



Monday, 3/3/2014

Dr. Paul Tang

Chairman, Meaningful Use Workgroup

Health Information Technology Policy Committee

Dear Dr. Tang,

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 Meaningful Use (MU) workgroup and Health IT Policy Committee's (HITPC) dialogue with great interest, and applauds your commitment to health information technologies that promote improvements in both personal and population health outcomes. JPHIT is concerned 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 with public health data from electronic health record technologies (EHR-Ts). We urge the workgroup to reconsider its preliminary decision to end incentives for some public health objective in Stage 3. JPHIT strongly believes that:

1. Electronic Laboratory Reporting (ELR) and Syndromic Surveillance (SS) should remain core measures for Eligible Hospitals (EHs) in MU Stage 3; and
2. MU must move even further to 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.

JPHIT supports the workgroup's Stage 3 recommendation for the immunization objective. We devote the remainder of this letter to sharing our perspective on ELR, SS and the EHR functionalities for reportable conditions.

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.

JPHIT develops and implements a shared informatics framework and action agenda for public health agencies and their partners. JPHIT Members are: AIRA—American Immunization registry Association; APHL—Association of Public Health Laboratories; ASTHO—Association of State and Territorial Health Officials; CSTE—Council of State and Territorial Epidemiologists; ISDS—International Society for Disease Surveillance; NAACCR—North American Association of Central Cancer Registries; NACCHO—National Association of County and City Health Officials; NAHDO—National Association of Health Data Organizations; NAPHSIS—National Association of Public Health Statistics and Information Systems; PHDSC—Public Health Data Standards Consortium. NAACCR – North American Association of Central Cancer Registries is a JPHIT Affiliate. The American Medical Informatics Association (AMIA), and the Healthcare Information and Management Systems Society (HIMSS) are among JPHIT's partners.



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 and its workgroups 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 Meaningful Use 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 may, however, further ease MU compliance work by lifting menu requirements for SS data transmissions from EPs; an area where messaging standards are absent.

In closing, JPHIT looks forward to working more closely with the HITPC's workgroup in the future. We believe that other constructive refinements to the Meaningful Use 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.

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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.

Best Regards,

A handwritten signature in black ink that reads 'Marcus Cheatham'.

Marcus Cheatham, PhD
JPHIT Co-Chair, NACCHO representative

A handwritten signature in black ink that reads 'William D. Hacker'.

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

cc. –

Karen DeSalvo, National Coordinator for HIT

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George Hripcsak, Workgroup Co-Chair, Columbia University

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Joshua Sharfstein, HITPC Member, State of Maryland

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Nedra Garrett, Associate Director for Informatics, DHIS/CSELS/CDC

Laura Conn, Associate Director for Surveillance, DHIS/CSELS/CDC

Charlie Ishikawa, JPHIT Executive Secretary

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