complicated and time-consuming process. It is a process that requires a prolonged period of engagement among data exchange partners. Stage 2 does not provide enough time for hospitals and public health agencies to complete this process and build sustainable connections.

Progress and work that EHs make in Stage 2 need to be built on in Stage 3 to meet the public's expectation that MU investments are being used to protect and secure population health.

It is also important for the HITPC to understand that poor compliance with laws that require providers 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 providers' requirements under these laws. It is therefore crucial that the MU programs provide a framework that incentivizes development of EHR functionalities that are necessary for case reporting. JPHIT suggests that this can be accomplished by adding electronic notification of reportable conditions as a third option under

the public health registries objective, and further requiring data transmissions for at least two of the three options.

JPHIT is sensitive to demands to reduce the burden of MU compliance for EHs and EPs in Stage 3. We believe that maintaining on-going ELR and SS transmissions as core, EH Stage 3 objectives will not be a significant burden. The MU workgroup's decision to lift the menu requirements for SS data transmissions from EPs, an area where messaging standards are absent, further eases MU compliance work.

In closing, JPHIT looks forward to working more closely with the HITPC and its workgroups in the future. We believe that other constructive refinements to the MU programs can be achieved over time if public health professionals have greater representation in ongoing HITPC processes.

Thank you for your serious consideration of our request. The public health informatics community deeply appreciates the integrity your leadership brings to these matters of grave concern to our nation's health. We would be happy to address any questions or concerns that you or the workgroup membership may have. You may reach us by contacting Charlie Ishikawa, the Executive Secretary to JPHIT, at cishikawa@jphit.org.

Sincerely,

/s/

Marcus Cheatham, PhD
JPHIT Co-Chair, NACCHO representative

/s/

William D. Hacker, MD, FAAP, CPE
JPHIT Co-Chair, ASTHO representative

cc--
Paul Tang, Vice Chair, HITPC
Art Davidson, Workgroup Member, Denver Public Health Department
James Daniel, Public Health Coordinator, ONC
Charlie Ishikawa, JPHIT Executive Secretary