PUBLIC HEALTH DATA STANDARDS CONSORTIUM

PHDSC

Promoting Standards Through Partnerships

The PHDSC Quarterly Standard E-Newsletter

Promoting Standards Through Partnerships

June 17, 2009, Issue #7

SAVE THE DATE	**2009 PHDSC ANNUAL BUSINESS MEETING** **November 12-13** **National Center for Health Statistics, CDC, Hyattsville MD**

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In this Issue:

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Health Information Technology Standards for Public Health: a New Module of the PHDSC Web-based Resource Center

By Dr. Anna Orlova, PHDSC

On June 17, 2009, the Consortium) launched a new Module of its Web-based Resource Center on ***Health Information Technology (Health IT) Standards.***

The ***Health IT Standards Module*** consists of 17 web-based pages that provide a wide range of materials on Health IT standards categories and Health IT standardization process & entities. Each web-page contains an extensive set of links to documents developed by Health IT standardization entities and other pertinent resources.

The target audiences for the PHDSC ***Health IT Standards Module*** include public health and clinical professionals, public health leaders & decision makers and IT professionals.

	Said Dr. Walter Suarez, PHDSC President, "This new Module is part of the extensive library of Health IT standards-related resources being provided by the Consortium to the public health community at-large. We invite members of the public health workforce to explore this new resource and to let us know how meaningful and practical it is." The ***Health IT Standards Module*** was developed by the PHDSC Data Standards Committee with support from the National Center for Health Marketing, Centers for Disease Control and Prevention (CDC). The Consortium will maintain and update the Module content to keep public health professionals informed about new advancements on policy and technical aspects of Health IT standard development and adoption. The PHDSC ***Health IT Standards Module*** can be accessed at: http://www.phdsc.org/standards/health-information-tech-standards.asp
Share Your Successes & Lessons Learned with the Public Health Community on Health Information Technology Adoption in the next PHDSC Standard E-Newsletter Issue. Send your stories to Emily Van Oeveren at evanoeve@jhsph.edu for the next issue of our Newsletter by September 4, 2009	**Working with EHR Vendors to Built Interoperable Health Information Technology Products for Public Health** By Dr. Anna Orlova, PHDSC Since 2007, the Consortium has been working with the Integrating the Healthcare Enterprise (www.ihe.net) to develop Health IT interoperability standards for public health. With the support from the Health Resources and Services Administration (HRSA), the Consortium has been participating in the *IHE Information infrastructure Committee* and the *IHE Quality, Research and Public Health Committee* to develop the following technical documents: *HE Information infrastructure Committee* • **White Paper: A Service-Oriented Architecture (SOA) - View of IHE Profiles** *IHE Quality, Research and Public Health Committee* • **White Paper: Newborn Screening** These White Papers were released for public comments in early June together with other IHE technical documents developed under the 2008-2009 IHE development cycle. The documents are available for download at http://www.ihe.net/Technical_Framework/public_comment.cfm. Pleased submit your comments to the online forums at http://forums.rsna.org by **July 1, 2009** on **SOA White Paper** and by **July 6, 2009** on **Newborn Screening White Paper**.
	Assure Health IT Standards for Public Health By Mr. Sacchidanand Girde, PHDSC The Consortium's Cooperative Agreement with the National Center for Health Marketing, CDC has been renewed. During Year 1of this agreement,

Visit our Web-site
www.phdsc.org

The Consortium continues to develop and expand its website which was re-launched last summer.

We see our web-site as one of the primary means to disseminate information on health information technology standardization activities to our members and the community at large.

Stay tuned for new content and some distinctive features in the near future.

Please send your comments about our Web-site to Emily Van Oeveren at evanoeve@jhsph.edu

the Consortium has been developing a ***Business Case on Public Health Participation in Health IT Standardization*** (please see below the PHDSC presentation on the Business Case at the '09 PHIN conference) and the Web-based ***Health IT Standards Module*** described above.

Web-based Interactive Model : Public Health in Health IT Standardization

During Year 2, the Consortium will focus on developing a ***Web-based Interactive Model entitled Public Health in Health IT Standardization***. This Model will be comprised of four modules:

1. ***Health IT Standards Module***, developed in Year 1, and aimed to serve as an informational resource about Health IT standards;
2. ***Health IT Adoption in Public Health Module***, aimed to convey best practices and lessons learnt;
3. ***Public Health Needs for Health IT Module***, aimed to identify public health future needs in HIT projects and products; and
4. ***Public Health Participation in Health IT Standardization Module,*** aimed to track participation of local and state representatives in the national Health IT standardization process.

The Consortium will collaborate with the National Association of Public Health Information Technology (NAPHIT, www.naphit.org) in this project.

Participation in Health Data Standards Development at the National Uniform Billing Committee and X12

With the support from the National Center for Health Statistics (NCHS), CDC, the Consortium's representatives will participate in the activities of the National Uniform Billing Committee (NUBC, www.nubc.org) and ASC X12 (www.x12.org) to update and maintain the ***PHDSC Health Care Service Data Reporting Guide*** (http://www.phdsc.org/standards/health-care-data.asp). Information about these activities will be communicated to a broader public health audience via educational webinars and web-based resources at the PHDSC Web-site.

HL7 EHR Functional Model for Public Health

Health Level Seven (HL7)'s Electronic Health Record Functional Model (EHR-FM) has undergone a series of enhancements since it was first evaluated in 2004 by the ***PHDSC Ad Hoc Task Force on Electronic Health Record – Public Health (EHR-PH)*** (http://www.phdsc.org/health_info/ehr-task-force.asp.)

With the support from the National Center for Health Statistics, CDC, the Consortium will re-evaluate the Model to determine if, extensions to EHR-FM for additional public health functions are needed or an independent Public Health Functional Model is warranted. We envision re-activating ***PHDSC Ad Hoc Task Force on EHR-PH*** starting September 2009 to conduct the re-evaluation.

Look for the PHDSC announcements to join us in the Re-Evaluation of the EHR-FM from Public Health Perspectives to guide further development of Health IT standards for public health.

PHDSC at PHIN-09

This year PHDSC presentations will be featured at the following Sessions at the 2009 Public Health Information Network (PHIN) Annual Conference, August 30–September 3, 2009 Atlanta, Georgia: (http://www.cdc.gov/phinconference/2009/about_conference/index.htm)

Monday, August 31, 2009: 1:30 PM-3:00 PM *Baker Hyatt Regency -- Downtown Atlanta*

B5-Cross-Jurisdictional Collaboration & Communication

Multi-Jurisdictional Information Sharing During the 2009 Presidential Inaugural
Wayne A. Loschen, MS*, JHU Applied Physics Laboratory; Richard Seagraves, BS, JHU Applied Physics Laboratory; Rekha Holtry, MPH, JHU Applied Physics Laboratory; Joseph Lombardo, MS, JHU Applied Physics Laboratory; Sheri Happel Lewis, MPH, JHU Applied Physics Laboratory*
Information Sharing During the H1N1 Outbreak ***Wayne A. Loschen, MS****, JHU Applied Physics Laboratory; Richard Seagraves, BS, JHU Applied Physics Laboratory; Rekha Holtry, MPH, JHU Applied Physics Laboratory; Joseph Lombardo, MS, JHU Applied Physics Laboratory; Sheri Happel Lewis, MPH, JHU Applied Physics Laboratory*
Health Information Privacy in Public Health Agencies: An Assessment of Current and Future Issues Affecting Public Health Practice ***Walter Suarez, MD, MPH****, Institute for HIPAA/HIT Education and Research; Vicki Hohner, MBA, FOX Systems*

Wednesday, September 2, 2009: 10:00 AM-11:30 AM *Inman Hyatt Regency -- Downtown Atlanta*

G8 - Public Health Roadmaps for Future Success

Business Case for Public Health Participation in Health Information Technology (HIT) Standardization
Anna Orlova, PhD*, Public Health Data Standards Consortium; Walter Suarez, MD, MPH, Institute for HIPAA/HIT Education and Research; Noam H. Arzt, PhD, HLN Consulting, LLC; Harold Lehmann, MD, PhD, FACMI, Johns Hopkins University; Vicki Hohner, MBA, FOX Systems; Sacchidanand Girde, MBBS, MS, Public Health Data Standards Consortium*
Towards a Unified Framework of Public Health Knowledge for Clinical Decision Support
William B. Lober, MD, MS*, University of Washington; Rebecca Hills, MSPH, University of Washington; Debra Revere, MLIS, MA, University of Washington; Alean Kirnack, MS, Software Partners*
Public Health and Health Information Exchanges: Developing a Common Roadmap to Future Success
Charles Magruder, MD, MPH*, CDC; David Dobbs, BS, PMP, SAIC; Bryant Karras, MD, Washington State Department of Health; Paul A. Blake, MS, PMP, Inland Northwest Health Services; Shaun Grannis, MD, MS, FAAFP, Regenstrief Institute; Geraldine S. Johnson, MS, New York State Department of Health*

Wednesday, September 2, 2009: 1:30 PM-3:00 PM *Baker Hyatt Regency -- Downtown Atlanta*

H4 - Service Oriented Architecture & Interoperability

Service Oriented Architecture (SOA) for Public Health: Health Information Technology Industry Perspectives ***Kenneth Rubin, BS****, Electronic Data Systems*
Service Oriented Architecture (SOA) for Public Health: Standard Development Organizations Perspectives
Alean Kirnak, MS*, Software Partners LLC*
Service Oriented Architecture (SOA) for Public Health: Public Health and Clinical Perspectives
Anna O. Orlova, PhD*, Public Health Data Standards Consortium; Sacchidanand Girde, MBBS, MS, Public Health Data Standards Consortium*

Poster Presentations, August 31 - September 2, 2009

"The American Immunization Registry Association Collaborates to Develop a Standard IOA for Interstate Exchange of Immunization Histories Between IIS", ***Sue Salkowitz***, American Immunization Registry Association

"Addressing the Needs of the Texas EHDI Program through the Creation of a Public HIE", ***Mary Gwen Allen***, Texas Department of State health Services and ***Mary C. Hess***, OZ Systems

Join Us at PHIN-09!

National Health IT News

"Meaningful Use" of Electronic Health Records (EHRs)

The American Recovery and Reinvestment Act of 2009 (ARRA) provides for Medicare and Medicaid incentive payments for eligible providers, such as physicians and hospitals, in order to promote the adoption of EHRs. To receive the incentive payments, providers must demonstrate "meaningful use" of a certified EHR. The Health IT Policy Committee, a Federal Advisory Committee (FACA) to the U.S. Department of Health and Human Services (HHS), met on June 16, 2009 to discuss recommendations from the Committee's Meaningful Use Workgroup on the ***Elements and Measures of Meaningful Use of a Certified EHR***. The Committee's discussions of and draft recommendations for the term "meaningful use" available at http://healthit.hhs.gov/portal/server.pt?open=512&objID=1269&parentname=CommunityPage&parentid=8&mode=2&in_hi_userid=10741&cached=true

Building upon the work of the Health IT Policy Committee, HHS anticipates developing a proposed rule to provide greater detail on the incentive programs and "meaningful use" for EHRs HHS expects to issue the proposed rule in late 2009, which will be followed by a comment period.

The Office of the National Coordinator for Health Information Technology, HHS has requested comments on the recommendations from the Meaningful Use Workgroup. The comments (up to 2,000 words in length) are due by June 26, 2009 at 5 pm/Eastern Time. Electronic responses to the request for comments are preferred and should be addressed to: MeaningfulUse@hhs.gov, subject line "Meaningful Use." Written comments may also be submitted to the Office of the National Coordinator for Health Information Technology, 200 Independence Ave, SW, Suite 729D, Washington, DC 20201. Attention: HIT Policy Committee Meaningful Use Comments.

Source: Judith Sparrow, Office of Programs and Coordination, Office of the National Coordinator for Health Information Technology. 202-205-4528, judy.sparrow@hhs.gov . June 16, 2009. HHS ACTION: Notice and Request for Comments. Section 3002, Pub. L. 111-5, 123 Stat. 115.

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The HITECH Act: Reducing Health Disparities through EHR-S Adoption, by *Emily Van Oeveren*, PHDSC

The Health Information Technology for Economic and Clinical Health (HITECH) Act, as part of the American Recovery and Reinvestment Act of 2009 (ARRA), will help advance the use of health information technology (Health IT). The bill will require that government take a leadership role in developing standards that will allow a nationwide electronic exchange and use of health information to improve quality and coordination of care. It will also involve investing 20 billion dollars in Health IT infrastructure.

One of the priorities of the HITECH Act is to reduce health disparities by ensuring access to Health IT for underserved populations. The Act guides the Office of the National Coordinator for Health IT (ONC) to develop ***regional centers*** "to enhance and promote the adoption of Health IT." The goals of the ***regional centers*** are to encourage adoption of electronic health record systems (EHR-S) and assist clinicians and hospitals to become meaningful users of EHR-S. Each ***regional center*** will provide technical assistance on Health IT adoption and information on the EHR-S best practices to hospitals,

federally qualified health centers, entities located in rural and other areas that serve the medically underinsured, and individual or small group practices focusing on primary care.

Source: Federal Register/ Vol. 74, No. 101/ Thursday, May 28, 2009/ Notices: p.25550-25552

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News from Certification Commission of Health Information Technology (CCHIT)

New 265 Volunteers to Assist with Certification Development for 2009-10

CCHIT has selected 265 members for its 19 all-volunteer work groups. These new and returning volunteers will take on the challenge of rapidly transitioning the Commission's existing certification programs, and developing new paths to certification, to directly satisfy the objectives and measures of meaningful use, to be released soon by the ONC and its Advisory Committees. The roster of newly selected work group members is published at www.cchit.org/wg.

CCHIT Transitions Timelines for 2009-10 Certification Program

The CCHIT-approved criteria and test scripts, developed during the 09 development cycle, have been published on the web site, www.cchit.org, along with a newly developed "Concise Guide to CCHIT Criteria". The Guide maps the criteria to the characteristics of a qualified EHR-S as specified in ARRA 2009 and highlights the 09 criteria changes. The Commission is also planning to transition its certification program timelines to adapt to the new requirements of ARRA.

Source: CCHIT eNews, June 16,2009

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Situational Awareness 2.0, by *Carl Taylor* and *Tim Stephens*, Rescobie Associates, Inc. Members of the National Association for Public Health Information Technology (NAPHIT)

Since its inception, the capably led Health and Human Services Hospital Preparedness Program has managed the leadership, direction, and funding of preparing this nation's healthcare facilities for disasters. Latterly, there is an increasing focus on situational awareness of events as they unfold in a hospital centric environment ostensibly to promote more inter governmental (local, state, federal) response.

A situational awareness goal is to assist hospitals before they are overwhelmed by events and operating beyond their (surge) capacity. Surge capacity is a numbers approach to beds; surge capability deals with the types of patients who can be treated with unique needs. Examples would be burn patients or acute respiratory distress patients needing ventilators.

There are underlying flaws in a hospital centric approach to situational awareness. On any given day, 89% of our patients are in their homes, not hospitals, and 80% of their care is delivered by a private physician not affiliated with a hospital. Additionally, situational awareness tools running solely in hospitals do not provide a full view of the external operating environment, nor what those externalities will bring tomorrow. We continue to experience major surge capacity gaps as a result.

We suggest that we have violated the Taylor version of Ashby's law of Requisite Variety. Requisite variety means that in any event there will be a variety of health care needs and that the entire variety of those needs must be met with a successful response. By becoming too hospital centric, we run the risk of incorrectly asserting that the emergency room is the only proper place for care. If we were to look at

the evacuation of nearly 900,000 people from New Orleans in 2005, we would find that their overwhelming health needs resulted from chronic disease, not the need for emergent care (of course the failure to respond adequately to their chronic disease may have produced a need for emergent care).

Similar to what Dr. Ben Schnedierman argued for in Science 2.0, we suggest we need Situational Awareness 2.0. Science 2.0 contends that a great new wave of scientific breakthroughs will occur by employing the tools of predictive models. Integrated, interdisciplinary problems (Preparedness) require mass collaboration outside of the controlled laboratory.

We must recognize that for some outbreaks or disasters, viz. H1N1, the home and housing center is superior to the emergency room. In other events, the assurance of continued medical supplies from WalMart is more important than intubation.

We need a new kind of situational awareness. One that is patient centric not hospital centric. Is this doable? Of course. Let's look at the tools.

First, any patient can be given access to a patient centric health record and home health monitoring capability as long as they have a phone. The patient could then report their conditions on a regular basis, becoming like a dot on a large map to track how they and their neighbors are doing. By knowing them before they have a need, the system can understand their comorbidities, transportation challenges, current medical providers, and medications.

Hospitals are too valuable to be the care of first resort. This is true of everyday indigent care in emergency rooms; it is essential during the scarcity brought on by an outbreak.

Assuming these patients have access to a medical home such as an FQHC, then that medical home becomes their health manager during emerging infectious disease such as H1N1. The FQHC using a team of nurses, lay persons, or public health professionals could deliver tamiflu, schedule visits, monitor health status and make a decision to refer the patient to the hospital when appropriate, but not as a matter of course.

Other tools are available:

- Patient centric health records from Medicaid claims data bases;
- Low cost interactive voice recognition VR systems are in multiple states;
- Free, open source tools such as Ushahidis case reporting tool and Googles Evolve to create outbreak maps
- Survey Monkey or TxtEagle inquiries can be sent out to CHCs in housing centers asking for the status of the health of the population;
- Social networking tools or a new site called Xtreme Collaboration Hub patients can be connected virtually to services such as Medical Disaster Response Network or Teladoc in case their FQHC is closed or needs additional assistance;
- Xtreme Collaboration is designed to promote emergent coherence, meaning self forming networks can assist in times of crisis but are frequently unseen or recognized by traditional disaster response.

What the patient gets is patient centric care; what the patient avoids is going to the emergency room for an unneeded trip. Moreover, by having the health data before an event, patients can be prioritized for vaccines based upon the relationship of comorbidities to suspectibility.

Situational awareness (2.0) is the fundamental component of preparedness. Understanding the combined choices of care, searches for medicines, and dynamics of population movements will ensure the better

outcomes and use of resources.

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