



March 15, 2010

Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Attention: HITECH Initial Set Interim Final Rule
Hubert H. Humphrey Building, Suite 729D
200 Independence Ave., SW.
Washington, DC 20201.
RIN 0991-AB58

Dear Office of the National Coordinator:

This letter contains recommendations from the Joint Public Health Informatics Taskforce (JPHIT), a consortium of seven public health associations (see below) created to improve population health through informatics. These recommendations are coordinated and harmonized from across the seven associations, and represent a unified voice from the public health perspective on meaningful use objectives and measures.

JPHIT first wishes to acknowledge the vision of the Office of the National Coordinator for the strong emphasis put on population health improvement throughout HITECH programs. We believe maintaining a focus on improving population health is critical to transforming healthcare and achieving the highest value possible from the public investment through HITECH.

Even though not related directly to these rules, JPHIT strongly recommends that the proposed Meaningful Use objectives and measures around reporting to public health agencies be fully retained. JPHIT believes that the areas chosen, and measures used, generally strike the correct balance between advancing the use of data for population health improvement and recognizing the limitations that exist with the current technology. We believe it is necessary, reasonable and justified that these objectives and measures not be reduced or in any way diminished (such as by offering the option for EPs and hospitals to defer until 2013), because:

JPHIT develops and implements a shared informatics framework and action agenda for public health agencies and their partners. Members of JPHIT include: ASTHO - Association of State and Territorial Health Officials; APHL - Association of Public Health Laboratories; CSTE - Council of State and Territorial Epidemiologists; 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; and PHDSC - Public Health Data Standards Consortium. The Public Health Informatics Institute serves as secretariat for JPHIT through a cooperative agreement from the Centers for Disease Control and Prevention.

- The three objectives related to public health are already very limited in scope, requiring eligible providers and hospitals only to test the capability of their systems to report uni-directionally with public health. Actual reporting is already occurring across much of the country for lab and immunization data, and is growing in terms of syndromic surveillance data.
- Many states currently have requirements for immunization and electronic laboratory reporting. Deferring and making objectives optional could potentially generate confusion among providers.
- Both lab and immunization reporting are key areas not only for population health improvement but also to support improvements in clinical care outcomes, coordination of care and other areas of interest to CMS and ONC. Experience during the recent H1N1 pandemic has shown the utility of real-time syndromic surveillance information to support public health, clinical decision-making and emergency response in communities.
- Although deferment/optionality may provide relief to some providers, it will not do so for public health agencies, which will still need to be prepared to accept data for all three policy objectives.

In addition, JPHIT strongly recommends that ONC return any state HIE plan to the state if its plan does not adequately address ensuring public health capacity for exchange. The ARRA-HITECH Act calls for the state HIE grant funds to be used for “supporting public health agencies’ authorized use of and access to electronic health information.” The federal funding opportunity announcement (FOA) was explicitly intended “to meet local health care provider, community, state, public health and nationwide information needs.” Starting in Stage 1, as HIE from hospitals and providers increases, public health will need to have the capacity to scale up to manage the increased workload and to be the good operational partners that the hospitals and providers want. Building that capacity will require financial and technical resources. Starting in Stage 2, expectations increase dramatically for public health capacity (sending immunization histories and immunization recommendations, sending targeted health alerts, receiving information for cancer and other registries, and receiving “anonymized electronic syndrome surveillance data.” Starting in Stage 3, public health will need to be able to receive “automated real-time surveillance....” *State HIE plans that do not include allocation of financial and other resources to public health for this capacity development will not be adequately comprehensive, and should be returned to the state for revision.*

In addition, JPHIT submits the following specific recommendations on the rules.

Citation	Proposed change	Rationale
<p>Subpart C §170.302 (m) Submission to immunization registries (page 2046)</p>	<p>Electronically record, retrieve, and transmit immunization information to immunization registries in accordance with: (1) One of the standards specified in Sec. 170.205(h)(1) and, at a minimum, the version of the standard specified in Sec. c. 5 of (2) The applicable state designated standard format.</p>	<p>This statement is inconsistent with Subpart B, § 170.205 (h), which clearly defines the content exchange standards as HL7 version 2.3.1 or version HL7 2.5.1. No mention is made in that Subpart of a “state-designated standard format.” We believe that allowing states to adopt their own format is problematic for EHR vendors and providers, and not in keeping with the concept of a uniform standard for exchange.</p> <p><i>Note:</i> The wording around “state-designated standard format” would also have to be deleted from Table 1.</p>
<p>170.205 (h) Electronic submission to immunization registries (page 2043)</p>	<p>(h) Electronic submission to immunization registries. (1) The Secretary adopts the following content exchange standards for electronic submission to immunization registries: (i) Standard. HL7 2.3.1 (incorporated by reference in Sec.170.299). (ii) Alternative standard. HL7 2.5.1 (incorporated by reference in Sec. 170.299).</p>	<p>JPHIT recommends that 2.5.1 be established as the sole standard for reporting to immunization registries in 2013.</p>
<p>Insurance Type as a demographic data element</p>	<p>Adopt the Source of Payment Typology as the standard for codifying Insurance Type. http://www.phdsc.org/standards/payer-typology.asp</p>	<p>The Public Health Data Standards Consortium created the Source of Payment Typology value set that has been recognized as an approved externally maintained standard by HL7 and ANSI X12. There is also ongoing work to incorporate this value set in any future version of ANSI X12 implementation guides. Several state data organizations (Georgia, Oregon, and New York) have already implemented the PHDSC Source of Payment Typology because of its hierarchical</p>

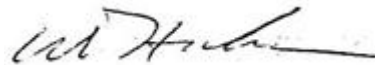
		structure of the relationship among payer categories. These relationships provide the basis for states to use the typology and to add lower levels of granularity for state-specific purposes while still maintaining a standard that can be used to compare data across states or for combining states' data to make national data sets. Another significant advantage of the PHDSC typology over existing value sets is the comprehensive definition of terms that do not exist in any other existing value set.
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Thank you for considering these recommendations.

Sincerely,



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