STATEMENT OF

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SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION

U.S. HOUSE OF REPRESENTATIVES

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

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, we estimate that we exchange 45k records per day with the "Federal HIE-DoD, VA and USCG". The majority of these are from the VA. 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.