Correspondence

Response to authors of “Barriers to hospital electronic public health reporting and implications for the COVID-19 pandemic”

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RE: Barriers to Hospital Electronic Public Health Reporting and Implications for the COVID-19 Pandemic, JAMIA, https://doi.org/10.1093/jamia/ocaa112

Dear Dr. Bakken (editor of JAMIA) and A Jay Holmgren, Nate C Apathy, and Julia Adler-Milstein (authors),

We applaud efforts to address concerns about information sharing between hospitals and public health systems, particularly during the COVID-19 pandemic. However, we have concerns about the validity and usefulness of the findings reported by Holmgren, et al and the characterization of the ability of public health agencies (PHAs) to receive electronic data.

First, the study findings do not match the situation “on the ground”:

- In 2018, PHAs were able to receive electronic data, particularly lab and immunization data. All relevant (50 states and 6 large cities, such as Los Angeles and New York City) PHAs were receiving laboratory data for electronic laboratory reporting (ELR) (Personal communication: Jason Hall, CDC, 2020) Similarly, 96% of these PHAs were receiving data for their immunization registries.1 In fact, these registries also provide data back to electronic health records and can report timely information about underimmunized populations at risk for outbreaks.2
- The authors reference a lack of local health department capacity in the text and Figure 2; but in reality, it is typical for state or large city PHAs to receive electronic data from hospitals on behalf of local agencies. State or large city PHAs host the IT infrastructure for electronic surveillance and manage interfaces with clinical systems, while staff from smaller PHAs access the hosted system.

Second, the authors overgeneralized the survey findings:

- The authors conflate syndromic surveillance with the larger concept of “electronic surveillance,” as if syndromic surveillance were the important data source for controlling the COVID-19 pandemic. Syndromic surveillance is useful for early detection and population-level monitoring, but it does not include patient-level data needed for case investigation and outbreak management.
- The authors have overinterpreted the responses to the 2018 American Hospital Association (AHA) Annual survey question, leading to possible bias. Hospital CEOs or their designees were asked: “What are some of the challenges your hospital has experienced when trying to submit health information to public health agencies to meet meaningful use (MU) requirements?”3 Four in 10 CEOs (41%) selected the barrier “Public health agencies lacked the capacity (eg, technical, staffing) to electronically receive data.”3 A hospital CEO or delegate may not be aware of their local and state PHA’s capacity to receive electronic health information, or even their own organization’s involvement with electronic reporting of lab results, immunizations, case reports or
other data. In addition, the response option does not provide clarity as to which data, when, and in what form. The AHA survey is important, but results should be interpreted in context.

We are concerned the publication could lead to incorrect assumptions at a time when clinical and public health systems need to communicate more than ever and may discourage health care providers, leaders, and health IT vendors from engaging with public health agencies to avail themselves of existing data exchange capabilities.

Given the critical need for both ELR and case reporting to manage the COVID-19 outbreak, major efforts are underway to expand electronic case reporting (eCR) (https://cdc.gov/ecr) and reduce the burden for health systems. As of July 6, 2020,

• the APHL Informatics Messaging Service (AIMS), a national resource for ELR and eCR reporting, had received 803,239 COVID-19 case reports from over 2000 facilities in 20 health care organizations which were shared with PHAs from 47 jurisdictions; and
• all but 2 state PHAs can receive eCR messages from the AIMS platform, and enhancements are underway to automatically integrate data into surveillance systems (Personal communication: Laura Conn, CDC, 2020).

Public health authorities describe reluctance from providers and health systems to implement electronic reporting on the grounds that implementation is too burdensome. More engagement is needed.

There is no question that inadequate resources have been a limiting factor for public health agencies to receive data from health systems. This problem is exacerbated by the many-to-one (hospitals-to-public health agency) nature of population health activities, the variable nature of hospital data contributions, and the resources required to onboard and manage interfaces with multiple health systems.

We encourage clinical partners to work with public health agencies to improve surveillance of both clinical and public health outcomes and leverage information exchange to benefit communities. We recommend increasing support for public health agencies to enhance their ability to exchange (both receive and send) information while health care systems receive support to send data.

AUTHOR CONTRIBUTIONS
CJS wrote the first draft. All authors provided input and revisions. All authors approved final submission.

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CONFLICT OF INTEREST STATEMENT
None declared.

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