

STATEMENT OF

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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.

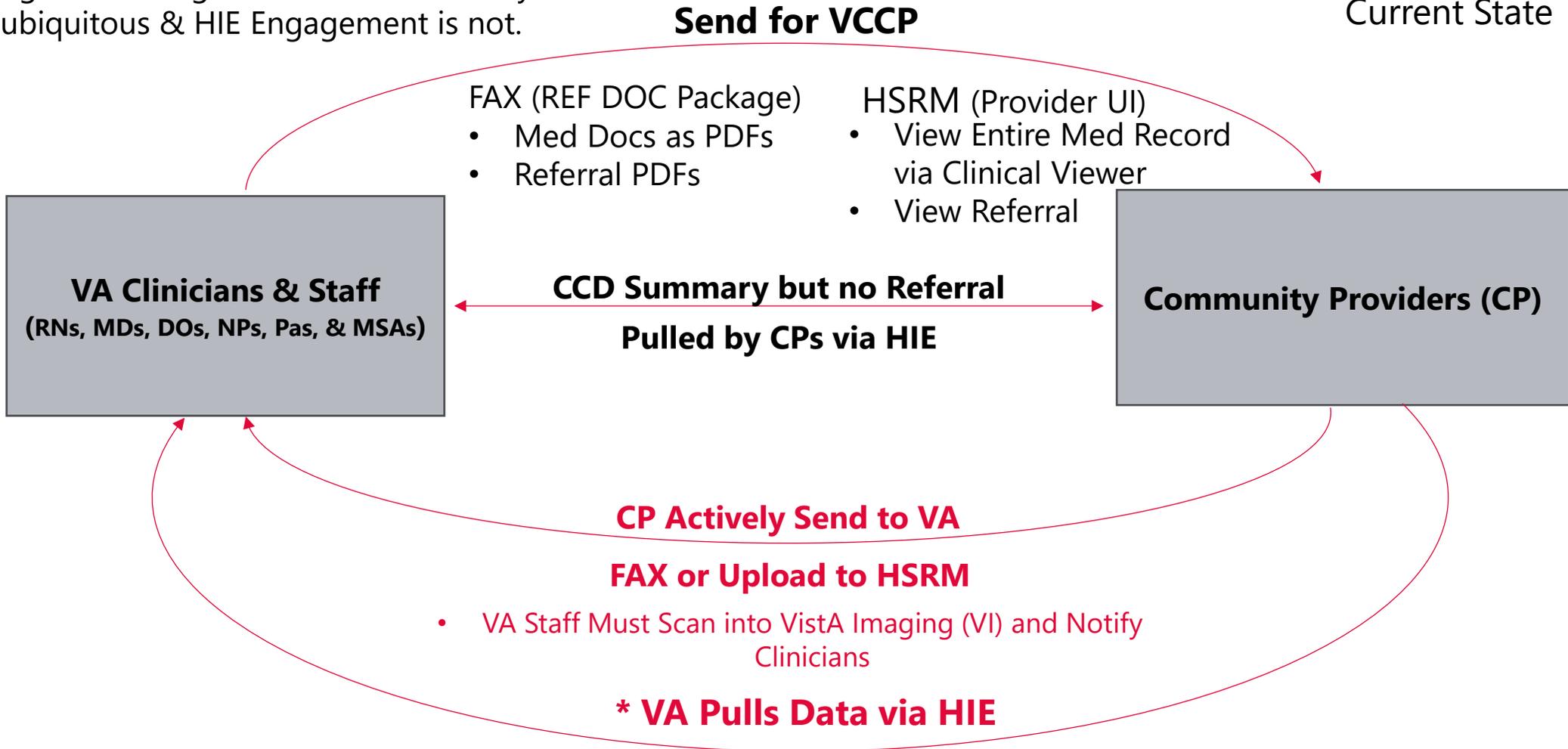
I look forward to answering your questions.

INTEROPERABILITY FOR VA & COMMUNITY PROVIDERS



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

Current State



*On CPRS via JLV Requires Upload to VI

*On Oracle Cerner – Easily Incorporated into Millennium

{ 30% Success Pull for VCCP }

{ either no data or not the needed data }

Figure 1

QUALIFIED HEALTH INFORMATION NETWORK (QHINS)



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

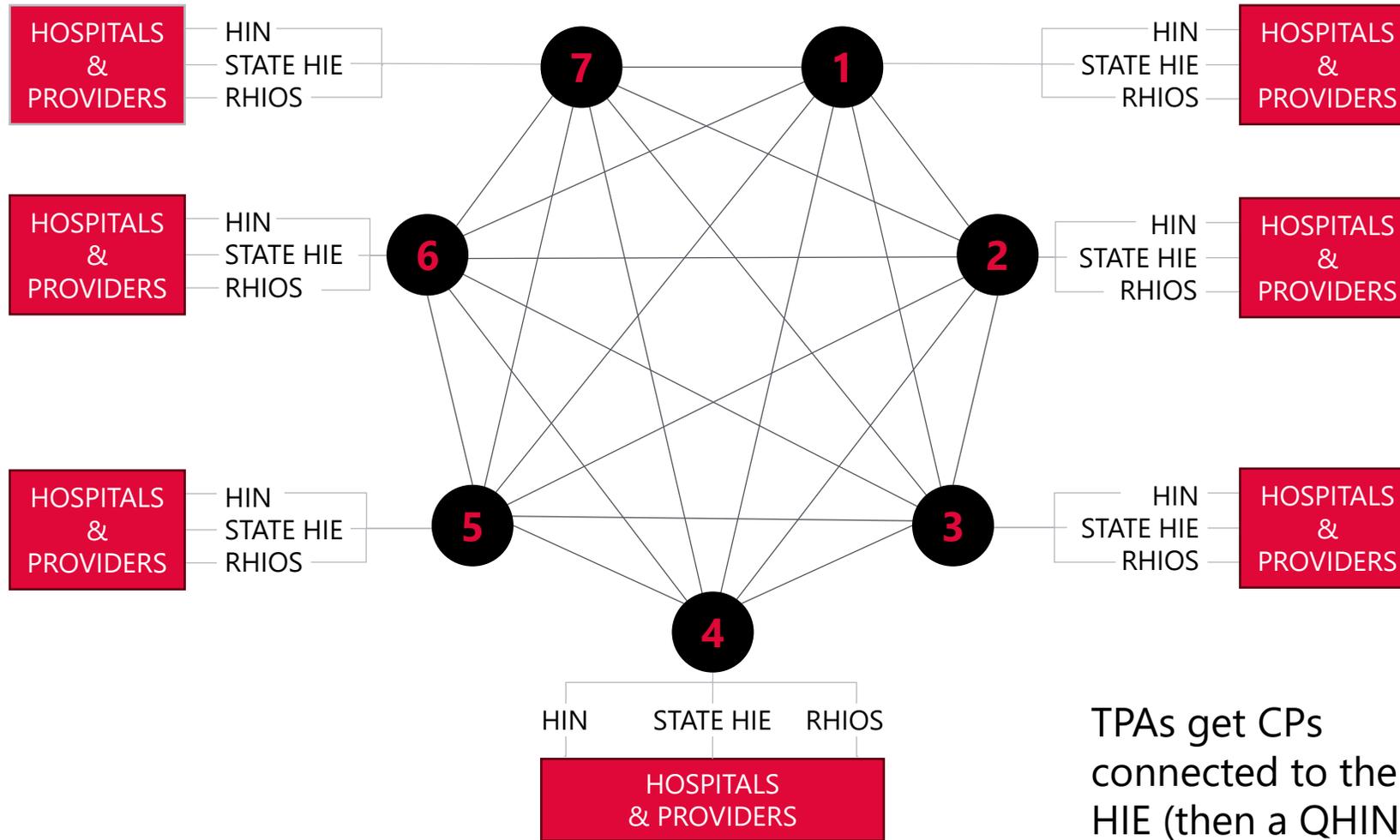


Figure 2

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

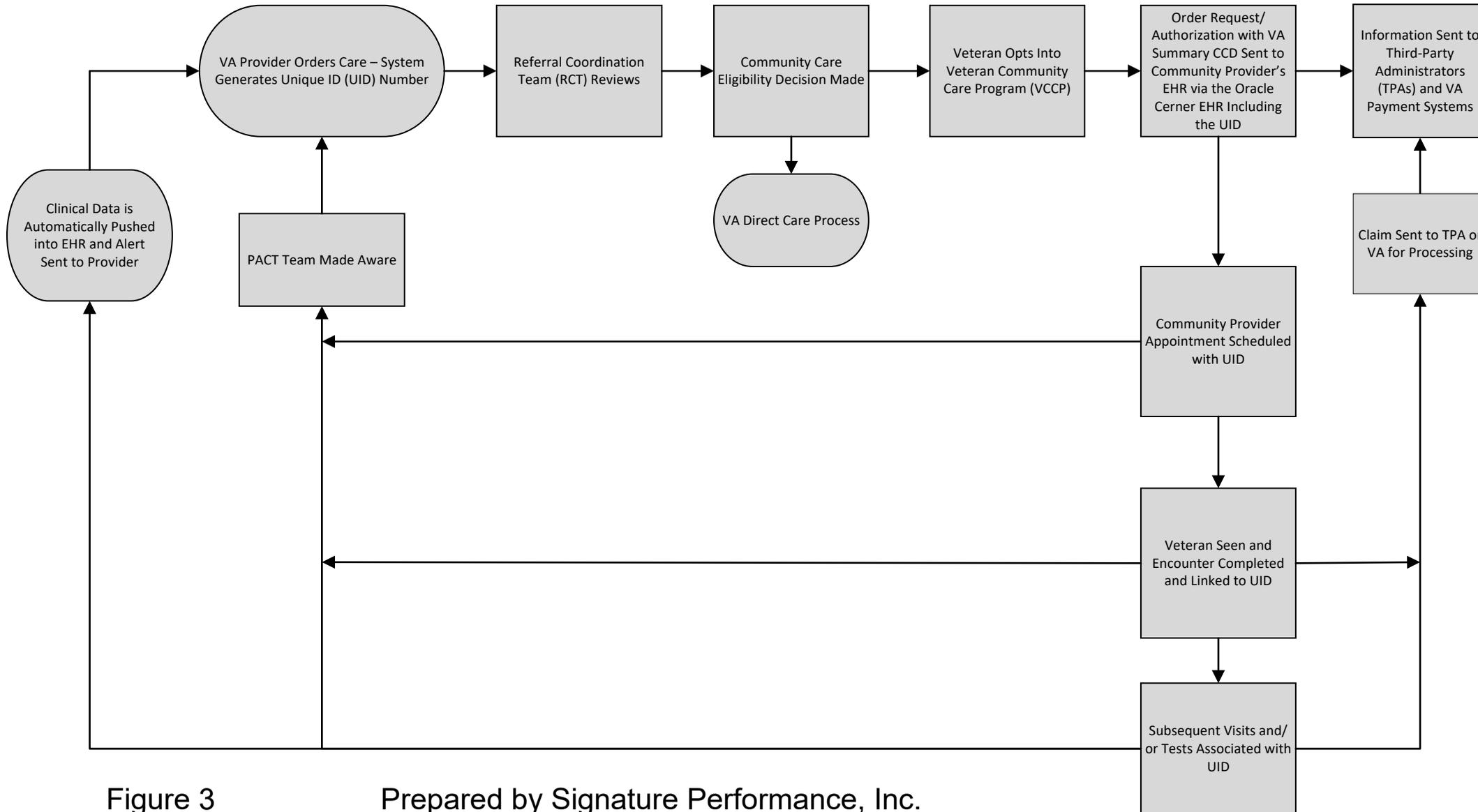


Figure 3

Prepared by Signature Performance, Inc.