



TESTIMONY
Before the
NATIONAL COMMITTEE ON VITAL AND HEALTH
STATISTICS
On
VITAL RECORDS

Submitted by:

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My name is Linette Scott and I am the Chief Medical Information Officer and the Deputy Director of the Information Management Division at the California Department of Health Care Services, known as DHCS. In this role, I work across the Department and with stakeholders to ensure that reliable data and information are available and used to drive improvements in population health and clinical outcomes through the Department's programs and policies. Prior to joining DHCS, I served as the Interim Deputy Secretary for Health Information Technology at the California Health and Human Services Agency and the California State Registrar and Deputy Director of Health Information and Strategic Planning at the California Department of Public Health. While serving as the State Registrar, I worked closely with the National Association for Public Health Statistics and Information Systems (NAPHSIS) on various committees and as a Board member. I also served as a General Medical Officer with the United States Navy, first as squadron physician with the Regional Support Group and later as the military physician for an Active Duty clinic. I am a Board Certified Physician in Clinical Informatics and Public Health and General Preventive Medicine. I have an MD from Eastern Virginia Medical School, an MPH from University of California, Davis, and a BA in Physics from University of California, Santa Cruz.

Thank you for the opportunity to respond to the questions and provide information to address the Committee regarding Vital Records.

DHCS is the single state agency responsible for California's Medicaid program, known as Medi-Cal. Medi-Cal serves approximately 13 million beneficiaries in a complex and diverse population. Vital records data are important to many of the business processes in the Medi-Cal program. As such, DHCS is an end user of the vital records registration processes. There are many activities within DHCS that have dependencies on vital records data.

One set of examples is the use of vital records data and certificates for eligibility processes, including the use of birth data to verify identity for eligibility for programs and death data to dis-enroll members and providers from programs. This is important to prevent fraud and abuse, and as such has been a focus of various audits and program reviews.

Another set of examples is the use of both birth and death data to assess quality of care and outcomes within the Medi-Cal program. The Centers for Medicare and Medicaid Services (CMS) established core sets of quality measures for children and adults. Both sets include maternal and perinatal health measures that benefit from birth data. Measures include "Live Births Weighing Less Than 2,500 Grams," "Prenatal and Postpartum Care: Timeliness of Prenatal Care," and "Prenatal and Postpartum Care: Postpartum Care." (<https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html>) (<https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html>)

As states work to report both the core set measures and other performance measures, data inconsistencies as well as program variations often limit national reporting and comparisons between states. This is one of the reasons that Medicaid programs have been advancing the adoption of national standards through activities such as the

Medicaid Information Technology Architecture (MITA) initiative, the Health Insurance Portability Accountability Act (HIPAA), and the Transformed Medicaid Statistical Information System (T-MSIS).

- The MITA initiative requires the adoption of national standards in order to advance the maturity of the various business processes in Medicaid. (<https://www.medicaid.gov/medicaid/data-and-systems/mita/index.html>)
- HIPAA requires the use of standardized code sets such as Healthcare Common Procedure Coding System (HCPCS) and International Classification of Diseases (ICD) for administrative claims processes. (<https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets/index.html>)
- T-MSIS has been modernizing data transmission and management with respect to data submitted by state Medicaid programs to CMS as required by federal law. (<https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/index.html>)

In each of these examples, national standards are being used to drive efficiencies for monitoring, evaluating, and reporting for programs and associated outcomes. Similarly, the national vital statistics system supports the development and adoption of standards for the state vital registration processes. Without these types of standards, results are open to interpretation and comparisons cannot be made.

The use of vital records to assess quality of care and outcomes is directly supported by the National Center for Health Statistics (NCHS) through its work with state vital records programs. NCHS establishes standards and definitions through the U.S. Standard Certificates and Reports that are adopted by state registration systems. NCHS supports cause of death coding and performs quality reviews for data submitted by states. NCHS has also convened workgroups to periodically update the Model State Vital Statistics Act and Regulations, which can then be adopted by states to increase consistency. Of note, the first Model Law for vital statistics was published in 1907. The use of standards allows for performance measurement nationally as well as comparisons between states. Without the standards set and supported by NCHS this would not be possible.

NCHS has been an active participant with NAPHSIS and the states in the development of vital records data transmission standards being adopted by Health Level 7. This has been a foundational step to support the integration of vital records data with Electronic Health Records (EHRs) in support of meaningful use requirements under the EHR Incentive Programs. The work to integrate vital records processes with EHRs and the health care environment, while still early, is laying the groundwork for transforming data collection and decreasing burden for providers. Additionally, the data from birth and death records when shared with providers are being used to assess quality and outcomes of the services provided. In my role as the Health Information Technology (HIT) Coordinator, I believe this is a significant advancement for improving quality, leveraging technology and decreasing reporting burden for providers.

In California, vital records are registered and maintained by the California Department of Public Health (CDPH). DHCS has been working closely with the CDPH to streamline the provision of vital records data to support Medi-Cal business needs for both real-time data and statistical year-end files. Funding for vital records varies from state to state.

Many state vital records programs do not receive state general funds, but instead are supported with fees for certificates and cost reimbursement from data users. In recognition of the importance of real-time vital records data for Medi-Cal business processes in California, DHCS requested and CMS approved enhanced federal funding for DHCS to obtain this data from CDPH.

DHCS is a HIPAA covered entity and as such has a secure data environment. Vital records data received by DHCS are maintained in that same secure environment. Additionally, DHCS staff that have a business need to use the vital records data complete additional agreements that acknowledge the state specific requirements for the protection of vital records data.

Both DHCS and CDPH are part of the California Health and Human Services Agency (CHHS). CHHS has been engaged in efforts to improve the availability and usability of public data through the CHHS Open Data Portal (<https://data.chhs.ca.gov/>). To support this data sharing, CHHS developed Data De-identification Guidelines (DDG) in 2016 that have been adopted by both departments to support consistent methodologies with respect to public data release.

(https://chhsdata.github.io/dataplaybook//resource_library/#datade-id)

Vital records infrastructure and funding have significant variability and complexity. However, the work done to date through partnership between states and NCHS has resulted in data sets that form the basis of a multitude of activities and have data quality and consistency that is a goal for many administrative data systems. Continued support for this foundational data and the state registration processes is essential as we work to continue to transform the health care system and improve health and health outcomes for our constituents.

Thank you for the opportunity to testify.