



Testimony Before the Health IT Policy and Standards Committees'  
Public Health Taskforce

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On behalf of the Joint Public Health Informatics Taskforce (JPHIT)

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Good morning ladies and gentlemen. Thank you for the opportunity to inform your developing health information technology policy and standards recommendations for Zika preparedness and response.

In response to your questions, my remarks draw on input from the Joint Public Health Informatics Taskforce (JPHIT)<sup>1</sup>. JPHIT is a coalition of ten national public health associations (Figure, page 5), and four partner organizations, that help governmental agencies build and enhance informatics infrastructure for public health assessment, policy development and assurance. As JPHIT's Executive Secretary, my role is to facilitate and communicate a complete and unified perspective on matters that effect the information capacities of governmental public health agencies and their partners.

- 1 -

Pregnancy data are routinely used for public health to protect and improve maternal, prenatal, and infant health. These data are needed by:

- immunization providers for ensuring that patients receive the right vaccines
- public health surveillance professionals for identifying, monitoring, and gauging the size, severity and impact of outbreaks
- maternal and child health professionals for identifying and providing timely health education and social support services

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<sup>1</sup> All input received from JPHIT associations are provided in this testimony's appendix. Those comments are sorted by question, and presented by perspective.



- public health epidemiologist and researchers for etiological studies and assessing the effectiveness of interventions, medical counter measures, and changes in clinical standards of care.

Given the scope and importance of these use cases, better and more accessible pregnancy data will make our communities more secure and resilient to present and future health threats.

Looking across these use cases, it appears that...

- the essential data element of pregnancy status that public health needs is: Pregnancy status (yes, no, maybe, or unknown), and
- the minimum data with regard to a pregnancy, seems to be gestational age (trimester), expected delivery date, and pregnancy end date.

Optimally, these pregnancy-related observations would be made for all women of child bearing age, remain current, persist beyond the end of pregnancy, and be linkable to mother and infant test results and health outcomes.

- 2 -

Currently, data on pregnancy status are captured by multiple parties and at multiple times along the continuum of care<sup>2</sup>. Those data may be based on direct clinical and laboratory observations, patient self-reports, or administrative claims. Pregnancy status is also inferred from data such as date of last menses, procedure codes, or a provider's medical or surgical specialty.

Pregnancy status information presently appear in standards-based syndromic surveillance data, immunization information systems (IIS) records, and all payer claims databases. Certified EHRs can provision pregnancy status data in chief complaints (OBX segment), diagnoses (DG segment), and as an immunization contraindication.

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<sup>2</sup> Clinicians, administrative assistants, social workers, and disease outbreak investigators and managers are among those who electronically capture pregnancy-related data.



- 2a -

If new processes or standards are introduced for capturing pregnancy status data, then it is important to consider how any change would impact the quality those data that public health and healthcare professional currently receive and use in the absence of the data they need. Examples of the loss in information and insight that standardized data capture can cause are found in what syndromic surveillance analysts experience when chief complaint data change from free-text to drop-down/pop-up entry.

- 2b -

Enabling authorized parties to combine or link pregnancy-related data from multiple sources would be a win-win for patient, population, and public health care. For example: A growing number of states and other healthcare organizations are using an episodes of care methodology to analyze conditions or illnesses of interest, such as pregnancy, using computerized algorithms that look across claims and encounter data sets<sup>3</sup>. Imagine how using those techniques and data sources in combination with public health reporting data and vital statistics data could fill in important information gaps. There would be opportunity to look at a single case longitudinally and episodically across multiple settings of care.

- 3 | 4 -

From a public health perspective, automation for clinical decision support (CDS)<sup>4</sup> would help in assuring the best patient care for Zika, and the automated processes should be architected in ways that can be useful for both emerging and routine public health threats. The requirements of immunization information systems for CDS are helpful in understanding the automation needs. For example, anytime there is a change to the ACIP immunization recommendations, there is a need to quickly update CDS. When the there is rapidly changing content, such as when a vaccine receives an emergency use authorization, there is an emerging event and changes to laboratory testing recommendations or clinical guidance, budgets limit the timeliness of updates or how quickly content can be modified. From that perspective, it is

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<sup>3</sup> See attached file, "Attach 1 - Structuring Bundled Payments for Maternity Care - NEJM Catalyst."

<sup>4</sup> See also attached file, "Attach 4 - AMIA Response to CDC RFI on CDS\_final.pdf."



important to separate what would require one-time system modifications (e.g., adding the agreed-upon fields for tracking pregnancy to databases and interfaces), from the triggers that would initiate when CDS information gets provisioned (e.g., when submitting an immunization).

In closing, please consider placing the following two contingency your recommendations to the Health IT Policy and Standards Committees:

1. State and local public health informatics infrastructure needs modernization and greater human capacity for our nation to fully benefit from better and more timely pregnancy status data.
2. Public-private partnerships like the Digital Bridge<sup>5</sup> will be critical to working out implementation details in mutually beneficial ways.

On behalf of JPHIT, thank you for your dedication to our nation's health. We appreciate your leadership, and the commitments of our clinical care and vendor partners for Health IT that improves and protects both personal and population health. JPHIT stands ready to work with this joint task force moving forward.

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<sup>5</sup> See attachment file, "Attach 3 - Digital Bridge Fact Sheet.pdf"

**Figure: Organizational structure of the Joint Public Health Informatics Taskforce**

