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ABSTRACT

Meaningful use and public health surveillance: to travel fast or far?

LA Lenert

Department of Medicine and Biomedical Informatics, University of Utah School of Medicine, Salt Lake City, UT, USA
E-mail: leslie.lenert@hsc.utah.edu

Objective
The objective of this paper is to review the limitations of current approaches to linkage of public health through meaningful use reporting requirements and to explore alternatives based on integration of public health data reporting requirements, with clinical quality improvement reporting requirements.

Introduction
There is an ancient African proverb that states, 'If you want to travel fast, travel alone—if you want to travel far, travel together.' This paper examines the issue of whether public health can and should 'go it alone' in efforts for creating linkages between clinical care systems and the public health sector, as part of meaningful use requirements. 'Going it alone' in this circumstances refers to whether public health should seek to require data flows, through meaningful use requirements, that meet its work flow needs but do not add value to clinical work flows. An alternative would be to look for synergies between public health goals and the goals of the clinical care system, which public health could exploit to achieve its ends through collaborative means.

Methods
Efforts to create meaningful use requirements are reviewed through the lens of social competition between public health interests seeking more data and more access, healthcare providers seeking to minimize costs and to prevent exposure from loss of confidentiality, and federal regulators seeking workable accommodations that move the state of the programs forward, balancing the needs of society.

Results
Although numerous proposals for submission of data to public health entities were discussed during a series of meetings held by the National Committee of Vital Statistics in Spring of 2009, only two types of data sharing were specified under the final rule for healthcare providers—sharing with immunization registries or submission of syndromic data to health departments, where such capacity exists. Rules for hospitals allow a choice between any of the three tasks: the former two, plus the option of submitting reportable laboratory results to public agencies. The result is an unfavorable one for public health agencies. Agencies need to provide the infrastructure to support all three types of submission, but providers may chose the type of data most convenient for them to submit. Further, because data types submitted by providers are self-selected, the value of the data of public health is diminished. Although the rule allows states to 'require more' data submission, incentives will be paid to all providers who submit one type of data, regardless of any additional requirements (that is, no enforcement.) The conclusion: public health lost this first round of negotiations on integration. It has the most requirements, received only minimal funding from HITECH to support its infrastructure needs to receive data, and has only limited ability to influence the choice that providers make in the type of data they submit through state legislation.

Consider, in contrast, how efforts to enhance population health through quality reporting fared. By 2112, the regulations will require denominator-based reporting on a core set of quality measures pertaining to blood pressure control, smoking cessation, and obesity (or on alternate core measures that include childhood immunization rates). There is also an additional list of 38 other potential quality measures that can be selected for reporting—these are substantiative requirements and everyone must participate.

What if public health chose to align its push for data from meaningful use with these quality measures? For example, smoking cessation quality indicators could be transformed into data on the prevalence of smoking in the practice and on the incidence of cessation interventions? Might not this data, which would use the same mechanisms and infrastructure used to produce quality reporting, be as valuable for public health, from a policy perspective, as data feeds to traditional surveillance systems? The value of the data could

be further enhanced by use of geocoding strategies, such as Geographic Interoperable Patient Summary Exchange formatting, which would allow combination of data across practices and views of the health of small areas and into health disparities.

Conclusions

In addition to the well-known (and experienced) financial limitations that public health faces, in social systems where public health interests compete with those of other sectors, there are limits on the political capital that public has as well. Applying that capital in a way that is synergistic, with other interests in the healthcare sector, may produce better long-term results than going against the interests of the sector. Given the alignment between quality of care measures and population level surveillance of chronic diseases, public health may travel farther 'together' alone in pursuit of traditional surveillance measures.

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