



Comments Submitted for the Record

House Committee on Energy and Commerce
Subcommittee on Health
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Member, Health Information Technology Advisory Committee (HITAC)**

Thank you for the opportunity to provide a statement for inclusion in the hearing record. I applaud the Energy and Commerce Committee for its important work to modernize our public health data infrastructure, including ensuring appropriate collection and use of data related to health inequities. I look forward to working with the committee and its members to foster a successful transition from current state to a modern, efficient, and effective system of public health data systems and infrastructure.

HCA Healthcare is one of the nation's leading providers of healthcare services, with over 180 hospitals in 20 states and the United Kingdom. Each year, approximately five percent of all hospital services in the U.S. happen at an HCA Healthcare facility. Last year, HCA Healthcare facilities witnessed over 32 million patient encounters and treated over 170,000 inpatients with COVID-19. HCA Healthcare is also the largest provider of Medicaid services in the country. Twenty-five percent of all hospital admissions and 50 percent of all ER visits in HCA Healthcare facilities either are covered by Medicaid or are uninsured patients.

HCA Healthcare is a strong advocate for the interoperability of health data, including public health data. With our presence in 20 states, we have a unique vantage point that allows us to identify opportunities and gaps to help inform the national roadmap. Internal investment across HCA Healthcare facilities on standardization of our data can serve as a model for how data and interoperability can benefit the health system. By using two key examples of HCA Healthcare's experience with public health emergencies, I recommend the committee focus on three key goals as it works to modernize public health data collection, reporting, and use:

1. Standardization – public health data should adhere to existing, private-sector-driven standards that allow machine-readable and human-understandable information to follow the patient without special effort.
2. Simplification – streamline the complex system of public health reporting to ease burdens on both providers (reporters) and states, local, and tribal jurisdictions (receivers) and ensure accurate and consistent reporting and availability of data.
3. Share – data reported up to public health agencies should not go into a black box. Instead, aggregate data should be shared with providers and others in the field to inform local and

regional decision making and foster collaboration between private entities and between government and the private sector.

COVID-19 Reporting

Complying with COVID-19 reporting required appointment of a “data steward” at each HCA Healthcare facility across the country. We found that we needed a person at each facility making sure that data from different departments was consistently collected and reported up to public health entities. Much of the data required manual reporting, so phone calls or walking around to rooms in a hospital to count gloves were common activities overseen by each data steward. Reporting lab test results was challenging. Initially there was not a specified code in the Logical Observation Identifiers Names and Codes (LOINC) terminology, so we had to figure it out ourselves. Because different COVID-19 tests reported results in different ways, calling to confirm results was common practice. To properly report the 1,605,000 lab tests performed in our facilities and the 335,000 tests our patients received in other facilities, our staff had to map 219 different mnemonics from the 225 laboratories we worked with into 2 LOINC codes. Even now, though LOINC codes are available, as a rule the laboratories do not adhere and still send test results with their own proprietary mnemonics.

The reporting itself was also a major challenge. For federal COVID-19 reporting, each of our 185 hospitals initially had to report individually through the National Healthcare Safety Network (NHSN) up to the Department of Health and Human Services (HHS)—a very inefficient process. Implementation of TeleTracking streamlined federal reporting for us, providing a single source rather than the varied reporting to different public health departments across the country through NHSN. However, in some instances the states themselves report COVID-19 data to HHS and we often have no receipt or confirmation that the data was then sent reliably to HHS. In fact, in many instances data was lost, putting hospitals at risk of appearing non-compliant.

Each public health department in each state in which HCA Healthcare operates has a different data use agreement our facilities must sign in order to share data. Additionally, even if a facility reports up to a state or local authority, there is no guarantee that information will be passed on or received by that entity.

In summary, reporting was incredibly burdensome for providers across our facilities but we were able to make rapid changes across the health system to meet the requirements. There was inconsistent implementation of report collection systems, leading to the need for individual contracting and technical troubleshooting between each end point involved. The lack of consistent standards contributed to this complexity, and all of this created high costs and significant personnel needs for compliance at each facility. By normalizing the variation across the country in both the technical requirements and standards as well as the legal agreements necessary between reporters and receivers, the federal government could ease burdens for both providers and public health authorities and reduce compliance costs. Additionally, the data shared with public health authorities in a crisis like the COVID-19 pandemic should be aggregated and shared back with providers on the ground to inform care decisions and resource allocation with the goal of improving patient outcomes.

Hurricanes

A relevant and prime example of how readily-available, standardized information contained within interoperable systems can be used to solve complex issues can be found in HCA Healthcare's response to the most challenging natural disasters. Forty percent of HCA Healthcare hospitals are routinely in the path of hurricanes. When hurricanes hit Florida a few years ago, our system was put to the test. While electronic health records are primarily focused on day-to-day transactional data documenting the encounters between providers and patients, the systems had to be leveraged to inform our disaster response. By implementing population-level data aggregation, real-time analytics, and clinical decision support, HCA Healthcare was able to assess patient risk and organize patient transports to facilities out of harm's way as needed. Historically prior to the data being mapped and available, that data had to be collected by nurse managers in 47 hospitals in the midst of a hurricane while moving rapidly throughout their hospitals recording the information on paper clipboards.

We were able to develop a risk assessment tool, Next-Gen Analytics for Treatment and Efficiency (NATE), to determine patient acuity, identify the most appropriate mode of transportation, deploy the necessary resources to the right locations, and get patients safely out of the path of the storm.

Thank you for the opportunity to submit comments for the record. In my role as Chief Health Information Officer at HCA Healthcare and as a Member of the Health Information Technology Advisory Committee (HITAC), I am committed to bolstering the exchange of health data to support improved health outcomes. I appreciate the committee's attention to this important matter and look forward to partnering as patient-driven solutions to improve the public health data infrastructure are contemplated.