



Senate Health and Human Services Committee
Testimony on Interim Charge No. 8
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Presented by the Texas Medical Association, Texas Pediatric Society, and Texas Academy of Family Physicians

Madame Chair and members of the committee, my name is Donald Murphey, MD, and I am the medical director of pediatric infectious disease at Cook Children's Medical Center in Fort Worth. I serve as a co-chair of the Texas Pediatric Society's Infectious Disease and Immunizations Committee as well as a member of the Texas Medical Association's Infectious Disease Committee. It is a privilege for me to speak with you today on behalf of TMA, the Texas Pediatric Society, and the Texas Academy of Family Physicians, collectively representing more than 48,000 physicians in Texas.

As someone who comes face to face with infectious diseases daily, I understand the importance of public health surveillance. The ability to monitor both disease outbreak and vaccination status is critical to ensuring a healthy population. The Texas immunization registry, ImmTrac, was created in 1994 after a measles outbreak in Texas occurred among young children. The outbreak resulted in 9,400 cases and 26 deaths in Texas from 1988 to 1993. Measles was a disease most people thought was eradicated in the United States; nationwide, 55,000 cases were reported, resulting in 11,000 hospitalizations and 150 deaths. The measles resurgence was attributed to low vaccination rates among preschool-age children. Electronic registries housing immunization data such as ImmTrac became a means of responding to undervaccination.

ImmTrac is terribly practical. How many of us can confidently say that we know exactly where our immunization records are and whether or not we are up to date on our recommended vaccinations? Electronic registries provide a wonderful, convenient resource for families, physicians, nurses, and schools.

ImmTrac is an extremely valuable public health surveillance tool. We are going to have outbreaks of disease. It isn't theoretical. New York has experienced 1,500 cases of mumps primarily in the Orthodox Jewish community since last summer. Most of the cases have occurred in individuals who received their mumps vaccine. This indicates that crowding in households or schools can overwhelm the protective environment of immunizations. The immunization registry gives us the ability to be more intelligent in how we respond to such outbreaks, allowing us to access data when making clinical decisions. For example, when a community in Texas is in the midst of an outbreak such as pertussis (more commonly known as whooping cough), we can access the registry to

determine whether or not an individual needs his or her pertussis vaccination. In doing so, we save taxpayers and the health insurance industry dollars by not giving immunizations when they're not necessary.

Although I was just completing my boards in pediatric infectious diseases at the time, I feel certain that the opt-in vs. opt-out debate began at the registry's inception. At question is whether people should be asked for consent before their data are placed into the registry, which constitutes an opt-in system. If their data are to be placed in the registry automatically but removed if requested, it is an opt-out system. Texas operates an opt-in registry. A recent Texas study outlines the significant cost incurred — \$1 million — through the administratively taxing consent process that caters to an extremely small percentage (4 percent) of the population. As most of you sitting around the table know, physicians have long been supportive of an opt-out registry. The cost savings associated with an opt-out registry is certainly a bonus, and while it's clear that \$1 million won't solve the state's current budget woes, the dollars certainly could be used to make the registry more functional.

Last spring, during the 81st session of the Texas Legislature, this committee worked hard on legislation sponsored by State Sen. Bob Deuell that created a disclosure process for families about the storage of newborn screening blood spot cards post-screen. As a result, families are now notified that card storage is an option after the birth of a child and are given the opportunity then, and again at a time of their own choosing, to have their child's blood spot card destroyed rather than stored long term for research purposes. Is the system perfect from an administrative perspective? No, but does it inform families of their options and ensure the destruction of data based on parental consent? Yes, it does. We recommend looking at how to best align these two important consent processes with a mind toward improving consistency within the Department of State Health Services (DSHS) and cutting down on administrative waste.

A fundamental component to any registry is data. Although ImmTrac houses vaccination data for 96 percent of the state's under-18 population, according to DSHS the data available aren't complete. Most of the data in ImmTrac are actually provided by health plans who agreed years ago to submit their claims data electronically to help populate ImmTrac. Physicians are required by law to report to ImmTrac but few do. Why? ImmTrac is not set up to receive data easily. In an age of electronic health records (EHRs), ImmTrac doesn't have the technical capacity to access immunization data directly from physician EHRs. Instead, if physicians want to report data to ImmTrac, they have to hire an employee, or redirect the attention of an employee, to upload data manually. And in those instances where an office uses an EHR, an employee must first input immunization data manually into the office's EHR, then input the same data into ImmTrac. Amid the ever-increasing demands of a physician's office, doctors and office staff decline to participate in ImmTrac rather than deal with its complexity. It is critical that a platform be developed to allow ImmTrac to communicate with all EHRs.

In 2007, during the 80th legislative session, lawmakers passed legislation to meet federal disaster planning requirements, designating ImmTrac as the state's registry for individuals receiving immunizations, antivirals, or other medication as well as any adverse reactions in connection with the preparation for, or declaration of, a disaster or

emergency such as a public health emergency or terrorist attack. ImmTrac, which housed similar data, became the clearinghouse for this information rather than wasting state resources by establishing a separate registry.

As such, physicians are required to report all H1N1 vaccinations to ImmTrac. Although doctors are still administering the H1N1 vaccine, early feedback tells us this reporting requirement was an additional burden on their time, adding to confusion and reporting delays. Of particular concern is that the H1N1 vaccine is a two-dose series for children under 10 years of age. The vaccine also must be separated by 28 days for optimal protection. Low reporting rates and time delays meant physicians couldn't rely on the registry for accurate information to determine appropriate spacing between shots. Additionally, the vaccine appeared in such odd quantities initially that patients may have received their first dose in a pharmacy and their second dose in their physician's office, further complicating reporting and tracking. The claims data that health plans reported to ImmTrac are typically on a 30-day delay, so even the electronic reporting we know works wasn't helpful during this outbreak. DSHS did offer physicians the ability to submit written records to the department to be entered manually into ImmTrac by DSHS staff, but such a service hardly makes sense.

Before I close, because the presumed budget deficit is weighing on everyone's mind, I think it appropriate to point out that DSHS houses a plethora of registries. While our focus today is on ImmTrac, the department also operates registries dedicated to birth defects, cancer surveillance, and newborn screening, just to name a few. They are all unique, catering to different audiences. Some are newer than others. Reviewing these systems and their purpose, how data are collected, and who uses them and how might be a worthy exercise as the legislature looks at how to maximize state and federal funding and conduct health planning.

In closing, physicians support ImmTrac. We know it is valuable and when appropriately populated, can serve as a tremendous tool to ensure Texans are fully vaccinated and protected against real and serious diseases. Enhancing the way the registry obtains consent and the way data are shared is an important piece in helping ImmTrac become a fully viable public health tool. Over the years, this committee has shepherded policies that have improved the state's standing in various public health measures. Enhancing systems that have a direct role in further improving Texas' disease state is necessary. We want Texas to be a hospitable environment for businesses and industries looking for a new home. The physicians of Texas stand ready to help the committee as it explores this important interim charge and focuses on how to optimize the state's immunization registry.

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