CSTE
Council of State and Territorial Epidemiologists
Leaders in Applied Public Health Epidemiology

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CSTE is an organization that supports epidemiologists practicing at the state, territorial, tribal, and local levels.

February 25, 2011

Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Attention: Joshua Seidman
Mary Switzer Building
330 C Street SW, Suite 1200
Washington, DC 20201

RE: CSTE Response to the HIT Policy Committee Meaningful Use Workgroup Request for Comments Regarding Meaningful Use Stage 2

Dear Mr. Seidman,

In response to the proposed objectives for electronic reporting of clinical quality measures, under the Meaningful Use Improving Quality, Safety, and Efficiency priority, the Council of State and Territorial Epidemiologists (CSTE) recommends that healthcare associated infection surveillance via reporting through the National Healthcare Safety Network be moved from a Stage 3 optional consideration to a Stage 2 Quality Reporting core requirement, shifting the financial incentive to 2013-2014 from 2015-2016.

CSTE's remaining comments concern the Meaningful Use priority to Improve Population and Public Health. In general, CSTE agrees with the movement of Stage 1 public health objectives from the optional menu set to the core criteria. Overall, CSTE recommends clarification of the language to be as clear and consistent as possible across all public health objectives in order to minimize differences in interpretation. We also recommend reformatting the table to clearly separate different objectives.

For submission of reportable lab data, CSTE recommends modifying the language to clearly distinguish between submission of reportable conditions and reportable lab results. Rather than being included under reportable lab data, reportable conditions should be removed to a separate objective for public health case reporting.

Regarding submission of reportable lab data by eligible hospitals, CSTE considers the inclusion of complete contact information in 30% of reports by Stage 3 to be too low. Complete contact information is crucial for disease surveillance and public health response to reportable conditions. Therefore, we recommend that 30% of reports with complete contact information be a Stage 2 objective, with 100% at Stage 3.

In addition, for reportable laboratory data, there continues to be confusion over whether reporting from laboratory information systems (LIMS), rather than from an EHR, fulfills the meaningful use criteria. CSTE strongly supports LIMS reports fulfilling the meaningful use criterion and recommends that this be explicitly stated in the set of recommendations for Stage 2. There are several reasons for this recommendation. First, the vast majority of state health departments and laboratories have already invested in and achieved successful lab reporting from LIMS. To require that reporting now come directly from EHRs for meaningful use would be very counterproductive in achieving broader laboratory reporting and extremely costly in developing new reporting data streams. It would also delay laboratory reports in reaching public health. Currently, lab reports are sent to public health as soon as the laboratory system uploads them and do not wait for their incorporation into an EHR. Speedy reporting is critically important for diseases where every hour can make a difference in public health intervention, such as a case of botulism or meningococcal meningitis.

While the electronic reports from labs may not contain all the demographic data needed at the time that the report is first available, this information can be obtained later from the EHR. Explicitly stating that laboratory reporting from a LIMS meets the meaningful use criterion in Stage 2 will alleviate a lot of current confusion regarding this standard.

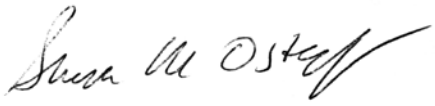
CSTE also encourages ONC to adopt the CDC Message Mapping Guide for Syndromic Surveillance as the technical standard for the Stage 2 syndromic surveillance requirement.

Regarding the "Public Health Button" proposed Stage 3 objective, CSTE would like to be involved in the process of developing this button, but we do not currently have enough information to recommend how it should be operationalized. We recommend further clarification on the button's proposed functionality and suggest that this be added as a Stage 2 optional menu item to allow for experimentation. CSTE also recommends that the statement "EHR can receive and present public health alerts or follow up requests" be a separate objective from the Public Health Button, as these are two different concepts. We welcome the inclusion of bi-directional interaction between public health and EHRs in the MU criteria and recommend that this be added to the optional set for Stage 2 and made mandatory in Stage 3.

The term "patient-generated data" in the proposed Stage 3 objective needs to be defined. If this refers to patient self-reported data, CSTE expects that the specificity of the data will be low and that its use for epidemiologic purposes will be limited. Rather than focus on this objective, we would prefer to see vendors prioritize other objectives with greater potential public health impact.

Thank you for the opportunity to comment as part of formulating final recommendations. Any questions on these recommendations from CSTE can be directed to Patrick McConnon at pcconnon@cste.org or 770-458-3811.

Sincerely,



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