CLOSING THE DATA GAP: IMPROVING INTEROPERABILITY BETWEEN VA AND COMMUNITY PROVIDERS

HEARING

BEFORE THE

SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION

OF THE

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C O N T E N T S

MONDAY, MARCH 24, 2025

CLOSING THE DATA GAP: IMPROVING INTEROPERABILITY BETWEEN VA AND COMMUNITY PROVIDERS

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SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:57 p.m., in room 360, Cannon House Office Building, Hon. Tom Barrett (chairman of the subcommittee) presiding.

Present: Representatives Barrett, and Budzinski.

OPENING STATEMENT OF TOM BARRETT, CHAIRMAN

Mr. BARRETT. Good afternoon. The subcommittee will come to order.

I want to start by saying I appreciate the effort of those on the panel that are here to testify today and appreciate your willingness to come before the committee. In the future, though, I would really appreciate, particularly for those here from the U.S. Department of Veterans Affairs (VA), if you can provide your testimony ahead of time. I know that a lot of work goes into that but, you know, the subcommittee staff here, myself and my staff appreciate the opportunity to review some of the commentary and remarks and everything ahead of these committees and would appreciate your willingness to provide that in the timelines that we have. I feel like we have been pretty generous with the timelines we have given, and it takes everybody's cooperation to make sure that we are able to do this in a timely and efficient way. Appreciate that.

I asked the VA to appear today because of interoperability impacts and what it does to every veteran across our country. The Department's testimony is critical for the subcommittee's oversight requirements.

Now, on to today's topic. Of course, I kind of mentioned briefly about interoperability, but this is important because all across the country right now as we are sitting here in this committee, a veteran somewhere is walking into a new doctor's office for the very first time. This veteran will not have any prior relationship with the provider they are encountering, and they may not have any of their medical records on file at that particular hospital or medical facility.

This doctor's office could be at a VA medical center. It could be at a community care facility. No matter the location, the doctor will

have the same question: How do I give this veteran the best care without knowing their medical history, without knowing their medication, without knowing their allergies, their lab results, whether or not this veteran has struggled with mental health challenges?

There are several doctors on our panel today, and I am sure they would agree that complete and accurate information is an important ingredient in high-quality healthcare.

Providers want their patients' healthcare data to be interoperable. They want to be able to exchange medical records regardless of which hospital they were created at and use that information to treat their patients.

I want to be clear. VA and the entire healthcare industry have made enormous progress for the last two decades and millions of healthcare records are exchanged every single year all across our country in various ways.

Even when data exchange does not happen, veterans still receive great healthcare every day when providers do not have access to their complete medical history. I know that we have very well-trained physicians who provide the absolute greatest level of care that they can. However, the best healthcare requires truly interoperable healthcare data that moves with the veteran regardless of which Electronic Health Record (EHR) is being used by the doctor and who is treating them.

There are gaps that remain and opportunities for improvement. VA provides healthcare to millions of veterans every single year, including myself. However, roughly one-third of VA care is provided by the Community Care Network (CCN).

Throughout their lifetime, veterans will visit an assortment of providers at the U.S. Department of Defense (DOD), the VA, and private facilities. Every appointment produces new information. VA has made a ton of progress exchanging data with larger hospital systems, but struggles to exchange data with many smaller hospitals and physicians' offices.

In order to live up to our commitment to veterans, VA must be able to share and use complete and accurate healthcare information with each of the Community Care partners. A big part of that is ensuring that when healthcare data is exchanged between VA and Community Care providers, it is standardized.

There is only so much a provider can do with a list of lab results if each hospital documents and displays the results differently. This is the difference between a read-only file and data that is searchable, sortable, and able to be organized and utilized. The quality of the data is just as important as the quantity.

That is why this committee put a requirement in the Dole Act for the VA to adopt health information interoperability standards for the Department and its Community Care providers. These standards are about data quality and will improve how VA and Community Care providers exchange data for care and benefits, patient identity matching, and more, ultimately improving outcomes for veterans inside and outside the VA.

During this hearing, I hope to hear some preliminary updates on VA's strategy. In addition, I hope to hear about some of VA's recent

progress and their plans to bridge the interoperability gaps that still exist.

VA recently created the Veterans Interoperability Pledge, which allows private hospitals to instantly confirm whether a patient is a veteran. There are many health issues that are assumed to be linked to military service. Simply knowing that a patient is a veteran allows healthcare providers outside VA's system to give the best care, consider service-related health issues, and quickly connect them to the right supports where necessary. This is an important leap forward for data exchange between VA and community partners. While it is only in its infancy, I am eager to hear more about its early success and VA's plans to expand to more Community Care providers.

VA is currently connected to over 90 percent of hospitals in America through Health Information Exchanges. Ten years ago, though, VA exchanged less than 100,000 healthcare documents a year. Now they are exchanging millions.

While VA is connected to roughly 90 percent of U.S. hospitals, the last 10 percent are the hardest to reach. Far less than 90 percent of physicians' offices are currently exchanging data with the VA.

I will close by saying that many of the technical challenges around healthcare interoperability are no longer obstacles. What remains is for VA to organize and collaborate with its Community Care partners to make sure that the provider I mentioned earlier who is seeing a veteran for the first time today has all the information they need to provide the best care possible.

Thank you again for being here. I look forward to your testimony.

With that, I will yield to the Ranking Member Budzinski for her opening statement as well.

OPENING STATEMENT OF NIKKI BUDZINSKI, RANKING MEMBER

Ms. BUDZINSKI. Thank you very much, Mr. Chairman.

Thank you as well to the witnesses for being here to discuss this critical topic today.

Interoperability is a crucial factor in ensuring safe, effective, and veteran-centric healthcare. It supports the care coordination that is a hallmark of VA healthcare.

Unfortunately, VA's interoperability efforts have been hindered for decades by the decentralized nature of its Electronic Health Record. In fact, one of three major goals of the Electronic Health Record Modernization, or EHRM Program, is to implement an EHR that is interoperable with DOD and Community Care providers, creating a complete medical record for the life of the veteran.

A complete medical record allows for better outcomes for veterans, as their providers, wherever they receive care, have all the information they need to make the best, most clinically informed decisions. I wholeheartedly support this effort.

However, getting from where we are today to complete interoperability is no small undertaking. It requires a combination of efforts from three corners: Technology, people, and process. VA utilizes a multitude of platforms, systems, and frameworks to approach inter-

operability from a technology standpoint, from the referral of services with the Health Share Referral Manager, or HSRM, to the standardization of the data, Veterans Data Integration and Federation Enterprise Platform (VDIF-EP), to the information sharing itself with Veteran Health Information Exchange and VA's growing work with Trusted Exchange Framework and Federation Enterprise Platform (TEFCA).

VA appears to be throwing everything they have at interoperability. VA's websites tout a seamless and secure interface for VA and community providers with this infrastructure, but from what I have heard that does not seem to be the case.

Despite these systems getting us closer to our interoperability goals, they do not encompass the full picture. VA's legacy EHR does not allow for complete integration of medical records even when they are shared through the Health Information Exchange.

This requires clerks to locate records, download them, and then upload them to Veterans Health Information Systems and Technology (VistA). Oracle Cerner's EHR has a direct link to the Exchange, allowing records to be pulled in and integrated in two to three clicks, though, again, these records can only be pulled through if providers are using the Veteran Health Information Exchange and if they know and remember to do it.

Without standard use of the Exchange, providers continue to rely on sending information via fax or E—I am sorry, or HSRM, which inevitably results in processing delays and backlogs and risks incomplete records that could have disastrous clinical impacts, including putting patient safety at risk.

I look forward to hearing from Dr. Greenstone, a former executive director of clinical operations at VA, and Mr. McGraw from the Michigan Health Information Network on systems that integrate referrals and document management into one workflow.

Technology is great, but it is nothing without the people. It takes a highly skilled and impressively dedicated workforce to deliver the world-class healthcare and benefits the VA is known for.

That is why the recent news of the Trump administration's personnel actions is extremely concerning. Their decisions to terminate over 2,400 probationary employees and its plans to further reduce the VA workforce by at least 15 percent, or 80,000 positions, is abhorrent. These actions have already resulted in negative patient outcomes for veterans and will continue to do so.

While it is great the VA purports to be exempting doctors and nurses from these cuts, that ignores the fact that there are dozens of other jobs, clinical and nonclinical, that make delivery of healthcare possible.

For example, scanning and file clerks in the Health Information Management, or HIM service, were impacted in the Secretary's probationary employee purge. Without sufficient HIM scanning and filing clerks, medical records will continue to pile up, not being entered into the veterans' files and further risking quality of care. If we expect world-class care for veterans at VA, we must ensure the VA is resourced adequately to do so.

Finally, VA's ongoing struggles with its processes have overcomplicated what was already a complicated process. Like most of VA's

modernization efforts, the move toward interoperability seems to be burdened by training and change management challenges.

Additionally, the variation of VA's clinical workflows makes the data standardization needed for interoperability difficult, and the agreements with Community Care providers and Third-Party Administrators leaves VA with little recourse for accountability.

The lack of connectivity depends on the user. Some Community Care providers are unaware of the Health Information Exchanges and their practices do not possess mature enough systems to utilize it. Others are not trained adequately to just the tools, defaulting to their comfortable workflows, like faxes, fax machines and phone calls.

By reverting to these antiquated workflows, providers and veterans may face weeks' or even months' long delays in accessing their records due to processing backlogs, backlogs that will likely only become lengthier with the Trump administration's cuts to the VA workforce and Information Technology (IT) contract support.

I look forward to today's discussion, but also think we need to have a bigger conversation with Oracle and the Third-Party Administrators for the Community Care Network in future meetings on their efforts to increase awareness, training, and use of interoperability tools and how they are going to hold both VA and Community Care providers accountable.

Ultimately, we must be realistic about what we are expecting VA to do and with what resources. Especially when we operate in an environment as we are today with an administration that wants VA to do more with less.

I believe this conversation today will be enlightening, and I look forward to further work on this topic.

Thank you, Mr. Chairman, and I yield back.

Mr. BARRETT. Thank you. I appreciate that.

I will now introduce our witnesses. From the Department of Veterans Affairs, we have Dr. Jonathan Nebeker, chief medical informatics officer and executive director of clinical informatics. Did I say that correctly? Very good, Doctor.

Dr. Laura Prietula—right?—deputy chief information officer for the Electronic Health Record Modernization Integration Office.

Also joining us from the great State of Michigan, of course, is Mr. Rick McGraw, Chief Growth Officer for the University of Michigan Health Information Network Shared Services; and Dr. Andrew Rosenberg, chief information officer at Michigan Medicine. Thank you.

Finally, we have Dr. Leo Greenstone, chief medical officer at Signature Performance.

Very good. Thank you all again, each one of you, for being here today. I ask the witnesses to please stand and raise your right hand.

[Witnesses sworn.]

Mr. BARRETT. Thank you. Let the record reflect that all witnesses have answered in the affirmative.

Going in order, Dr. Nebeker, you are now recognized for 5 minutes to deliver your opening statement on behalf of VA.

STATEMENT OF JONATHAN NEBEKER

Dr. NEBEKER. Good afternoon, Chairman Barrett, Ranking Member Budzinski, and distinguished members of the subcommittee.

Joining me here today is Dr. Laura Prietula, deputy chief information officer of the Electronic Health Record Modernization Integration Office.

Thank you for the opportunity to discuss interoperability between the Department of Veterans Affairs and communities beyond VA. Our efforts to expand veterans' access to care, both inside and outside VA, mean more veterans are using their benefits to seek care.

Recently enacted laws like the Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) and John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Acts empower veterans to seek care from the community providers when it is in the best interests or for—best interests for the veteran or when VA care is unavailable.

As a result, the need for care coordination and exchange of health information among VA and community providers has surged. Exchange and use of healthcare data are essential for ensuring the veterans have better access, better health, and reduced out-of-pocket expenses.

In 2009, VA and DOD began allowing clinicians to view shared data to reduce reliance on paper records. Launched in 2014, the Joint Longitudinal Viewer, or JLV, provided a more reliable and user-friendly solution.

In January 2025, now, over 110,000 VA employees accessed and opened 2.2 million Community Care documents in JLV. User surveys showed JLV improved patient outcomes, saved time, and reduced duplicative testing.

The Joint Health Information Exchange, commonly referred to as JHIE, established by VA and DOD in 2020, has significantly improved Federal EHR interoperability. It connects well over 100,000 provider sites through two national exchanges, eHealth Exchange and Commonwealth. In January 2025 alone, JHIE exchanged over 360 million documents for 18 million patient matches.

The Trusted Exchange Framework and Common Agreement, also known as TEFCA, is a nationwide framework for health information sharing. VA aims to participate in TEFCA, contract with a Qualified Health Information Network (QHIN) provider, and be fully functional and tested for purposes of treatment by early December 2025. Key considerations include accurate patient matching and cost.

The deployment of the Federal Electronic Health Record will also advance this interoperability agenda. Despite the significant progress, VA continues to address connectivity gaps, especially with small provider organizations not using a top five EHR system.

While about 80 percent of veterans actively enrolled in VA care visit at least one—sorry. While 80 percent of veterans actively enrolled in VA care visit at least one provider connected to the national exchange, only 30 percent of providers billing VA for Community Care are connected to eHealth Exchange or Commonwealth.

Connectivity to State or metropolitan exchanges via Regional Health Information Organizations, or RHIOs, may help close this gap. Moreover, RHIOs enhance care coordination by offering unique services, like longitudinal viewers and push notifications that national exchanges currently do not.

VA is collaborating with industry partners to improve data quality gaps, which impact clinical decision support, quality measurement, population health and benefits adjudication.

Examples of challenges include incorrect weights, missing serum sodium values, incomprehensible codes and misclassified allergies. Stakeholders are developing open-source technologies to objectively code data quality and provide improvement suggestions.

The Veteran Interoperability Pledge (VIP) demonstrates a cost-effective approach to interoperability, yielding significant benefits for veterans. Launched in 2023, with 13 high-quality healthcare systems, VIP addresses goals beyond TEFCA, including identifying veterans, connecting them with VA and community resources, and ensuring reliable care coordination. Our partners have already identified over 200,000 veterans that may benefit from the COMPACT and PACT Acts.

VA plans to expand VIP membership to more healthcare systems, payors, and technology companies, prioritizing automation in benefits determination and care coordination. These efforts will ensure that VA can connect veterans to Federal, State, and donated benefits.

VA remains committed to putting veterans at the center of its operations, focusing on customer service and convenience, which interoperability makes easier.

We appreciate the subcommittee's commitment and oversight to ensure VA serves veterans with excellence, and we look forward to responding to any questions you may have.

[THE PREPARED STATEMENT OF JONATHAN NEBEKER APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you, Doc, appreciate it.

The written statement of Dr. Nebeker will be entered into the hearing record.

I think we are moving next to Mr. McGraw. Is that correct? Dr. Prietula, do you have a separate—okay, very good. Then, Doc, I will get back to you in just a moment. I think we are going next to Mr. McGraw for your remarks for 5 minutes. Thank you.

STATEMENT OF RICK MCGRAW

Mr. MCGRAW. Thank you. Thank you for the opportunity to testify today about the vital role that Health Information Exchanges (HIE) play in the interoperability of our overall healthcare infrastructure. Today, I will concentrate my testimony on the over 10 million residents of Michigan, with over 461,000 veterans of our military services.

Michigan Health Information Network (MiHIN) is our statewide HIE. MiHIN was formed in 2010 as a public-private partnership with the Health Information Technology Commission, housed in the Department of Health and Human Services. MiHIN was designed to play a pivotal role in advancing healthcare interoper-

ability by facilitating seamless information sharing across Michigan's healthcare ecosystem.

Since MiHIN's inception in 2010, we have interfaced with nearly 80 individual Electronic Health Record systems and two national networks that only represent a limited number of use cases. A use case is a unique instance of sharing specific information regarding patients and their health.

MiHIN, however, operates over 50 use cases for our clients, ranging from hospitals, primary care facilities, payers, community mental health facilities, skilled nursing facilities and local city and county health departments, to name a few.

From the 5,300-plus healthcare facilities connected to MiHIN, we have routed over 8.3 billion messages to enhance care coordination and vital data delivery across the State. For example, 97 percent of all State admission, discharge, and transfer summaries pass through MiHIN today.

MiHIN's direct interfaces with local healthcare facilities' EHRs provides instantaneous record submissions immediately following an encounter with a patient. In less than 4 minutes, that information is received, verified, and routed to our portal, where the patient's longitudinal record is updated with their latest information.

Our most recent use case is collaborating with a mobile technology company to route realtime data from ambulances en route to emergency rooms (ER). Emergency medical technicians en route will have access to a patient's Electronic Medical Records (EMR) while also transmitting current vitals to the receiving emergency department (ED).

Alerts sent to the ED will notify them that the patient is en route so they have access to the patient's longitudinal record from MiHIN. The best quality healthcare is not only local, but it is in near real time.

For security and privacy considerations, MiHIN, as a business associate to the largest health and government systems in Michigan, provides security and privacy of healthcare data while ensuring it is interoperable and accessible.

MiHIN and our major technology vendors are certified under Health Information Trust Alliance (HITRUST) Risk Based, 2 year (r2) certification. This industry-leading certification requires external penetration testing, security in operations, and security during the development of custom applications, ultimately ensuring best practices across all our systems and services.

MiHIN designed our Active Care Relationship Service model, which allows realtime association of patients with their providers using the information found in the data ingested by MiHIN. This service restricts patient data access to only those providers that actively care for that patient.

With all of this in mind, let us consider a veteran's healthcare journey. If a veteran goes to their primary care doctor that uses one EHR but also goes to a community mental health facility that uses a different EHR and also sees a specialist on a third EHR, without an HIE like MiHIN these providers would not be able to access critical patient information from those other encounters.

Because of MiHIN's broad network of connectivity, MiHIN has all interactions from all three facilities available in that patient's longitudinal record to improve overall care coordination.

Today, however, in Michigan, the VA and DOD are a blind spot to a veteran's overall healthcare. The VA does not only not submit data through the network but cannot access its patients' records from encounters outside of the VA.

From a provider perspective, HIEs bring critical value. A 2024 survey of primary care physicians found that 81 percent spend less time with their patients than they would like, 57 percent write prescriptions or refer patients out due to time constraints, 46 percent report a lack of adequate time with patients as a top stressor and almost two-thirds feel their work is more transactional rather than relational.

Accessing patient information within an HIE's longitudinal record has shown that a provider can save up to 15 minutes per patient per visit while the cost of this access is nominal.

Today, the VA does not comprehensively see interactions outside of its facilities, and like the patient journey example I gave you, Community Care facilities cannot see veterans' interactions with the VA hospital either.

There is no such thing as a lifetime record of a veteran's healthcare residing in one EHR system. It simply does not exist. There is also no such thing as a national exchange with a handful of EHRs that can replace the infrastructure we have spent the last 14 years perfecting.

We can and we must do better to provide higher quality care to our veterans in Michigan. There is always potential for improvement, and I believe we can achieve it with the right strategies, support, and collaboration.

Thank you for the time and attention to this important issue. Your support and understanding are greatly appreciated.

[THE PREPARED STATEMENT OF RICK MCGRAW APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you, Mr. McGraw.

The written statement of Mr. McGraw will be entered into the hearing record.

Dr. Rosenberg, you are now recognized for 5 minutes for your opening statement on behalf of Michigan Medicine. Thank you.

STATEMENT OF ANDREW ROSENBERG

Dr. ROSENBERG. Good afternoon. I want to use my time to emphasize three areas in my statement. I want to take the perspective of a provider in particular, but also with an organization that is providing the care in the communities that we have discussed.

Exchanging the information that we are talking about is not controversial. This is common sense. It is a common expectation that we as providers have, our nurses, our doctors, our administrators. It is a common expectation of patients and their families. This is a good discussion for us to be having. I would also say it is really an ethical responsibility. The providers feel very, very strongly to do this and to do it well, as you have already mentioned.

The reality is when I think about some of us, Dr. Nebeker or Dr. Greenstone and I, when we were training, we did Health Informa-

tion Exchange a few times a day, at best. Usually it was a packet of papers in an envelope and occasionally later on a CD that we would hand walk down and try to get the images loaded. The reality is these were at very, very good places really only 10 years ago.

Now, as you have already mentioned, we are doing a lot of Health Information Exchange. At Michigan Medicine alone, across our large health system in our somewhat unique role in the State, within our electronic medical record we are exchanging over 220,000 records a day. With our excellent State HIE, we are exchanging tens of thousands of records and results, particularly admission, discharge, and transfer notices, that are critical in that infrastructure to make this work, for a community doctor or others to know when a veteran has been seen or not.

Within our VA itself, although somewhat new, we are exchanging almost 3,000 records a day. Especially as we, Michigan Medicine, sign onto the QHIN VR EHR and with the VA already involved in eHealth Exchange, those numbers are going to go up more and more and more.

From where we were to where we are now is a very good news story. Obviously, we want to do better. Why is that happening? I was recently in the U.K. I was lecturing at some very good health systems, and they were challenged exchanging information even within their own health system; whereas, for us, because of the networks we have, Commonwealth, Care quality, and especially now TEFCA, the frameworks and the networks themselves, eHealth Exchange—and I would argue that the direct EHR to EHR and EHR into these nodes is the way that we are expanding the use of this.

We have good to very good government regulations. We have agreed-upon open standards, Health Level Seven (HL7), Consolidated Clinical Document Architecture (C-CDA), the Fast Healthcare Interoperability Resources (FHIR) standard. We have a very good set of agreed-upon data elements and categories with United States Core Data for Interoperability (USCDI). We have a number of tools that are currently working to give us those numbers that I have just mentioned and even more that are in my statement that we can focus on.

Then the third element of—this has been one of our challenges. Within Health Information Exchange, one of the challenges that all providers right now are having as we get more digital are the digital systems themselves. We have an enormous amount of data that we can look up whereas before we could not. We have an enormous need to document these, not just for patient care but for quality care and efficiency and improvements.

Health Information Exchange is no different from that. We want to do it, and yet at the same time we are also overwhelmed with all of the other work that our doctors, nurses, and others have to do.

Also, we know that with all these options we have to choose. Which do we use? How do we sign up? How long does it take to sign up for one versus another? These are things that we can continue to improve upon because, as I said, in the end we are so

much better now but the reality is we know that we can still do better.

I will yield the rest of my time but, hopefully, that helps.

[THE PREPARED STATEMENT OF ANDREW ROSENBERG APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you, Doc. I appreciate your testimony. We will enter that. Your written statement will be entered into the hearing record.

Dr. Greenstone, you are now recognized for 5 minutes to deliver your opening statement on behalf of Signature Performance. Thank you as well for being here today.

STATEMENT OF LEO GREENSTONE

Dr. GREENSTONE. Thank you, Chairman Barrett, Ranking Member Budzinski. It is a pleasure to be here to talk to you about interoperability between the VA and the community.

I come to you as a former VA physician for over 18 years, primary care doctor; as well as an executive at the local Ann Arbor VA for 11 years; and a senior executive in the Office of Community Care for 6 and a half years; and now working in the private sector for Signature Performance, where we are focused on decreasing administrative cost burden within the industry.

There is no question that we absolutely agree that interoperability is so important and so necessary and as also we have to recognize it has been really, really hard. People have been working at this for a couple decades now, and you can hear the incredible progress that has, in fact, been made over the years.

One of the things that I think is critically important to recognize is that—I am going to give you a perspective from the Veteran Community Care Program that I care deeply about—is that we absolutely have to, as the ranking member mentioned, focus not just on technology but on people and processes, because the technology will not be fully adopted unless we have pretty much ubiquitous and reliable tools.

That is why within healthcare today, we still have a lot of use of those tools, telephones and fax machines. A lot of that is used today within VA to actually get records back and forth, and we want to get rid of that. I would love to sunset fax machines but, boy, are they still, you know, pretty active today.

You know, one of the things that I think is critical as well is that VA really needs to stay—and they have been really good at doing this, but staying in lockstep with U.S. Department of Health and Human Services (HHS), in lockstep with industry, understanding what is happening with the EHR vendors, what is happening with—in the community, and staying very close with their colleagues at the Integrated Veteran Care Office within VA so that we can ensure that VA staff as well as the Community Care Network providers are working very closely together to try and ensure that there are work flows that utilize a lot of the technologies that we have been hearing about and work flows that really support the work that individual folks are doing. We have to have thoughtful change management for the implementation of these great technologies that we have been talking about.

Within the Veteran Community Care Program, we not only have to make sure that providers in the community are receiving appropriate clinical information about the veterans that have been referred to them, but those providers also need an authorization.

The way things stand now within the Veteran Community Care Program, it requires an authorization. That means that the provider in the community needs to know what the VA is authorizing, what the VA will be paying for, what VA—how long is that referral for, and for some services how many visits are available. That referral and authorization is not available in the Exchange today, but perhaps it could be and that may be a future.

When we look at the solutions going forward, there are a couple of things that I think will be valuable to think about in the short term and perhaps even a little longer.

One is, let the VA take advantage of the Dole Act, where there is incentive to actually have Third Party Administrators (TPA) in the Community Care Network and their providers work together, because all of the TPAs, Optum Serve, TriWest, they have Veterans Integrated Service Network (VISN)-based provider groups that go out and can, in fact, work with providers in the CCN network and those providers who get a fair number of referrals.

They can ensure that those providers are connected to an Exchange that is connected to a QHIN, that that information will be available for VA providers to be able to see and best care for veterans, and that that information can be made available to VA providers and other staff within the PPMS. This is the Provider Profile Management System. It is the directory for the Veteran Community Care Program of all its providers.

Then VA has an opportunity to send referrals to those providers who actually are connected to an Exchange. That means I may want to do that because I know I can actually get access to the data that I need to care for veterans.

The other thing to consider is, you know, they have this closed-loop referral data transfer process that is something that is worth further investigating. What I mean is this: Is that when a VA provider writes an order and that veteran opts to go to the community, the authorization and associated medical documentation is passed through the infrastructure of the Exchange into the EHR of the receiving provider. Then when that veteran is seen, that provider's information that they generate is passed on into VA's EHR.

Therefore, you have this closed-loop referral and medical documentation system that is in play today in some places, and it is something that the VA may want to consider.

Thank you for your time, and I look forward to further questions.

[THE PREPARED STATEMENT OF LEO GREENSTONE APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you, Doctor.

The written statement of Dr. Greenstone will be entered into the hearing record.

With the opening statements complete, we will now proceed to questioning. I will now recognize myself for 5 minutes.

Again, thank you all for being here and for the time and attention you put toward this.

A few questions I had just jotted down, based on some of your opening statements.

Dr. Rosenberg, maybe you can answer this and Dr. Greenstone too: Do you know of examples where we have duplicated procedures, whether it is testing or other, you know, procedures, diagnoses, tools that you have, things like that, where we have duplicated that because of a lack of transferability of medical records or the cumbersome nature of it or the lack of interoperability that would apply? I will let both of you answer that question separately.

Dr. GREENSTONE. Sure. I can certainly start with that, Chairman Barrett. I can give an example. I was in a clinic at the VA last summer and I saw a veteran who said, hey, Doc, I passed out about 2 weeks ago and went to an outside hospital. I am like, oh my goodness.

I looked to see if that was care that was actually authorized by VA, and it was. I went into our systems to look to see whether a fax had come in, and it had not. I then went to the Joint Longitudinal Viewer to ping the Exchange. Look, I saw a record from the ER from where he was. When I opened it, I was excited because I thought I was going to see everything I needed, and all I saw was a problem list, meds and allergies. At the top of the problem list, it said syncope, which means he passed out. That is what he already told me.

Then I had asked my clerk to try and call over to get the information faxed. Then I have this veteran in front of me who I have to start from square one to order tests to figure out what the heck was going on with him, do his exam, his history.

I probably was ordering things that may have already been done, right? I had to do all that I had—what I had available, as you mentioned before, hey, good docs, we do what we have to do, but I will bet you that I ended up doing things that may have already been done. I did not have access to do that, but I had to come up with a treatment plan.

Mr. BARRETT. Thank you. Do you think the—and that to me is not based upon the ability to send data back and forth. It is based on the perhaps data protocols of how we organize these things so that you are able to access it and read what it says and interface with it in a usable way.

Is that—am I understanding that correctly?

Dr. GREENSTONE. Yes. Even when providers within my great State of Michigan are connected, not all the information is readily available, right? We talked about quality of data and we talked about all the data, like notes. Very often office notes are not there. Procedure notes may not be available.

The question is: Why are not all those things available when folks have connections and, therefore, some information is available? We need better information to be able to make clinical decisions.

Mr. BARRETT. Sure. Okay. Dr. Rosenberg.

Dr. ROSENBERG. Quantifying your excellent question is a bit difficult, but I will give you my impression. It is probably somewhere in the thirds. It depends on the situation. A patient arriving in an emergency department where you know nothing about them, we

are going to be repeating—or we are going to be drawing and sending labs and imaging no matter what we find.

Sometimes it would be helpful to know what preexisting conditions or data, labs, imaging existed before, but it is usually not that we are going to either rely on those data, rely on what might be old data for the situation.

Another third would be where we have some data but we need more complete data or different. It will depend on if we are primary care or we are quaternary care itself.

I think the area that you are focusing on that is especially important is when the data are more expensive and difficult to get, a biopsy, for example, an expensive or difficult radiologic study that we would normally not get or that we would want to compare to. Those are still elements where, depending on the system, the proximity, the closeness, we will either have those data or we will not.

I think where efficiency would be gained is that, as I have mentioned before, the common elements of medications, of basic labs, of conditions and documentation where you can frequently find the results of data, even if it is not a discrete variable, will help some of that gap.

I would argue that for those things that really are difficult to get and expensive, those would be interesting and good targets. For example, MiHIN fits into that in the ability to act as a broker where a biopsy result is from another element that we can commonly get to where we sometimes close those gaps, but to quantify that I think would be difficult.

Mr. BARRETT. Sure. Thank you. I do appreciate that. I know my first round of questions just run out of time.

I want to recognize the ranking member for your questions.

Ms. BUDZINSKI. Sure. Thank you, Chairman.

Actually, to kind of build on your initial question, I wanted to ask Dr. Nebeker from the VA, because in your testimony you talked about how the Federal system is 90 percent interoperable with hospitals today.

I think the question, after we have heard from, you know, both Dr. Greenstone and Dr. Rosenberg and those experiences, you know, how are you measuring interoperability and how are you certifying that?

I just—I find it hard to believe that—where that 90 percent is coming from, based on at least Dr. Greenstone's story.

Dr. NEBEKER. Yes. Thanks for the question. That number comes from eHealth Exchange that has looked at who are connected to and knows a number of hospitals that are in each healthcare organization that we are connecting to. That is where that 90 percent comes from.

Ms. BUDZINSKI. Do you know how they gauge that?

Dr. NEBEKER. I could speculate, but I am not sure. I mean, each organization has a website that has—you know, it usually states the number of hospitals that they have. The American Hospital Association also has similar information on it. I imagine—it is, again, speculation, but I imagine that is how they arrived at that number.

Ms. BUDZINSKI. Okay. Can I ask you, continuing just about Community Care providers, what is the requirement for Community Care providers to return records to the VA?

Dr. NEBEKER. I might want to ask you to clarify the question. For my practice, for example, most of the documents that I am looking for are actually not paid for by VA. It just happens to be the way my patients are and the Salt Lake City area is.

There are no requirements, you know, obviously for those people when they go out and use their own health insurance to get a specialty appointment or they are seeing sometimes a primary care physician. I practice primary care geriatrics.

Then there is the Community Care documents that—that there is a requirement to return documentation on. That is as far as I can go, because I am not, you know, overseeing the Integrated Veteran Care (IVC) Community Care Network contract.

Ms. BUDZINSKI. It is possible, basically, you are seeing a veteran and that their complete record might not be completely captured is what you are saying, because it is not all required to be passed back to the VA.

Dr. NEBEKER. Yes. As Dr. Greenstone was stating, the—so, I mean, I saw a guy who had—a really healthy 88-year-old guy last Friday, I said, how is everything going? No problems at all, Doc, I am doing great.

Then I open up JLV and, click on the button. Up comes these records. I say, oh, well, you were in the hospital 2 months ago for a urinary tract infection. That actually prevented me from ordering a whole raft of lab tests and everything that I was thinking about ordering at the time. This was an emergency room visit.

More often than not we do not see notes in the national exchanges. It is kind of a mystery to us as to why. You know, we deal with—primarily with Hospital Corporations of America (HCA), with Intermountain Healthcare, you know, that currently has Oracle, and University of Utah that has Epic. From all those institutions I am often missing inexplicably data that I would expect from a hospitalization and emergency room visits. Also, doctors' office visits are rarely there.

The—you know, what Dr. Greenstone was talking about of getting—and also Mr. McCormick, about using—getting the office notes, that is kind of really valuable data. Missing office-visit notes sometimes results from the way that people craft their continuity of care documents. It is often not driven by office visits but more by emergency room visits and hospitalizations.

There is a bit of a gap in recent ambulatory-care visits. Sometimes, if there is an emergency room visit or hospitalization after a consult, a specialty care visit, then we will see those notes, but not for recent specialty care visits, again, whether paid by VA Community Care network or not.

We can take for the record and get back to you what the—what the requirement is on the VA contract.

Ms. BUDZINSKI. That would be—I would be very interested in that and like what the timeliness is of Community Care providers as well to provide that information back to the VA, you know, and then what recourse the VA has if you are running into Community Care providers that just are not providing that type of timely information, because, to me, interoperability would be if it is successful it is capturing the full picture for the veteran patient, not just some, and we are eliminating those gaps.

I will yield back to the chairman.

Mr. BARRETT. Sure. Thank you very much.

Just following up on that, Dr. Nebeker, is that missing data that you are talking about, is the reason for that because that record does not exist or because it is not being displayed, because you cannot access it because it is not, you know, sent through the system? What do you attribute most of that to?

Dr. NEBEKER. We are not getting those records because they are not being sent from the exchange system. Remember, it is a query system that we use typically from these exchanges. We send the query out, say, hey, give us your documents. They say, okay, here are the documents. Then the excellent portal, the gateway that Dr. Prietula and Oracle and others have worked on to provide for us collates all those documents and gives them to us. A lot of those data just are not getting there in the first place.

Mr. BARRETT. That is—where is the pinch point in that? Like, what—is it the system that collates it, the system that you are querying? I mean, if you were to look up my name and my date of birth and Social Security number, it would probably give you all my medical records is my assumption. It sounds like what you are saying is some of that might be missing.

Dr. NEBEKER. Yes, yes. The EHRs do really well what the EHRs were designed for, which is, you know, storing records and transactions for a lab test and radiology test and that sort of thing.

They could use some work on getting those data into their external gateway and then pushing those out in response to a query.

Mr. BARRETT. Okay. I might need some more guidance around if they have the information and they are sending some of it, why are not they sending all of it? Like, it seems to me like it would be an equal amount of work to send all and maybe even harder to only send some of it, because you are stopping part of that.

Dr. NEBEKER. We do not think it is intentional.

Mr. BARRETT. Right.

Dr. NEBEKER [continuing]. that they are leaving out information. I think that would be a nice experiment to, you know, talk with some of our partners in the VIP Pledge, for example, why are you getting everything there consistently?

Mr. BARRETT. Okay. Then the—that Veteran Information Pledge—am I saying that correctly? Is that the name of that program?

Dr. NEBEKER. The Veteran Interoperability Pledge, yes.

Mr. BARRETT. Yes. One question I had about that is, I know some veterans are not eligible for VA care because of the status of their discharge. Does that account for that in that system or not?

Dr. NEBEKER. The first piece of work we did was around the Veteran Confirmation Application Programming Interface (API). This is also known as the Dick's Sporting Good API.

What this does is use—draws on DOD and VA records and uses the Title 38 definition of a veteran whatever that definition is at the time. Demographic information are sent to our API, the Application Program Interface, on our side, and we send back a simple confirmed or not confirmed answer.

Mr. BARRETT. Okay. That would be determined by the definition within that, not necessarily all of the protocols, like a general discharge, dishonorable.

Dr. NEBEKER. That goes into that Title 38, but it is a legal definition created by Congress.

Mr. BARRETT. Okay. All right. Okay, thank you.

Mr. McGraw, I know that MiHIN has quite a bit of market share throughout Michigan. Most network or most systems, providers, and other things through Michigan are included within that.

Can you I guess explain if you have records outside of Michigan or we have, you know, snowbirds who go down to Florida, for example, then come back to Michigan and spend a predominant share of their time outside the State, are you—what is the process by which their records would be able to transfer back and forth or is that still a coverage gap that exists?

Mr. MCGRAW. We do have—we pay a certain amount of money, several hundred thousand dollars a year for access to the three national exchanges. We do not just keep the records within the State of Michigan. If they do snowbird down to Florida and we know that they snowbird down to Florida and they come back, we will ping those exchanges to get that data from the national exchanges.

All of our clients can access those national networks through an aggregated volume that we have purchased from those exchanges. They do not have to go one-on-one. The whole State of Michigan can come through us. We connect to those exchanges to fill in those gaps.

Mr. BARRETT. Okay. Are the VA facilities in Michigan part of MiHIN?

Mr. MCGRAW. Today, they are not.

Mr. BARRETT. Okay. Dr. Rosenberg, with the amount of time I have left, if you can tell us, I know that Michigan Medicine and the Ann Arbor VA, just as an anecdotal example, have quite an arrangement between the two of them together.

How is that information shared without using MiHIN? Like, what is the functional way in which that patient information is shared across both sides?

Dr. ROSENBERG. Our method of exchanging is fairly typical for geographically nearly collocated and very tightly managed academic Veteran Affairs where, if not all, most of the faculty who work at the Veterans Affairs Hospital are less than a mile away from the campus, as you saw recently.

Right now, I would say more of the exchange is from interpersonal discussions with each other and the fact that the care delivery are frequently similar teams. That, of course, does not scale rural America or even within the State of Michigan.

The more contemporary digital methods, as I have mentioned now, are the beginning of our use of Carequality and then TEFCA to start exchanging those core records.

One thing I wanted to mention from the previous conversation, I think it is helpful for us to talk about core records, medications, allergies, problems. For more complex—a primary care visit would be part of a core record, basic labs.

For example, as a cardiac anesthesiologist/intensivist, the kind of data that I need to do very special critical care or even anesthesi-

ology are not typically in core medical records. That is where the expanded use of the data, the data elements within TEFCA will improve the further exchange of those kinds of records.

Then a final point: There is, very importantly, very privileged, very confidential data that we want to be careful about that we make sure that the patient and their consent is allowing that data to be sent very, very specifically, mental health, substance use and things like that.

When we talk about the records that we are sharing, I do think it will be helpful for us to stage out what we mean by those specific elements.

Mr. BARRETT. Thank you, Doctor.

Ranking Member Budzinski, do you have further questions?

Ms. BUDZINSKI. I do. I actually just kind of wanted to go back to what Dr. Rosenberg brought us back to, which is this bidirectional Community Care VA complete interoperability record. I wanted to ask both Dr. Greenstone, Mr. McGraw, and Dr. Rosenberg a little bit more about where you believe that disconnect is. If you could speak, I guess the three of you could each speak to where you think that disconnect could be.

I think from Dr. Rosenberg, what you were saying, though, is you are not suggesting, though, that like a complete—like the mental health record or substance—that should all still be encompassed within a record of a veteran.

Dr. ROSENBERG. Absolutely. It is I think appropriate, like some other confidential data, frequently behind extra levels of protection, but it is absolutely part of the medical record.

What I would say, I would say there is not so much a disconnect right now. My opening statements, I really mean that. I think it is an evolution and maturity.

For us, for example, and I will use Michigan Medicine, it might not be as indicative of across the country, but it probably is. It takes a certain administrative workload to procure, contract, and administratively set up these systems. That is not a—that is not a criticism of the network or the exchanges or the frameworks, but it is a reality.

For us, Epic to Epic works extremely well, and that is one reason why Epic has such a large exchange of information among itself. I suspect as Oracle Cerner continues to roll out, we will enjoy those benefits of contemporary EHRs connecting to each other as well and/or I should say probably through the QHINs as part of TEFCA.

I also think that while query-based, as Dr. Nebeker pointed out, is still perhaps the predominant method of getting that data, there are also mechanisms now for push, as Dr. Nebeker mentioned.

As push starts to occur and as expanded data within this framework occurs, those disconnects, which are really not disconnects, but those gaps will narrow from the common data to the more sophisticated to the more nuanced data.

Ms. BUDZINSKI. Mr. McGraw, would you be willing to add anything?

Mr. MCGRAW. Yes. A lot of the disconnects we see in the State of Michigan is around connectivity, the local facilities' EHR systems.

The two impediments that we see the most is really a time constraint. Sometimes the implementation of that connectivity could be up to 6 months. Sometimes it is a fiscal constraint.

The EHR companies, you know, they are not charity organizations, they are for-profit companies, so they will charge thousands of dollars to just connect and then an annual maintenance fee.

You know, as the facilities will ask, you know, is the juice worth the squeeze? The juice in the State of Michigan is we really work well with our payer partners, and they put incentives together. Those incentives incentivize facilities to submit data.

What MiHIN does is we get that data that comes in. It is a push. The second that record is saved, as I mention in my testimony, it is pushed to us. Within 4 minutes, it is available in the longitudinal record.

That push comes to us. The incentives are there is a lot of information in an admission, discharge, and transfer document. Today, 27 of those elements are incentivized. We have physician organizations that do transition of care that say, this is not enough for us to do transition of care, can you go back to the payers and can they incent the facilities to provide more.

Those incentives are financial incentives. The conformance comes through us. We look if 95 percent of what they submit to us has all columns filled in, and then we check the box and we tell the payer they are eligible for the incentive program.

I think the mention before was someone mentioned something about quality. Today it is a quantity thing. At MiHIN, we are really ahead of other HIEs in the country, and our next phase is the data that you are coming in meets the quality standpoint, but is the data quality, is it usable or is there just stuff in a particular area of the data or is it—can we use it for gaps in care, population health management.

We are moving away from quantity and getting into the quality. That is how we incent people, and those are the impediments I see today. It is not enough incentives. There is no interoperability issue. There is an incentive misalignment.

Dr. ROSENBERG. May I add something about the incentive? It is not so much for us to do the work, as I mentioned before, but, as Mr. McGraw said, it is around the quality.

It is expensive. It takes people with expertise and the time explicitly to make sure the data quality, the data entry, the data mapping work, and we audit to make sure it works well.

MiHIN, our HIE, our EHR provider and I would argue really as a broader TEFCA goal is to incentivize organizations to be able to have the resources to do that quality and that ongoing quality check, because if we get some of those data wrong, it is amplified, it is copied, and it could be very difficult.

Ms. BUDZINSKI. Dr. Greenstone, do you want to add anything on this as well, please?

Dr. GREENSTONE. Well, I will say that everything you have heard is things that we have absolutely seen and experienced. In my organization, we work very closely with numerous critical access hospitals where they do not have big IT departments.

Some of them have the ability to connect, but there may not be knowledge of how to do it. They may not have the funding to be able to do it. They do not fully understand it.

I was talking to Mr. McGraw, and until 2 years ago he was unfamiliar with the Exchanges, right? It is like—and he was not alone. Still, you know, when I look at where veterans are seen in a lot of these rural places, these small hospitals and health systems, you know, are not sort of connected. They do not know. They do not understand.

That is where this opportunity for our TPAs to go out there. If they are seeing veterans, let us go out there and help them actually get connected and find ways to do that and use incentives to help them in that way.

I would also say that it is been wonderful in the last sort of year that in practicing when I have veterans who go to Michigan Medicine, I can find almost everything I need when I actually ping an Exchange for queries.

I think that, you know, before that I would be so frustrated. They are across the street. They are our friends. I have to call somebody as opposed to in my workflow being able to find it. Now we can. I think that is what we want to see everywhere in all States and territories where veterans are.

When they are traveling, like the chairman mentioned, they go down, you know, to Florida and out to Arizona, we need to be able to ping the Exchange and be able to see the records where those veterans are in the community out there and then be able to use JLV to see when they are seen at another VA medical center.

Ms. BUDZINSKI. Thank you. That is very helpful.

Thank you. I yield back.

Mr. BARRETT. Thank you. The more discussion we have the more questions I end up writing down. I will start just from ones I have not written down so I do not forget them first.

Mr. McGraw, you were mentioning that for those people that are not within your network of—you know, within Michigan, for example, and transferring data back and forth, that you are part of a broader, bigger network to, you know, switch to other regional areas, things like that.

Does that then—is that part of the service that you offer to the subscribers within your network so that they are not having to subscribe to a separate network in order to do that?

Mr. MCGRAW. Correct.

We have, obviously, all the information in the State of Michigan, and then we work with those national exchanges. We buy in bulk the ability to ping those national exchanges several million pings a month for our clients, and then they can all go through us to those national exchanges——

Mr. BARRETT. Okay.

Mr. MCGRAW [continuing]. so that they do not have to work directly with thousands of individual clients.

Mr. BARRETT. Sure. Then you were saying the whole longitudinal record and pushing the record forward and a few minutes only to kind of update that record.

Forgive my ignorance, but MiHIN, you are not storing the actual patient information, right, you are merely transferring it to the EHR that is actually storing that record, so——

Mr. MCGRAW. All that data in the State of Michigan is stored in our cloud-based servers.

Mr. BARRETT. Okay.

Mr. MCGRAW. We do store all that information. The longitudinal record that we are talking about as access is MiHIN's portal. We do store for Health Insurance Portability and Accountability Act (HIPAA) rules all that——

Mr. BARRETT. Okay. An individual with their principal record through their network that they are a part of—Oracle, Epic, whichever it is—they are not actually storing that information. They are logging into your server, they are bouncing a signal to your server that has that patient's records stored there.

That way, if they go somewhere else, the idea being that it would automatically update so the next time they go to their local doctor's office it already has the urgent care, emergency care visit that they had 6 weeks ago or something like that.

Mr. MCGRAW. Yes. It is in both. As soon as they save that record, it is always going to be in the EHR system for 7 years or more.

The second that they save it, then a copy of that is sent to us within seconds. Then, within 4 minutes, it is on our longitudinal record.

Mr. BARRETT. Okay. Then if they go across town to somewhere else, that provider should be able to see it in there as well.

Mr. MCGRAW. If they are attached to our network. Even if they are not attached to the network, let us say they are not submitting data to us, they still have access through our portal to see that patient's interaction everywhere outside of them.

There are people that use our portal to see the longitudinal record of a patient for all their interactions. They may not have started submitting data to us yet. They can see that.

As I mentioned in my testimony, we have connected I say nearly 80 for dramatic effect, but it is 79 EHR systems that we've connected to in our 14-year history.

Mr. BARRETT. Okay.

Dr. Rosenberg, I think it was you that mentioned the sensitive nature of some records that we want to make sure we are keeping as secured and stored as safely as possible.

Some number of years ago, I worked for the State treasurer. This was an issue we had with people's tax information. We did not want people browsing the Governor's tax returns or something like that.

Is there a similar mechanism through MiHIN to make sure that somebody—like, would it—is there a mechanism by which you could tell if somebody was trying to open a patient's record when they did not need access to it for that nefarious purpose?

Mr. MCGRAW. Yes.

Mr. BARRETT. Like, even if they are a licensed provider, right? Like, you hear about this occasionally with law enforcement officers looking up somebody's record who they do not actually have a reason to, and then that violates the protocol for the record management.

Mr. MCGRAW. Yes. That is our Active Care Relationship Service, ACRS, and that means that you have to have an interaction with that patient in order to view their record.

One of the things we also have is what we call common key services. Sometimes a patient might have their name spelled different ways in different EHR systems, and then we commonize that and give them one unique identifier—think of it as a Social Security number for your medical history in the State of Michigan—and then only providers that have interactions with that patient in their EMRs are allowed to see that patient's record.

You could not just log into our system and look up anybody's healthcare information. It is extremely restricted.

Mr. BARRETT. Just because you have access, you do not have—like, it is not just once you are in the door you can just go start perusing around or something like that?

Mr. MCGRAW. Correct.

Dr. ROSENBERG. There are several avenues to do this.

One, as you have mentioned, is to assure that the people asking for the data are appropriate. That changes, again to the previous comment of the expense it takes to maintain those records and make sure that they are up to date.

Epic has a concept of "break the glass" either for accessing data or accessing data within the record itself. If I remember, when I was doing TeleCritical Care for the VA, there was within VistA a similar way to identify when some data you may be wanting to look at was a bit more privileged, a bit more protected.

Then there are also indirect methods. The reality is, if I look at a medication list and I see an antidepressant on the medication list, I do not have to have access to the problem list to potentially see that a patient may have a mental health condition that is important for all of us to know.

There are layers and then there are matrices, almost, of where these data come together. I think part of the complexity, part of those gaps, as we mentioned, is to try to do it properly. If anything, we are probably a bit conservative to start with, and that is one reason of many why we might not be as fast in some areas.

Mr. BARRETT. All right. Thank you.

Ranking Member Budzinski.

Ms. BUDZINSKI. Thank you, Chairman.

I know we have talked a lot about—or somewhat about—people and the importance of people as it relates to interoperability. We also can acknowledge that a lot of the functionality is still happening manually through fax or HSRM.

With these systems, clerks and Health Information Management, or HIM, staff must manually upload documents to the VA's EHRs.

Dr. Nebeker, I would like to know how many individuals in this workforce have been impacted by the mass terminations carried out since January 20th of 2025.

Dr. NEBEKER. Thanks for that question. I just do not have the answer for that. Sorry.

Ms. BUDZINSKI. Would you be able to get us the answer?

Dr. NEBEKER. We will take it back. Yes, ma'am.

Ms. BUDZINSKI. Okay. We will be able to. Okay.

I was obviously very relieved when Judge Alsup came back and said that those probationary employees that were terminated need to be rehired, but then the administration immediately put those same 2,400 employees on administrative leave.

Do you know why the VA decided to put those 2,400 employees on administrative leave?

Dr. NEBEKER. I am sorry. I really do not know.

Ms. BUDZINSKI. Would you be able to follow up with the committee on the rationale behind that?

Dr. NEBEKER. Sure.

Ms. BUDZINSKI. Okay.

Dr. NEBEKER. I mean, my esteemed colleagues will help with that, yes.

Ms. BUDZINSKI. Okay. Thank you.

Are individuals in this workforce—well, let me say this.

Have any of the HIM staff, do you know, taken the "Fork in the Road"?

Dr. NEBEKER. Again, I do not have that information, but we can take it back.

Ms. BUDZINSKI. Okay. Great.

What are VA's plans to make VA fully operational with QHIN participation by December 2025 without many of these critical skilled staff that are needed to carry out this work? How are you looking at that with these folks off?

Dr. NEBEKER. I think I can answer that one.

Ms. BUDZINSKI. Okay.

Dr. NEBEKER. Really, the people that do that work are in central office for connecting the QHIN, and I am not aware that we have any problem with the current Federal staff to meet the needs of connecting to the QHIN and rolling that out to the local facilities.

Ms. BUDZINSKI. Okay.

My next question is for Dr. Prietula.

The subcommittee has heard reports of several canceled contracts that support the EHRM project. How many contracts or other support services have been cut by Department of Government Efficiency (DOGE) since January 20th of 2025?

Dr. PRIETULA. We have received the requests for information for all those contracts, and the office is currently reviewing those, and I am sure that as soon as that is completed we will be providing it to this committee.

Ms. BUDZINSKI. Okay. At least one of these terminated contracts we know focuses on supporting interoperability across VA, DOD, and community providers. While some of these have been reinstated, the contractor stated that the smaller workload, quote, "probably is not enough for them to keep doing business with the VA in the long term," end quote.

What would be the impact of losing such a contractor's support for the EHRM program?

Dr. PRIETULA. I am not aware of the contract that you are talking about. We can take it back for the record and see what the impact would be on that one.

Ms. BUDZINSKI. Okay.

I just want to say I think it is extremely concerning that the VA's witnesses today do not have answers to these important ques-

tions around staffing and contract support. Without this information, the committee is significantly inhibited in its requirement to perform oversight of the Department's activities.

I look forward to receiving this information from VA in a timely manner and working with Chairman Barrett to continue oversight of this program.

I have another question for Dr. Nebeker.

Has VA performed any audits of providers where veterans may seek care in the community to see if they are connected to the exchange?

Dr. NEBEKER. Yes. We are right now, as I mentioned earlier, going through all of the academic affiliates to make sure that they are connected. The University of Michigan just recently connected with us. Now we are going to go systemically through all the academic affiliates.

In addition to people that are not yet connected, we have a data quality monitoring program by which we look at all the messages that are coming across. Those are saved in an Oracle location. Right now we have a bit of a contract gap to get those data back to the VA, but we expect that to be resolved shortly. Dr. Prietula's team is doing a great job with that.

Then we actually sample the data to look for data quality problems. We do it based on various scenarios for care coordination of what is quality sufficient. Then we go back to the healthcare systems and help them improve the quality of data that they are sending us.

Ms. BUDZINSKI. Okay. Thank you.

I yield back to Chairman Barrett.

Mr. BARRETT. Thank you.

Dr. Nebeker, just briefly, I know that in Michigan we learned that VA is not part of the local or regional Health Information Exchange. Is it common or unusual for VA facilities to be members of their regional HIEs?

Dr. NEBEKER. We are not members of any of the regional HIEs. We have been in discussions on this topic for, I do not know, 10 years about how do we participate or not. I was not involved in most of those discussions previously.

Mr. BARRETT. Neither was I. I have only been here 2 months.

Dr. NEBEKER. Well, what we are looking for now—so right now there are 50—over 50 Regional Health Information Networks that are connected to eHealth Exchange. Eight of those are connected to a QHIN, to the eHealth Exchange QHIN. The rest are in the traditional network.

Our strategy is that we will join a QHIN, and many of the RHIOs—and we are in discussions with some of those, all those that we have talked to are planning on joining the QHIN. We will then get connectivity to those Regional Health Information Organizations through TEFCA.

Mr. BARRETT. Okay.

Then I know the Indian Health Service currently is the only Federal agency that is connected to a QHIN right now. Is that the case?

Dr. NEBEKER. Given that the other of the Federal on our gateway——

Mr. BARRETT. Right. There are only two, correct?

Dr. NEBEKER. To my knowledge, yes.

Mr. BARRETT. Okay. Do you know which EHR they use?

Dr. NEBEKER. Indian Health Service uses a variant of VistA. A lot of it is based on VistA. They have what is called Resource and Patient Management System (RPMS), Computerized Patient Record System (CPRS) is equivalent to RPMS. It is a similar shared technology but a little bit different.

Mr. BARRETT. Okay. They do not have one of, I guess, the more mainline modernized EHRs that VA is currently going through the process of upgrading?

Dr. NEBEKER. Correct. They have contracted with Oracle to provide that but not joining——

Mr. BARRETT. Tell them to get ready.

Dr. NEBEKER. I mean, I have, of course, a lot of friends in that organization. They are just starting their journey toward their implementation.

Mr. BARRETT. Okay.

Then VA is not sure yet which of the QHINs—now, is it true that Oracle is trying to create their own QHIN? Is that also accurate?

Dr. NEBEKER. Yes.

Mr. BARRETT. Okay.

Dr. NEBEKER. Right now the reason we have to do this, it takes a little bit of time, is we have to do it with DOD. The Federal Electronic Health Record Modernization (FEHRM) is hosting some of those discussions. Dr. Prietula's team is really doing a lot of the heavy lifting as far as the technical approach, and we should have a decision on that fairly soon.

Sorry, the second part of your question?

Mr. BARRETT. Oracle is creating their own. Then would it be natural to assume that that will follow—that VA and DOD will follow into that?

Dr. NEBEKER. I would not make any assumptions. I do not make assumptions on this category. It is logical that that might happen.

There are testing and certification requirements that take about a year to get through after there is an establishment of technology for QHIN. You will have to talk to Oracle about how they are meeting those timelines.

I would add that the barriers for switching—for entry and switching among QHINs—are extremely low. If Oracle comes up with a great product and it is better than what else we are seeing, the price is right, it would be logical for us to switch to an Oracle solution.

Mr. BARRETT. Okay. Thank you.

Then could you explain also, through TEFCA—which will establish these, the kind of framework for these QHINs with quality of information and everything else—how is that—or how can that address VA's interoperability gaps that exist in some of the examples we heard about today?

Dr. NEBEKER. TEFCA is primarily about the trust framework, about what can we exchange, the legal framework for trusting each other to exchange information. Then about the pipes, that is the QHIN part, the Qualified Health Information Network. We are using the same technology to exchange the data.

QHINs, with active RHIO help we really need the help from the RHIOs—will solve a lot of the connectivity problem, but there is still the data quality program that this does not—it is pretty much silent on data quality.

Mr. BARRETT. Okay. Are there discussions in place around that standardization, if you will, and where do those go in this process?

Dr. NEBEKER. Yes. I have got to say I really appreciate your interest in these questions. It is such a nerdy topic.

Right now Leavitt Partners is leading a coalition around data quality. It involves Centers for Medicare and Medicaid Services (CMS). It used to involve Centers for Disease Control and Prevention (CDC). They are replacing a member there. Then payers some of the Blues are participating. Also other data exchange and quality organizations. National Committee for Quality Assurance (NCQA) is participating.

The goal of this collaborative is to address exactly the data quality problem, because all of us want to be able to provide better decision support, better quality management of the care, better population health, et cetera, and we need data we can compute on.

For example, our studies have shown that only in 35 percent of our patients can we tell from the information exchange whether they need a colonoscopy for screening or not.

It is very poor data that we are currently getting. It is not 100 percent bad, but has gaps.

There is a lot of progress on this. I see that we are over time a little bit. There is a vendor that stepped up to donate and will provide through open source some of their technology that allows objective scoring of data, and the score is also accompanied with, "Hey, this is what you might be doing wrong because the data came out this way."

It is going to be a really powerful initiative. We are hoping that insurance companies more powerfully participate. – like how MiHIN has a tight partnership with their payers. They recognize the value of this interoperability, not only the connectivity, but also the quality of the data. We hope that they will be writing in their contracts data quality provisions to really incentivize for us this exchange of high-quality data, not just data.

Mr. BARRETT. Thank you.

Ranking Member Budzinski.

Ms. BUDZINSKI. Thank you, Chairman.

Dr. Greenstone, can you share what is the utilization rate of these tools that VA utilizes, like HSRM, JLV, and the Veterans Health Information Exchange, among community care providers?

Dr. GREENSTONE. Sure. I can clearly speak to HSRM, which I was a product owner for many years.

HSRM is the referral and authorization system for VA, and what it creates is the true authorization that providers in the community need to have so they know what VA is authorizing, and there is a referral number that has to be associated with the claims that are actually submitted.

There are approximately 130,000 providers in the community, in this Community Care Network, who are provisioned to use HSRM as the means by which they receive their referrals as well as hav-

ing access in one click to the entire veteran medical record in an organized way.

The challenge, however, is that it is only for veterans who are seen in that 165 sort of medical centers that are still on our legacy VistA CPRS system.

Those five facilities that are on Oracle Cerner have not had that data in Oracle moved over to our Middleware VDIF that actually—HSRM actually uses to show the data.

We know that—let us say if you receive as a provider in the community more than two referrals a day, about 75 percent of those providers are using HSRM to receive their referrals and to upload medical documents. If you receive more than 10, we are talking 95 percent to 100 percent of providers.

Those providers who get a lot of referrals want to organize their data and their referrals, and they do that within HSRM. That is why they log in. That is why they see the entire veteran medical record. That is why many of them will then upload data.

Some of them are being challenged because some VA medical centers are like, "Hey, our back-end people are using faxes and phone calls and scanning all day long. We do not want to use HSRM. Send us faxes."

That is a problem that still exists today, when VA medical centers are telling folks to fax and not utilize the system that providers want to use because it makes it easier for them to actually do their work.

Ms. BUDZINSKI. That is a great point. Fax machines have come up a few times, I think, today.

I would like to ask Dr. Nebeker, when we are talking about interoperability and things like fax machines are coming up, what is the VA's plan to address this reliance and push people to utilize more interoperable tools like HSRM or the exchange?

Dr. NEBEKER. Thanks for that question.

Back when I was starting out as a young faculty member at the University of Utah, I had what then seemed to be a very large contract with Medicaid, and we were providing really great decision support on drugs when people were prescribing drugs together that they should never prescribe together, like Viagra and nitrates, for example.

The providers loved it. When we went out and we asked them, "What do you think about these forms we are mailing to you?" (We mailed back in those days) They said, "They are great. We love them. I just take them and I throw them in the garbage." I said, "Why?" 3 percent of their patient volume is Medicaid, and they cannot create workflows in their office to deal with 3 percent of their volume.

My answer is we have got to join the rest of the community. Dr. Greenstone was really emphasizing this in his opening comments. We have got to do things the same way as the rest of the community.

Then, thankfully, the Elizabeth Dole Act Section 108 was a gift in this matter because it directs the Secretary of VA to work with the Secretary of HHS. We need that teamwork.

Here we are as the largest integrated healthcare provider in the country, and we are not part of that health community oversight

process. To have a more cohesive policymaking, I think, is really going to be important to address that disconnect in oversight.

If you have any further technical questions about that, Dr. Prietula could cover those.

Ms. BUDZINSKI. Would you like to add anything, Dr. Prietula?

Dr. PRIETULA. Yes. We have been working on interoperability, as you all said, probably about 20 years, whether it is healthcare or otherwise, and we will continue to do that, consistently improving, whether it is e-faxing and turning them into something else.

We have plans as well for bringing some of that interoperability more to rural communities and helping them. We have secure messaging as well that they can use so that, instead of faxing they can, well, email, if they have that ability, so that then we start having also some more computable information.

As Dr. Nebeker and the rest of the panel here have said, we really need to get into everybody really working toward semantic interoperability, making sure that our data models are similar, if not the same.

Open source is a great way for us to start really looking into what do others do that can help us so that it is not a closed-door or behind-the-door kind of discussion around interoperability.

Ms. BUDZINSKI. Thank you.

I yield back.

Mr. BARRETT. Thank you.

I know I have got to go to closing remarks because, unfortunately, we have to move on to other activities.

Dr. Nebeker, just—and I can follow up with you later—but when you talked about quality of record and everything else, I do not know if that means the data itself through the system or, like, how a physician describes a certain thing.

I will give you an example.

When I was in Ann Arbor last week, a few days ago, they said that the carpal tunnel condition procedure could be categorized one of several different ways by the physician, and the next physician looking it up may not look at it through the same lens perhaps.

I just would be curious. I mean, we spent a lot of time making sure we had standardized language in the Army for the things that we did there. I assume that is probably a goal in medicine as well.

I am happy to ask you some of those follow ups offline unless you have got some brief comments you want to make.

Dr. NEBEKER. Yes. Very briefly.

The kind of nuanced classification of diseases is what we think about more for internal interoperability when we are generating the data.

The kinds of quality that I was talking about before is about getting those data that are in the EHR and that are great in the EHR across that divide to where they are actually going out in a way that can be read. And so that is——

Mr. BARRETT. You are talking ones and zeroes, not human interfacing?

Dr. NEBEKER. More are they getting the right information in the right slot? Are the units for blood pressure millimoles per liter instead of millimeters of mercury, which is very different.

Mr. BARRETT. Sure.

Dr. NEBEKER. Are they plausible values? Is the blood pressure 500? We are seeing these data quality problems, when they are going from the EHR, being pushed out to the exchanges, the data is getting scrambled.

Mr. BARRETT. Okay. You crash a lunar module when you have one guy measuring meters and the other guy measuring feet. Okay. All right.

Thank you. I really appreciate all of your testimony, each of you for being here today. Definitely learned quite a bit from your testimony. I am only slightly more confused than when I started, so that shows that we are making progress.

VA is the largest healthcare system in the Nation, but it only represents—oh, I am sorry.

Ranking Member Budzinski, go ahead. You can do your statement first.

Ms. BUDZINSKI. Sure. Thank you, Mr. Chairman.

Mr. BARRETT. I will get this right over the next——

Ms. BUDZINSKI. It is Okay. We are in it together.

I appreciate the testimony and answers from our witnesses this afternoon. Having a truly seamless and secure interoperability program is crucial for our veterans to be able to seek the care they need.

There has been a series of active interoperability efforts, but there are still major issues that need to be addressed about the sharing of information between the VA and the non-VA providers. I am glad to see that the VA is actively taking steps to figure out how to securely exchange information so veterans can continue to receive care inside and outside of the VA.

While these efforts are on the right track, I would be remiss to not acknowledge the impact of the recent personnel actions on VA's ability to ensure that veterans have a complete medical record.

It is critical that VA have sufficient staffing in Office of Information and Technology (OIT) and EHRM, as well as the clinical settings, to ensure that VA can participate in the information exchange processes. Otherwise, our veterans are the ones that will suffer.

Relying on only technology alone is not going to work for a seamless exchange of information. We need to work together to figure out how to produce complete medical records for our veterans so they can receive the care that they so rightfully deserve.

Thank you so much, Mr. Chairman, and I yield back.

Mr. BARRETT. Thank you.

I want to thank the ranking member for participating and being here for the entire committee hearing today.

Thank you.

I want to thank our witnesses.

As I was beginning to say, the VA is the largest healthcare system in the Nation, of course has more medical records perhaps than any other system out there, but still only represents about 3 percent of all U.S. hospitals. While it is the largest, it is still not the majority by any stretch.

Veterans are people at the end of the day and the other 97 percent of hospitals will always play a role in veterans' healthcare.

As I said in my opening remarks, roughly one-third of VA care has currently gone through the community. The healthcare data in the Community Care Network will always form a large part of the complete picture of a veteran's medical history.

Republicans on this committee are prioritizing making sure that veterans have access to community care when they are eligible for it and are given the opportunity to choose what is best for them and placing them in the driver's seat.

Part of how we make VA stronger and deliver better outcomes for veterans is to continue moving the ball forward on interoperability so there is that seamless ability and no coverage gap exists.

This includes VA producing a thorough, actionable plan on healthcare information interoperability standards, expanding the Veterans Interoperability Pledge and fostering more direct information exchange with community partners, building stronger partnerships for providers like Michigan Medicine as well as Health Information Exchanges like MiHIN that we learned a lot from today and appreciate that, participating in TEFCA to bridge the data exchange gaps with community care providers that still exist.

I urge the VA to be a leader in interoperability and build on the progress of recent years. America's veterans have much to gain from your work.

I thank you all again for participating in today's hearing.

I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

With that, we are adjourned.

[Whereupon, at 4:26 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Jonathan Nebeker

Good morning, Chairman Barrett, Ranking Member Budzinski, and distinguished Members of the Subcommittee. Joining me today is Dr. Laura Prietula, Deputy Chief Information Officer, Electronic Health Record Modernization Integration Office. Thank you for the opportunity to testify about the interoperability between the VA electronic health record (EHR) system and the systems that facilitate care for Veterans in their communities beyond VA.

Efforts to expand Veterans' access to care have led to unprecedented utilization of their earned benefits. the Veterans COMPACT Act of 2020 ("the COMPACT Act," P.L. 116–214) and VA MISSION ACT of 2018 (P.L. 115–182) empower Veterans to seek care from community providers when it's in the best medical interest for the Veteran or when VA care is unavailable. As a result, health information exchange between VA and community providers has reached an all-time high, enhancing care coordination and accessibility.

The exchange and use of health care data are essential for ensuring that Veterans have better access, better health, and reduced out-of-pocket expenses. VA is working to improve how different health care systems talk to each other, or enhance interoperability, by using a common set of rules called Fast Healthcare Interoperability Resources. Achieving more benefits for treatment, quality improvement, population health, and benefits adjudication requires more functionality and higher quality data than what traditional health information exchanges (HIE) or current Qualified Health Information Networks (QHIN) offer.

Since 2009, clinicians have been able to view all VA and Department of Defense (DoD) data, reducing the need for paper records. The 2009 product, VistaWeb, had some challenges. In 2014, VA and DoD released the Joint Legacy Viewer, now known as Joint Longitudinal Viewer (JLV) which is more reliable and user-friendly. JLV now contains nearly all necessary VA and DoD data and can display community care documents. To illustrate its widespread use and utility, in January 2025 alone, about 110,000 VA employees used JLV over 7.4 million times, opening over 2.2 million community care documents. A survey last year showed that 48 percent of users reported that the JLV system improved patient outcomes, 70 percent reported time savings, and 23 percent reported reductions in duplicative testing.

Since VA and DoD launched the Joint Health Information Exchange (JHIE) in 2020, Federal EHR interoperability has increased significantly, with data exchange partners reaching more than 90 percent of U.S. hospitals in 2024. Through two national exchanges–electronic health exchange (eHX) and CommonWell (CW)–JHIE connects to over 100,000 provider sites. In January 2025, JHIE exchanged over 360 million documents for over 18 million patient matches.

As the demand for interoperability with community care provider increases, VA continues to work to address interoperability gaps in collaboration with multiple communities. One issue is connectivity to small provider organizations that do not use a "top-five" EHR, such as Epic, Allscripts, Meditech, and Athena Health. Many of these smaller organizations connect to State or metropolitan exchanges provided by regional health information organizations (RHIOs). A 2024 study by one of VA's third-party administrators showed that approximately 80 percent of Veterans enrolled in or otherwise receiving care from VHA, also receive care from at least one provider connected to national health information exchanges. At the same time, only ~30 percent of providers billing VA for community care are connected to eHX or CW.

RHIOs offer services not available through eHX and CW, such as longitudinal viewers and push notifications for hospital admissions, transfers, and discharges. VA providers often receive notifications by word of mouth, impairing care coordination.

VA is also working with community partners to improve data quality that impacts clinical decision support, quality measurement, population health, and benefits adjudication. Examples of data quality challenges include incorrect weights, empty serum sodium values, incomprehensible codes, and misclassified allergies. Stake-

holders are collaborating to create open-source technologies to objectively code data quality and offer suggestions for improvement.

The Trusted Exchange Framework and Common Agreement (TEFCA) is a nationwide framework for health information sharing. The goal is to remove barriers for sharing health records electronically among health care providers, patients, public health agencies, and payers. VA aims to participate in TEFCA, contract with a QHIN provider and be fully functional and tested for the purpose of treatment by early December 2025. The Federal Electronic Health Record Modernization (FEHRM) office, which is charged with coordinating EHR implementation across the Federal Government, VA, and DoD are working together toward this aim. VA obtained an independent and comprehensive assessment by the Institute for Defense Analysis Systems and Analysis Center – a DoD sponsored federally Funded Research and Development Center–relative to QHIN candidates that can support VA and DoD health data exchange across different health information networks in accordance with TEFCA. The key decision points are the accuracy of patient match and cost.

QHIN participation will increase our connectivity but impose a practical deadline for participation of December 2025. A prominent feature of a QHIN is that once connected to one, a health care participant is connected to all QHINs. However, QHINs do not exchange data with traditional HIEs. Our JHIE gateway is currently connected to traditional national HIEs (e.g., eHX and CW). After December 2025, health care systems that use Epic, and the Epic QHIN, will start disconnecting from traditional HIEs because of the extra costs associated with the continued connection to traditional HIEs. Epic tells us that their partners will accelerate disconnecting over the first quarter of calendar year 2026. Epic systems originate 60 percent of community documents that VA providers read. If VA is not fully operational with QHIN participation by the December 2025 deadline, we could lose access to these records, thus reducing care coordination.

The Veteran Interoperability Pledge (VIP) and associated activity is an example of a creative approach to interoperability that is yielding a significant benefit to Veterans at a low cost to VA. In 2023, VA met with 13 high-quality health care systems. Together, we created the VIP, which addresses interoperability goals beyond TEFCA and other U.S. Department of Health and Human Services (HHS) initiatives. The major goals are:

1. Accurately identify Veterans when they seek care from providers in our communities.

2. Connect Veterans with VA and community resources that promote health and health care—especially VA services that lower Veterans' out-of-pocket expenses.

3. Responsively and reliably coordinate care for shared patients–including exchange of information about care requested and provided.

The first phase of VIP involved getting health care providers to connect to VA's Veteran Confirmation application programming interface (API). Given demographic information, this API returns a simple "confirmed" or "unconfirmed" as meeting the title 38 definition for Veteran. Tufts University and Sanford/Marshfield Clinic worked with Epic and Oracle, their respective vendors, to develop functionality so that all users of their EHRs can access the API. This work was done at no cost to VA or vendor partners. Several partners are now using the API at check-in and once a year thereafter. On average, partners are identifying 20 percent more Veterans than by self-reported status.

Community partners are now using the Veteran Status API to provide crucial benefits to Veterans. Some are sending Veteran status to their financial department, which prevents initiation of collection activities on a Veteran's health care debt. Some provide Veterans with VA information about VA benefits at check-in. Some trigger workflows for social workers, so Veterans in suicidal crisis can receive full benefits provided by the COMPACT Act. Some trigger workflows for clinicians to identify patients with conditions related to toxic exposure who may be eligible under the Honoring our PACT Act of 2022 ("the PACT Act" P.L. 117–168). By the end of last calendar year, providers had identified over 200,000 Veterans that can benefit from either the COMPACT Act or the PACT Act and helped connect those Veterans to these benefits.

Next, VA will work to expand membership to more health care systems, payors, community organizations, and vendors that help coordinate health care benefits. Health care systems and organizations have asked VA to work with the industry to automate benefits determination. We also expect this collaboration to result in improved Veteran access to many Federal, State, and donated benefits.

VA's interoperability goals demonstrate our commitment to put Veterans at the center of everything VA does, focusing relentlessly on customer service and convenience. In addition to the interoperability efforts cited above, VA is continuing to move forward with a modern, commercial EHR solution in close coordination with our Federal partners, including DoD and the FEHRM. This new Federal EHR system and the interoperability it provides will, improve the Veteran experience, allow care teams to understand patient medical history more holistically, and ultimately ensure Veterans receive care that is more seamlessly coordinated across the enterprise. VA's interoperability efforts and deployment of the Federal EHR will remain a key enabler of VA's ability to deliver the comprehensive health care Veterans deserve.

We appreciate the Subcommittee's commitment and oversight to ensure VA serves Veterans with excellence. We look forward to responding to any questions that you may have.

Prepared Statement of Rick McGraw

Thank you for the opportunity to testify today about the vital role that Health Information Exchanges (HIEs) play in the interoperability of our overall healthcare infrastructure. Today, I will concentrate my testimony on the over 10 million residents of Michigan, with over 461,000 veterans of our military services.

Michigan Health Information Network (MiHIN) is our statewide HIE. MiHIN was formed in 2010 as a public/private partnership with the Health Information Technology Commission housed in the Department of Health and Human Services. MiHIN was designed to play a pivotal role in advancing healthcare interoperability by facilitating seamless information sharing across Michigan's healthcare ecosystem.

Since MiHIN's inception in 2010, we have interfaced with nearly eighty individual Electronic Health Record systems (EHRs) and two national networks that only represent a limited number of use cases. A use case is a unique instance of sharing specific information regarding patients and their health. MiHIN, however, operates over fifty use cases for our clients, ranging from hospitals, primary care facilities, payors, community mental health facilities, skilled nursing facilities, and local city and county health departments, to name a few. From the 5,300+ healthcare facilities connected to MiHIN, we have routed over 8.3 billion messages to enhance care coordination and vital data delivery across the State. For example, ninety-seven percent of all State admission, discharge, and transfer summaries pass through MiHIN today.

MiHIN's direct interfaces with local healthcare facilities' EHRs provide instantaneous record submissions immediately following an encounter with a patient. In less than 4 minutes, that information is received, verified, and routed to our portal, where the patient's longitudinal record is updated with their latest information. Our most recent use case is collaborating with a mobile technology company to route real-time data from ambulances en route to emergency rooms. Emergency Medical Technicians en route will have access to a patient's electronic medical records while also transmitting current vitals to the receiving emergency department. Alerts sent to the ED will notify them of the patient en route so they can access that patient's longitudinal record from MiHIN. The best quality healthcare is not only local, but it is in near real-time.

For security and privacy considerations, MiHIN, as a business associate to the largest health and government systems in Michigan, provides security and privacy of healthcare data while ensuring it is interoperable and accessible. MiHIN and our major technology vendors are certified under HITRUST's r2 certification. This industry-leading certification requires external penetration testing, security in operations, and security during the development of custom applications, ultimately ensuring best practices across all our systems and services. MiHIN designed our Active Care Relationship Service (ACRS) model, which allows the real-time association of patients with their providers using the information found in the data ingested by MiHIN. This service restricts patient data access to only those providers that actively care for that patient.

With all this in mind, let's consider a veteran's healthcare journey. If a veteran goes to their primary care doctor who uses one EHR but also goes to a community mental health facility that uses a different EHR and also sees a specialist on a third EHR, without an HIE like MiHIN, these providers wouldn't be able to access critical patient information from those other encounters. Because of MiHIN's broad network of connectivity, MiHIN has all interactions from all three facilities available in that

patient's longitudinal record to improve overall care coordination. Today, however, in Michigan, the VA and DOD are a blind spot to a veteran's overall healthcare. The Michigan VA does not only not submit data through the network but cannot access its patients' records from encounters outside the VA.

From a provider perspective, HIEs bring critical value. A 2024 Survey of Primary Care Physicians found that:

-81 percent spend less time with their patients than they'd like.

-57 percent write prescriptions or refer patients out due to time constraints.

-46 percent report a lack of adequate time with patients as a top stressor, and

-Almost two-thirds feel their work is more transactional than relational.

Accessing patient information within an HIE's longitudinal record has shown that a provider can save up to 15 minutes per patient per visit, while the cost of this access is nominal.

Today, the VA does not comprehensively see interactions outside of its facilities. And—like the patient journey example I gave you—community care facilities cannot see veterans' interactions with the VA hospital either. There is no such thing as a lifetime record of a veteran's healthcare residing in one EHR system. It simply does not exist. There's also no such thing as a national exchange with a handful of EHRs that can replace the infrastructure we have spent the last 14 years perfecting.

We can—and must—do better to provide higher-quality care to our veterans in Michigan. There is always potential for improvement, and I believe we can achieve it with the right strategies, support, and collaboration.

Thank you for your time and attention to this important issue. Your support and understanding are greatly appreciated.

Prepared Statement of Andrew Rosenberg

Good afternoon. Chairman Barrett, Ranking Member Budzinski and distinguished members of the Subcommittee, I would like to add my appreciation that you have convened this panel to discuss the important details and issues related to how we exchange health care data and coordinate care between the Department of Veterans Affairs (VA) and health care organizations such as Michigan Medicine (Mich.Med). As a physician, and Chief Information Officer, I would like to further explain how we currently exchange information and the opportunities available to improve this soon. Michigan Medicine is neither the best nor worst at HIE and our examples may be representative of US health organizations. I will begin by briefly summarizing how we do health information exchange (HIE) at a large, statewide health system and then several challenges we face and how we are working to address these.

Health providers such as Mich.Med. benefits from the excellent national interoperability frameworks as well as distinct data sharing networks across, and within, the states themselves that guide and facilitate HIE. The US frameworks and networks have improved how we are sharing data than earlier methods that included sending stacks of paper, CDs or worse, faxing random bits of information (something still occurring today). Notable examples you are aware of include the Carequality, CommonWell Health Alliance, eHealth Exchange (eHX), and most recently, the Trusted Exchange Framework and Common Agreement (TEFCA). Our peers in global health care do not have these national standards. We should not take these resources for granted.

Details for Michigan Medicine's health information exchange practices may be of interest and are representative of large, quaternary health systems across the United States. Regardless of the various network and frameworks, the most detailed, secure, and efficient exchange of health information for us at Michigan Medicine is through our primary electronic health record (EHR) system, Epic. I am not here to extol the virtues of any one contemporary EHR, however you all are aware of the dominant position Epic and Oracle/Cerner have in the US EMR market, and Michigan Medicine is no exception. Since beginning EPIC's Care Everywhere HIE, in 2014, Michigan Medicine's health system (including UMH West and UMH Sparrow) has exchanged over 361M records, including 83M records this year to date. The EPIC organization itself reports exchanging over six billion records a year at this point.

Specifically for VA patients, since August 2023, we estimate that the combined record exchanges within The University of Michigan Health System were 77k records per month. This practice will only increase as we join the TEFCA trust

framework through the Epic Nexus QHIN in the fall and more robustly take part with other organizations exchanging data through Carequality, eHX and our State HIE, MiHIN. We expect significant increase in the amount and quality of data exchanged for both acute and ambulatory/outpatient care.

Similarly, Michigan Medicine providers connected to the MiHIN State HIE over 38k/month to query data on 600k actively seen Michigan patients for such things as ADT messages (800k/mo.) lab results (560k/mo.) and radiology results (100k/mo.). These data cover the 148 hospital, 665 outpatient facilities, 298 skilled nursing facilities and all forty-four provider organizations in the State of Michigan. Taken in total, we estimate exchanging over 275k records per day across Michigan Medicine alone.

While the variety of available HIE methods offers advantages, it also presents the challenge of deciding which systems to use and integrate into routine practice. Each needs specific expertise, different technical support, and cost. Diverse options can lead to fragmentation of which network to use and the design, configuration, and data mapping practices inherent to one method of HIE compared to another.

What can we do to continue to improve our interoperability and exchange of health information? The single most important step is to encourage, advance and accelerate the adoption of the TEFCA framework to health care organizations. This and the continued progress to adopt and upgrade contemporary EHRS will only improve the data sharing I have previously mentioned. The second is to seek specific areas of improvement within these frameworks, evaluate them for benefit and priority of adoption and seek methods to accelerate this process. Examples within the TEFCA framework we and our colleagues discuss frequently include methods to improve data segmentation, encourage adopting current UCSDI versions, widen the use of FHIR to include more public health reporting, controlled prescription, patient outcomes and other determinants of health in the interfaces (APIs), broaden the data shared for benefits, and improve the precise and strict onboarding and organization validation for those who can participate in these networks. Use case, auditing, and individual access are also important considerations.

Additionally, where they exist, strong State health information organizations such as Michigan's MiHIN, the Indiana Health Information Exchange (IHIE), the Maryland CRISP, Colorado CORHIO, Utah's UHIN and others provide added value. Local and regional data sharing often includes care coordination among competing health providers, public health and quality improvement initiatives population and chronic disease management and managing other determinants of health. These are often 'value added' capabilities that State HIEs and third-party companies provide better than a given health organization can do on its own. I believe if these firms are rigorously following the rules of the road established by the broader ecosystem and trust frameworks previously mentioned, there is enormous value from these more nimble and focused organizations to also participate in the collective health information exchange and interoperability work we have briefly discussed here today.

Thank you once again for the opportunity to address this subcommittee. I am eager to work collaboratively to ensure that our Nation's health IT infrastructure supports the exceptional care Americans expect and uphold the ethical standards to which we are all committed. I am happy to answer any questions you may have.

Prepared Statement of Leo Greenstone

STATEMENT OF

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FORMER PRIMARY CARE GENERAL INTERNIST, VA ANN ARBOR HEALTHCARE SYSTEM
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FORMER EXECUTIVE DIRECTOR, CLINICAL INTEGRATION AND FIELD OPERATIONS,
OFFICE OF COMMUNITY CARE 2017 to 2022 AND
RETIRED WITH DISTINGUISHED CAREER AWARD 2022
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS

THIS TESTIMONY IS FOR THE

COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION
U.S. HOUSE OF REPRESENTATIVES

On

"CLOSING THE DATA GAP: IMPROVING INTEROPERABILITY BETWEEN VA AND COMMUNITY PROVIDERS"

March 24, 2025

Good afternoon, Chairman Barrett, Ranking Member Budzinski, and distinguished Members of the Subcommittee. Thank you for the opportunity to testify today about the interoperability between the Department of Veterans Affairs' (VA) Electronic Health Record (EHR) system and the systems that facilitate care for Veterans with providers in their community.

When the Secretary and other leaders speak of the commitment to providing Veterans with timely, well-coordinated, and high-quality care, that pledge rings true for all Americans. To accomplish this goal, however, it will take a holistic and comprehensive approach that is beyond technology modernization alone. Technology will undoubtedly play a significant role, especially when people and processes are implementing the technology in a coordinated fashion within efficient workflows. Also, VA must be appropriately funded to stay in technological lockstep with Health and Human Services (HHS) and its rules and regulations, with industry and its advancing technology, and with the Integrated Veterans Care (IVC) Office with its reach into the VISNs and medical centers for change management. IVC will need to work with their Third-Party Administrators (TPAs) who are managing the Community Care Network (CCN) of providers to support technological advances and implementations.

The Health Information Exchange (HIE) is a structured web that has the potential of connecting all providers with Electronic Health Record Systems to each other for provider-to-provider document exchange as well as exchanging aggregated clinical data from provider to payer like community providers to VA within the Veteran Community Care Program (VCCP). The latter exchange of aggregated performance measure data from a large population of patients is critically important for the VA to ensure high quality care is being provided to Veterans by providers within CCN. VA needs to know that the providers and health systems caring for Veterans are providing high quality performance measured care to their entire population which will include some Veterans. This has been a significant gap within the VCCP historically and is actively being pursued by VA and their Third-Party Administrators within the CCN contract. The sharing of these data will improve care coordination, increase affordability with fewer duplicate studies being performed, improve patient safety and quality. The quality data passed to VA allows for appropriate assignment of referrals.

Additionally, not all providers and hospitals are connected to a Health Information Network (HIN), Regional Health Information Organization (RHIO), or National Qualified Health Information Network (QHIN) in all states and territories. Even when providers are connected, not all relevant information like office notes for referred care, or complete emergency department notes are available. I have seen where only a problem list with medications from an encounter is available. Without these comprehensive referral-based office notes, VA will be unable to provide the care coordination necessary to deliver high quality care.

So, I agree that HIE represents the future, especially when using Fast Health Care Interoperability Resources (FHIR) to enable provider to provider document exchange and provider to payer aggregated clinical quality data. These gaps of not all providers participating and those participating not providing all the needed data must be filled. The other major challenge that exists for the VCCP is that all care must be authorized. That means that community providers not only need relevant clinical information regarding the Veteran, but they also need to know what is being authorized by the VA; what is going to be paid for, for how long, and for what types of care (there are many), especially rehabilitation care, how many visits are authorized? (See Figure 1) That critical referral-based information is not passed on via the HIEs today - but it could be.

Potential Solutions:

As mentioned earlier, VA must stay in lockstep with HHS, the commercial industry, their own IVC colleagues/stakeholders and workflow architects with clear guidance from VA and

congressional leadership to fulfill their mission. Any IT solutions must be user friendly, easy to use, and they must simplify the end users' work to make it more efficient. Otherwise, staff will resort to dependable ubiquitous phones and fax machines. Change management is hard with 170 VAMCs and thousands of staff members attempting to carry out the same mission.

A short to mid-term initiative that could move the needle in closing gaps is to have the VA CCN TPAs work with their VISN-based provider relations teams to perform an inventory of their providers who most commonly receive referrals from VA and ensure they are connected to the HIE (HINs, QHINs or RHIOs) (See Figure 2). The results are to be sent to VA via the Provider Profile Management System (PPMS), the directory of all VCCP providers. This will allow VA to preferentially refer to providers on the HIE if desired. Also, the TPA team could help the unconnected providers to connect and use industry partners as needed to help expedite the process. This initiative could be piloted using the Elizabeth Dole Act financial incentive provision in a few VISNs to validate the concept.

The longer-term suggestion is to begin investing in a process like the 360X Closed Loop Event Driven Referral Management and Document Exchange Protocol (See Figure 3). VA's Community Care Referral and Authorization system (CCRA) should have the capability to perform such a function. This is a well-documented and industry proven process whereby when an outgoing referral is created within an EHR, it, along with relevant clinical information is sent directly into the EHR of the receiving consultant. When that appointment is made in the consultant's EHR, the information regarding the date and time is automatically passed back to the referring provider within their EHR as a notification. Additionally, when the care is completed and the encounter signed off, the medical documentation is automatically pushed through the HIE into the electronic health record (EHR) of the referring provider. This type of closed loop event driven push is within the workflow of the referring and receiving provider where data is automatically pushed to the appropriate provider at the appropriate times. Given that nearly all community care is referral-based, this type of solution should be considered now and in the new Oracle Cerner platform (it could benefit the DoD as well) since the hope is that all CCN providers will be on the exchange and therefore able to utilize the 360X protocol. The funding cycle for VA health IT is long so investments should be considered as soon as possible so that design and implementation can be tested, piloted, and fully implemented as VA continues the rollout of the Oracle Cerner EHR.

I look forward to answering your questions.

INTEROPERABILITY FOR VA & COMMUNITY PROVIDERS

- Faxing & Scanning are used because they are ubiquitous & HIE Engagement is not.

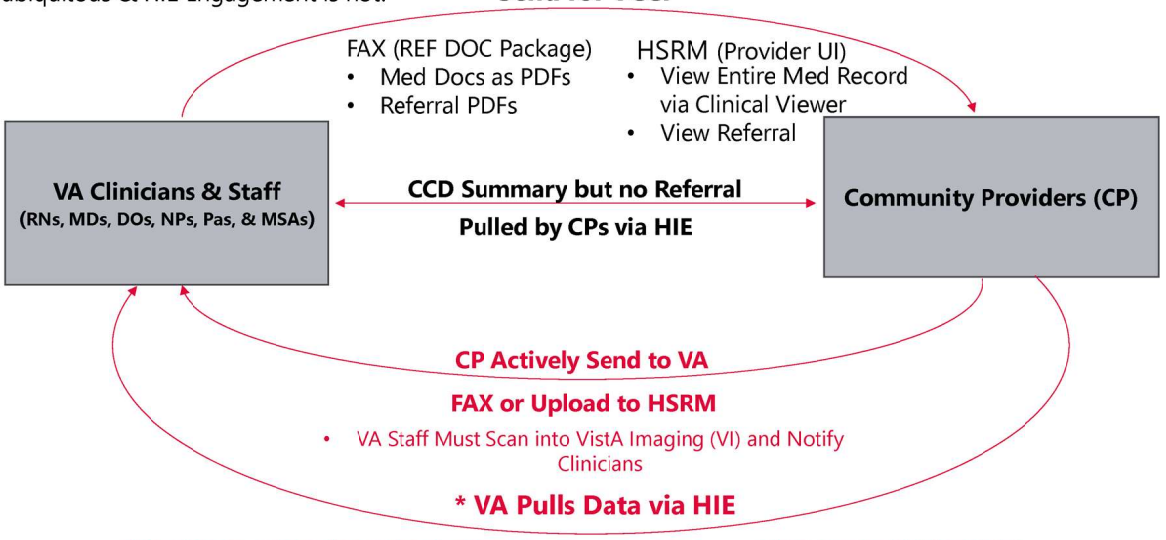
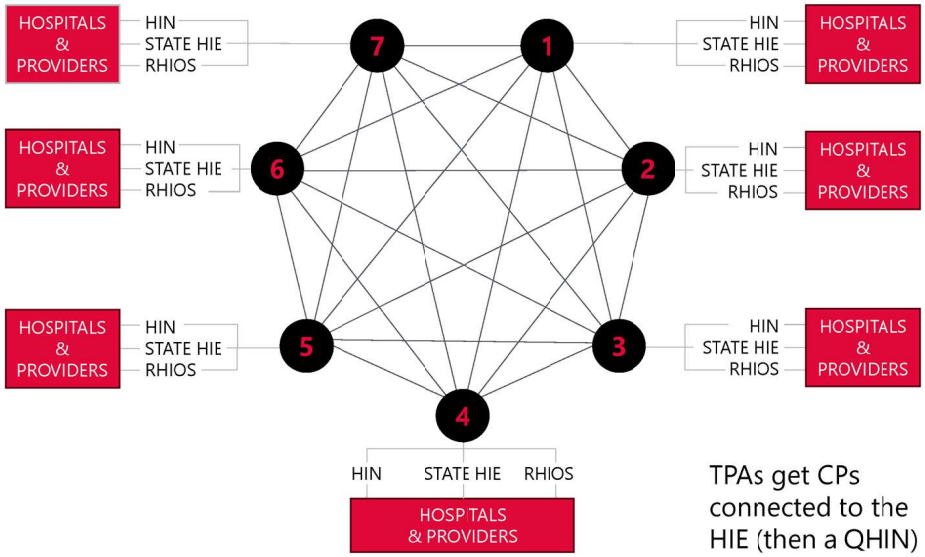


Figure 1

QUALIFIED HEALTH INFORMATION NETWORK (QHINS)

IF YOU CONNECT TO ONE QHIN, YOU CAN GET DATA FROM ALL



TPAs get CPs connected to the HIE (then a QHIN)

VA gets connected to a QHIN

Figure 2

360X CLOSED LOOP, EVENT-DRIVEN REFERRAL MANAGEMENT AND DOCUMENT EXCHANGE PROTOCOL

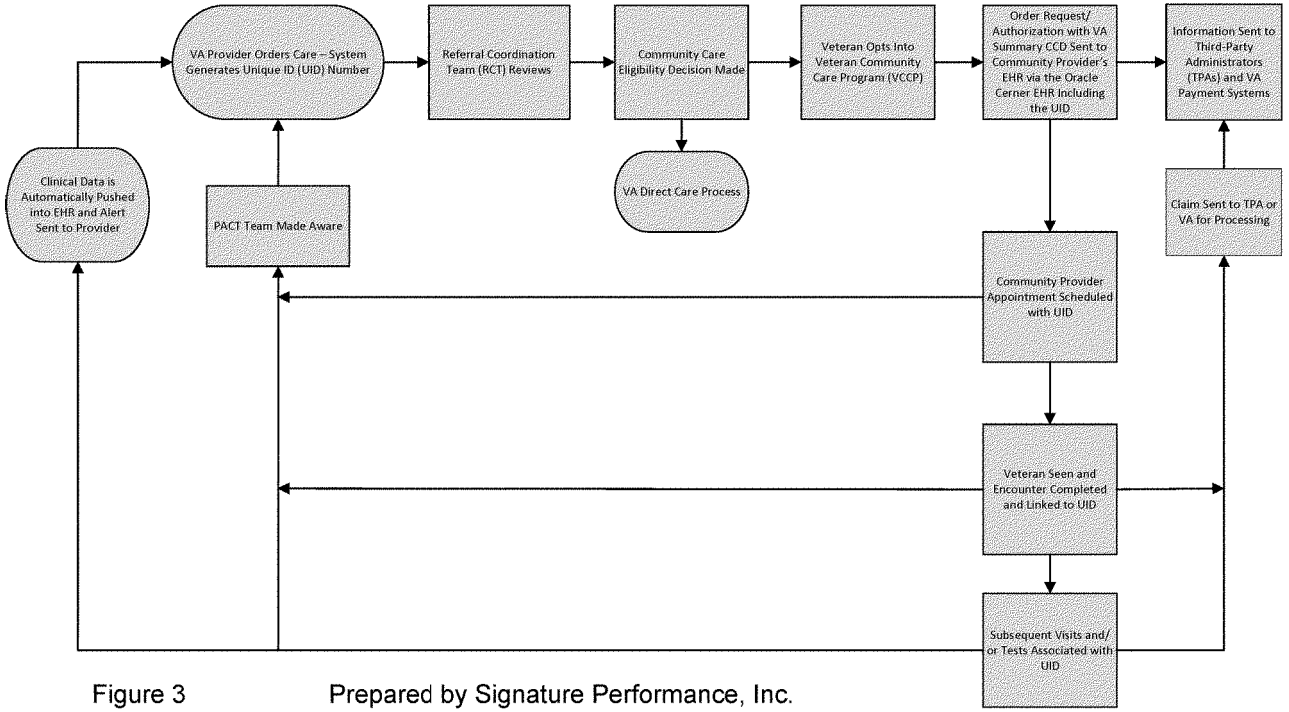


Figure 3 Prepared by Signature Performance, Inc.

Statement for the Record

Prepared Statement of DirectTrust

Scott Stuewe
President and CEO, DirectTrust
Scott.Stuewe@DirectTrust.org
916-222-0630
3/31/2025

The Honorable Tom Barrett
Chair, House Committee on Veterans' Affairs Subcommittee on Technology Modernization
U.S. House of Representatives
Washington, DC 20515

Subject: Statement for the Record – House Committee on Veterans' Affairs Technology Modernization Subcommittee Hearing, *"Closing the Data Gap: Improving Interoperability Between VA and Community Providers."*

Enhancing VA Interoperability Through Direct Exchange

Dear Chairman Barrett, Ranking Member Budzinski, and Members of the Committee,

I appreciate the opportunity to submit this statement for the record regarding the House Committee on Veterans' Affairs Hearing held on March 24. My name is Scott Stuewe, and I serve as President and CEO of DirectTrust. I am submitting this information to emphasize DirectTrust's role and partnership with the Department of Veterans' Affairs (VA) in supporting interoperability efforts mandated by the Elizabeth Dole Veterans Benefits Act (H.R.8371/S.141).

As a nationally recognized leader in secure, standards-based health information exchange, DirectTrust plays a pivotal role in ensuring trusted communication across the healthcare ecosystem. DirectTrust was created in 2012 as a result of the 2009 public-private partnership "The Direct Project," facilitated by the Office of the National Coordinator to create a secure and simple mechanism for the communication of sensitive health information. Since the founding of our non-profit in 2012 to continue the work of the Direct Project, DirectTrust's Direct Secure Messaging (often called Direct exchange) framework has facilitated billions of secure messages exchanged among hospitals, providers, and federal agencies—demonstrating its ability to support the VA's interoperability initiatives. Of importance to note, DirectTrust is a non-profit, vendor-neutral framework and network, rather than a commercial platform.

Background and Push and Pull

Personally, I have over 30 years of experience in health information technology and in clinical interoperability in particular. I have first hand knowledge of most of the interoperability standards in use in healthcare today and intimate understanding of the applicability of each standard and the adoption levels and data quality challenges each standard suffers.

Healthcare Information Exchange in the US is enabled by multiple national and regional networks, as well as many mechanisms or modalities of exchange and many different standards. A broad categorization of such mechanisms could separate these into "pull" and "push" modalities. Pull mechanisms, such as searching for information during unplanned care, are supported by TEFCA and their predecessor frameworks Carequality and CommonWell. The dominant push mechanism today is Direct Secure Messaging, through the Direct Standard® and the DirectTrust Network.

The best use cases for pull are where the patient presents for the first time at a new organization. Querying for the available records allows providers to collect data from all the prior encounters a patient may have. The vision of TEFCA and the other national networks is that this would be possible regardless where those prior encounters may have occurred. While TEFCA was imagined as a "single on-ramp" for information exchange for all modalities and use cases, there is already such a secure, ubiquitous, vendor neutral option for push messaging that is mandated under the EHR Certification Rule in Direct Secure Messaging.

Every certified EHR technology is required to support Direct Secure Messaging both inbound and outbound. As a consequence, far more small and rural hospitals and practices have access to Direct than have access to a query network. Over 230,000 locations have Direct addresses. There are over 2.7 million Direct addresses that exchange over 400 million messages a quarter. While many EHRs incorporate Direct Secure Messaging directly into their product at no or little cost, other technology vendors offer web-based platforms to access Direct. While DirectTrust neither monitors nor sets pricing in this competitive market, it is well known that small practices can get access to Direct for a few hundred dollars annually. This means that it is easier for the entire care continuum to access and use Direct. Furthermore, because the technology supporting Direct is already ubiquitous, it means there isn't necessarily new technology to implement, rather it becomes an education campaign for community care providers to understand the tools they have at their disposal to more readily coordinate care with VA providers.

The most common push use case is clinical referrals for care coordination. This involves a provider sending a curated communication to another provider that includes what the sending provider wants the receiving provider to know about their patient; for instance, a primary care provider referring to a cardiologist would use Direct to "push" information about the patient to the cardiologist. Direct Secure Messaging is the only currently available standard that supports clinical referrals at all and in a great many EHR systems a Direct message is the natural and automatic outcome of referral workflow. While referrals is what Direct is most known for, there are a large variety of use cases that Direct Secure Messaging supports.

The Evolution of Direct and Push Use Cases

The Direct Standard® has continued to evolve as well. The Direct Standard® itself is "payload agnostic" meaning it can carry any electronic format whether standardized or not. At its inception, Direct supported a few use cases specifically, but users of the network almost immediately expanded the scope of messages communicated and to improve the workflow of existing use cases.

For referrals and care coordination, workflow improvement took the form of a standard Integrating the Healthcare Enterprise (IHE) profile that was a collaboration between industry and the Office of the National Coordinator called 360x, which uses Direct Secure Messaging as the transport mechanism for these messages. 360x does more than just stipulate what messages are sent back and forth, it also requires specific workflow functions in order to make referrals into "closed loop" referrals. Referrals are naturally conversations that might begin with "can you take this patient" that require a response and when a referral is accepted, and the patient ultimately presents for a visit, a consult is returned to the sending provider for his or her records. Essential metadata about the message including a referral identifier that can be exchanged on all messages enables not only the conversation, but appropriate workflow of the systems involved in the transactions. Demonstrations of this profile can be seen on the DirectTrust website here. 360x Closed Loop Referrals is now live in a few sites and multiple vendors have either implemented it or are committed to doing so. The list of those vendors can be found on our website as well.

When the CMS Patient Access Rule was finalized, many HIEs that had the ability to send Direct messages communicated the mandated Admit, Transfer, and Discharge Event Notifications using the base standard. As with referrals, the community of DirectTrust members worked together to establish a standard profile for these messages so that receiving sites could route the message to the right person or workflow.

DirectTrust®

During the COVID-19 Pandemic, public health authorities needed to receive initial Electronic Case Report messages in order to understand how the disease was spreading. A grassroots effort to create a mechanism to generate the report and send it directly from the EHRs to public health enabled millions of these transactions to flow before the end of 2020 and millions a month to this day. Direct Secure Messaging delivers roughly half of this traffic to the Association of Public Health Laboratories who then forwards these on to the appropriate state and federal jurisdictions.

Other messaging use cases which are already flowing through our network require some standardization in order to allow for more streamlined acceptance of these messages. Prime examples include payers sending care gap messages, pharmacies sending medication interchanges (where a patient's prescribed medication is no longer on formulary or is contraindicated and will need to be changed), and order messages for durable medical equipment. DirectTrust is convening a new standards effort to generalize the metadata requirements for any general use case so that provider burden can be minimized and workflow can be optimized.

Conclusion

As the Committee considers legislative and policy actions to enhance VA interoperability, I urge the inclusion of DirectTrust as a trusted partner in the creation of a plan for implementing the secure, efficient, and standards-based data exchange needed to fulfill the goals of the Elizabeth Dole Veterans Benefits Act.

Thank you for considering this submission for the record. We are available to provide additional details or answer any questions as needed.

Sincerely,

Scott Stuewe
President and CEO
DirectTrust