February 4, 2022

Chair Patty Murray
Committee on Health, Education, Labor,
and Pensions
US Senate
154 Russell Senate Office Building
Washington, DC 20510

Ranking Member Richard Burr
Committee on Health, Education, Labor,
and Pensions
US Senate
217 Russell Senate Office Building
Washington, DC 20510

RE: PREVENT Pandemics Act

Submitted via email to *HELPPandemicbill@help.senate.gov*

Dear Chair Murray and Ranking Member Burr:

Thank you for the opportunity to provide feedback on the PREVENT Pandemics Act draft legislation. The past two years of the coronavirus pandemic has shown the increasing need for investing in our public health system, and we applaud your continued leadership in this area.

AHIMA is a global nonprofit association of health information (HI) professionals. AHIMA represents professionals who work with health data for more than one billion patient visits each year. AHIMA's mission of empowering people to impact health drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and clinicians. Our leaders work at the intersection of healthcare, technology, and business, and are found in data integrity and information privacy job functions worldwide. AHIMA members also bring the expertise and knowledge around health information and data that is necessary to inform investments in our healthcare system, including data modernization, patient identification and access, public health, social determinants of health (SDOH), and privacy.

We appreciate the commitment to addressing challenges within the public health system. To ensure a robust bill that meets the needs of patients, providers, public health, and research, AHIMA suggests some critical areas of focus below that we feel would strengthen this already forward-looking piece of legislation.

Section 201: Regarding Improving Standardization of Social Determinants of Health Elements

The COVID-19 pandemic has laid bare the ways health disparities occur within underserved populations. Considering upstream components of health, including social determinants of health (SDOH), are vital to reducing these disparities. However, simply collecting this information is not enough. Underlying the collection of SDOH data is the importance of accurately capturing standardized and structured SDOH elements. Consensus-driven structured data standards are needed for the capture, use, and exchange of SDOH. Today, a lack of agreement over which data to collect and a lack of data standardization has

limited the collection and sharing of SDOH, often leading to confusion about the tools available to providers. This is compounded by the lack of alignment of common terminologies within and across healthcare and social service providers. Therefore, we recommend the following adjustment:

> In Section 201(a)(1), on page 64, lines 4-12, we recommend inserting the word "standardized" after "improve" and the words "exchange, and use" after the word "collection," so that the language reads: "Establishing, maintaining, or improving, in consultation with State, local, or Tribal health departments, technology platforms or networks to support coordination among appropriate entities, and providing information on health and related social services, which may include activities to improve *standardized* data collection, *exchange, and use* for public health purposes, in a manner that is consistent with applicable Federal and State Privacy law."

Sections 211 and 213: Regarding Accurate Patient Information within the Public Health System

We are pleased to see the prioritization of and focus on public health data standards in this legislation. Improving the exchange of electronic health information between public health agencies, laboratories, and clinical care settings is critical for public health responses to widespread diseases. However, a fundamental issue with health information persists – the lack of strategies to ensure complete and accurate information to aid in patient identification and matching.

A complete and accurate health record is essential for tracking the long-term health effects of diseases like COVID-19. Contact tracing also relies on accurate demographic information to verify any exposure to a virus. Furthermore, large-scale immunization programs also depend on accurate patient information to identify who has had the disease, who has been vaccinated, and what their outcomes are.

Despite the importance of accurate patient information, the lack of a nationwide patient identification strategy means that the underlying data informing public health may not always be correct. Public health agencies, including the CDC, as well as laboratories, are increasingly relying on electronic health record (EHR) data in their disease surveillance systems. In a recent AHIMA survey of health information (HI) professionals, nearly 20 percent of respondents noted that their EHRs have error rates of over four percent. HI professionals handle millions of patients in their databases, so even a small percentage of incorrectly matched patient records can result in hundreds of thousands of incorrect records feeding into the public health surveillance systems.

Therefore, to ensure these factors are considered when addressing public health data standards, we recommend the following changes:

> In Section 211(2)(C)(ii)(III)(cc) on page 71, lines 12-17, we recommend adjusting the language to read "(VII) strategies to *improve linkages between laboratory test results and electronic health records* to support rapid and accurate reporting of laboratory test results and associated relevant data, *including strategies to improve accurate and reliable patient identification and matching*."

> In Section 213(a)(3)(B)(i) on page 80, lines 8-9, we suggest adding the words "accurate and complete" before the word "exchange," so that the language reads: "(i) the *accurate and complete* exchange of electronic health information for – "

> In Section 213(b)(2)(C), on page 82, lines 12-14, we recommend the addition of "relating to patient identification and matching" after the word "elements," so that the language reads: "(C) identify challenges related to collection and reporting of demographic and other data elements, *including data relating to patient identification and matching*, with respect to laboratory test results;".

<u>**Section 221 – Improving Recruitment and Retention of the Frontline Public Health Workforce**</u>

Ensuring a robust public health workforce is essential to the health of our nationwide public health system, and AHIMA applauds the attention to this vital issue. Our public health system requires a wide range of areas of expertise to ensure the many areas of public health are addressed. One of these expertise areas includes health information professionals.

Safeguarding the accuracy, completeness, and timeliness of patient health information is at the core of what health information professionals do. Health information management professionals play large roles in their state and local public health departments by helping to standardize data, contributing to the collection, assessment, and management of health data, as well as serving as privacy officers to maintain the confidentiality, privacy, and security of health data consistent with state and federal law. Public health is consistently relying on greater interoperability of electronic health data, which health information management professionals regularly manage. Therefore, it is our recommendation that health information degrees and certificates be included in the list of programs eligible for the Public Health Workforce Loan Repayment Program. We recommend:

> In Section 221(a)(2)(A), on page 93, lines 16-24, to insert the words "health information management" after "data analytics," so that it reads "(1)(A)(i) be accepted for enrollment, or be enrolled, as a student in an accredited institution of higher education or school of public health in the final semester (or equivalent) of a program leading to a certificate or degree, including a master's or doctoral degree, in public health, epidemiology, laboratory sciences, data systems, data science, data analytics, *health information management*, statistics, or another subject matter related to public health;"

> In Section 221(a)(2)(B), on page 94, lines 14-23, to insert the words "health information management" after "data analytics," so that it reads "(II) by striking a 'public health or health professions degree or certificate' and inserting 'a certificate or degree, including a master's or doctoral degree, in public health, epidemiology, laboratory sciences, data systems, data science, data analytics, *health information management*, informatics, statistics, or another subject matter related to public health';"

AHIMA thanks Chair Murray and Ranking Member Burr for their leadership in strengthening our public health system and for the opportunity to provide feedback. We look forward to working with you to ensure a public health system that is adequately prepared to handle future pandemics and crises. Should you or your staff have any additional questions or comments, please contact Kate McFadyen, Director, Government Affairs, at kate.mcfadyen@ahima.org or (202) 480-6058.

Sincerely,

Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer