



## **Testimony Before the HITPC MU Workgroup Panel #3: HIT Support for Advanced Models of Care**

**Charlie Ishikawa, MSPH**

**On behalf of the Joint Public Health Informatics Taskforce**

**May 27, 2014**

Good morning ladies and gentlemen. Thank you for the opportunity to speak with you about public health's experience with Meaningful Use and how it can better promote advances in public and population health care.

I serve as Executive Secretary to the Joint Public Health Informatics Taskforce (JPHIT). JPHIT is a collaboration of nine, national associations (Figure 1) that help governmental agencies build and enhance informatics infrastructure for public health assessment, policy development and assurance [1]. We represent a broad spectrum of governmental public health practice and policy in the United States.

Today, my remarks draw on responses to your questions that we have collected from local, state and federal public health professionals. Based on that experience, I have four messages to share. These are:

1. Public health agencies are ready and committed to receiving and using EHR data, but it is difficult for providers to acquire accurate readiness information;
2. Implementing public health EHR data transactions benefits both personal and population health with better public health data quality and reporting;
3. Continuing the core public health objectives from Stage 2 into Stage 3 will be crucial to realizing the full population health benefits of meaningful use; and

---

\*JPHIT develops and implements a shared informatics framework and action agenda for public health agencies and their partners. Members of JPHIT include: 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.

4. Stage 3 rules must support efforts to build greater Health IT capabilities for immunizations and reportable conditions.

Public health agencies are ready and committed to implementing meaningful use. Over the past three years, state and local agencies across the country have made significant investments to utilize EHR data. To meet meaningful use requirements they have: Modified well-established data collection processes and systems; Revised data use agreements, materials and programs; and developed new, more efficient registration processes and tools for health care providers and EHR vendors. Critical keys to public health's success in building these capacities have been leveraging existing federal funds, and the provision of technical assistance from the CDC and the ONC. In the future, additional and more stable funding to support the public health informatics infrastructure will be critical to sustaining the public health gains from Meaningful Use.

It is difficult for providers to acquire accurate public health readiness information. Knowing what health agencies to report to, their relative readiness and priorities for public health data, and how to get into an onboarding queue and anticipate wait times is a challenge. A national database that can be regularly updated by health agencies would ease this challenge, counteract misinformation about public health's lack of readiness, and help clarify when a third-party barrier to meaningful use.

Implementing public health EHR data transactions benefits both personal and population health with better public health data quality and reporting. Meaningful Use (MU) provides a structure for public health and health care professionals to work constructively on ELR, syndromic surveillance, cancer and immunization registry data exchange. Stage 2 is especially effective in promoting the benefits. For example, during 2013, providers with EHRs reporting to the New York City Centralized Immunization Registry for Meaningful Use had



higher data quality and reported administered vaccinations faster than providers with non-certified technologies [3].

Continuing the core public health objectives from Stage 2 into Stage 3 will be crucial for the public and health care providers to realize the full benefits of investments made over the last 3 to 4 years. With time ELR and syndromic surveillance data quality and reporting will lead to greater capacities for early disease detection and more real-time population health assessments during public health emergencies (e.g., H1N1, pertussis outbreaks, MERS).

Stage 3 rules must support efforts to build greater Health IT capabilities for immunizations and reportable conditions. Bi-directional communications for immunization and reportable conditions is important for public health for assurance and control measures, and it is important for clinicians so that they can address population health issues with individual patients and across patient panels. Real-time querying of immunization information systems for patient histories and clinical decision support should be required in Stage 3. It is a service that registries across the country are using (Figure 2). 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 syndromic surveillance 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.

In closing, on behalf of JPHIT and the public health community, thank you for your dedication to our nation's health. We appreciate your leadership, and the commitments of our clinical care and vendor partners to Health IT that improves and protects both personal and population health. Thank you for the opportunity to appear before you today. JPHIT stands ready to work with this committee moving forward.

---

\*JPHIT develops and implements a shared informatics framework and action agenda for public health agencies and their partners. Members of JPHIT include: 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.

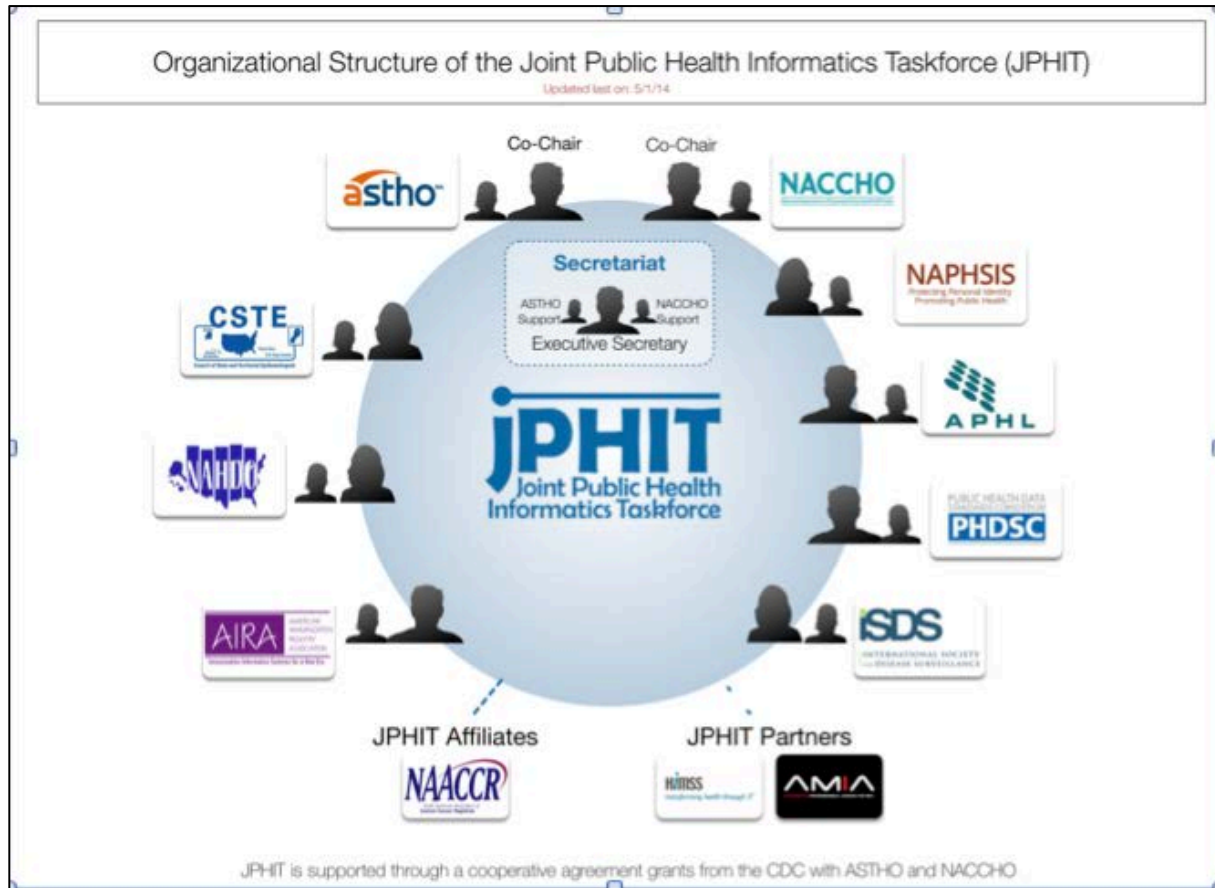


Figure 1: The organizational structure of the Joint Public Health Informatics Taskforce on May 1, 2014

\*JPHIT develops and implements a shared informatics framework and action agenda for public health agencies and their partners. Members of JPHIT include: 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.

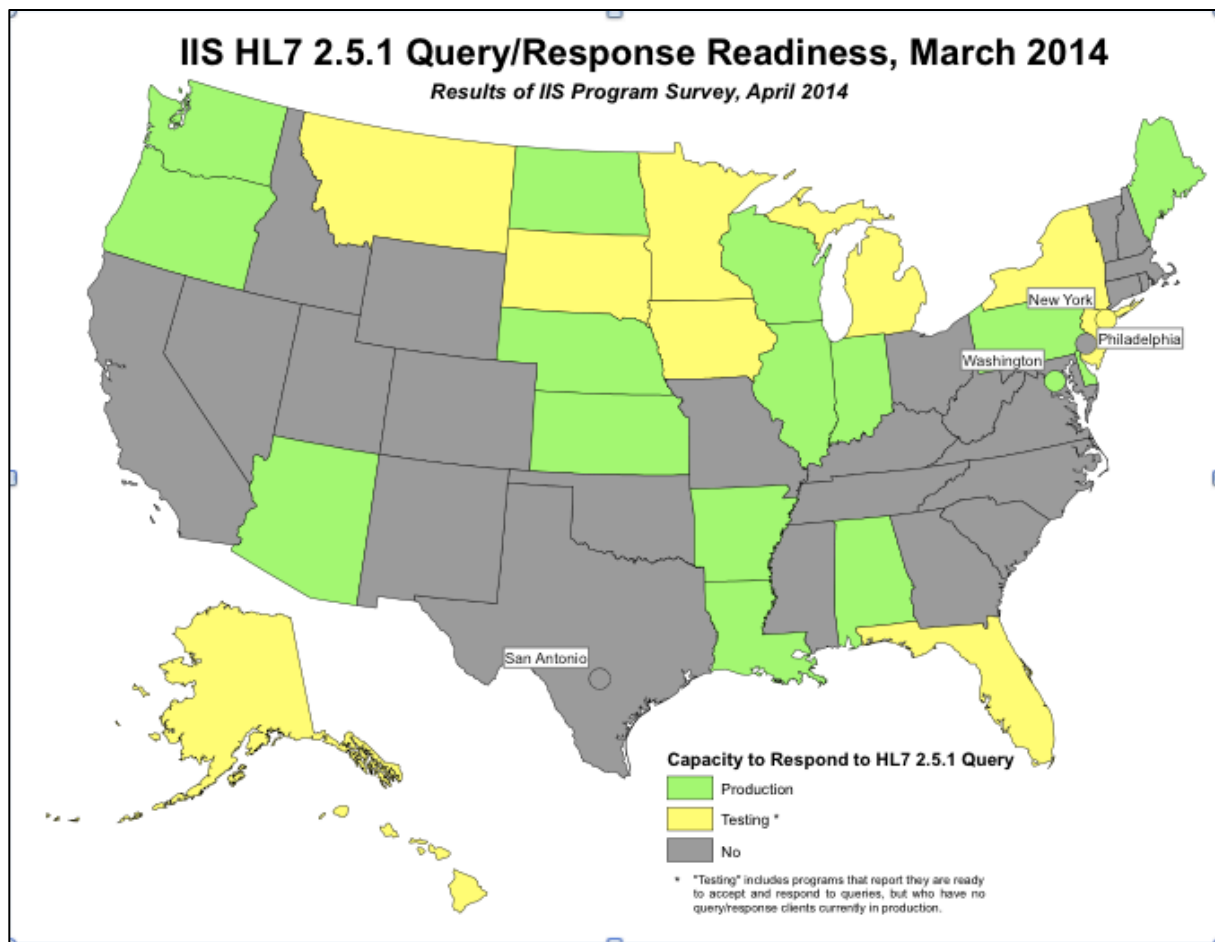


Figure 2: CDC conducts a quarterly survey on Meaningful Use readiness among our state and urban awardees, and as of December, 2013, a total of 14 awardees reported that they already have in-production interfaces with at least one EHR system that is now querying the IIS for immunization records and receiving responses using HL7 2.5.1 messaging standards. An additional 8 programs reported testing query/response with one or more EHR systems, although these have yet to put any providers into production. By 2017, the currently-projected start date for Stage 3, we anticipate many more states will have successfully implemented query/response. (Source: Unpublished CDC survey data, received by email communication 5/22/14)

## END NOTES

1. The ten essential public health services:  
[http://www.cdc.gov/nceh/ehs/ephli/core\\_ess.htm](http://www.cdc.gov/nceh/ehs/ephli/core_ess.htm)
2. JPHIT Letter to HITPC's MU Workgroup: Available on-line at: <http://jphit.org/wp-content/uploads/2014/03/JPHIT-Letter-to-MU-Workgroup-030314.pdf>
3. The NYC CIR reports that in 2013 94.1% of MU EHRs reported vaccinations included VFC status, compared to 88.1% for non-MU systems; 97.4% of MU EHRs reported vaccinations included lot number, compared to 59% for non-MU systems; MU compliant EHRs reported vaccinations in less than 1 day, compared to 3 days for non-MU systems; In NYC, standard EHR immunization reporting messages using HL7 for Meaningful Use have gone from 0 in 2010 to: 379,360 messages in 2011; 1,101,274 messages in 2012; and 4,591,611 messages in 2013 (Source: AIRA, email communication received 5/23/14)

## Attachment

Reponses from JPHIT Associations to the Workgroup's questions

The JPHIT Secretariat asked JPHIT associations to share thoughts, anecdotes or data that will help the HITPC MU Workgroup learn from their experience in establishing on-going Meaningful Use public health data connections. In turn, JPHIT associations and partners gathered input from memberships and staff. Below are the responses that were collected and relayed to the Secretariat by Friday, May 23, 2014.

## General Comments