

October 15, 2023

Representative Michael Burgess, M.D. (TX-26)
Chair, Health Care Task Force
House Budget Committee
204 Cannon House Office Building
Washington, DC 20515

RE: Request for Information from Stakeholders on Improving Outcomes while Reducing Health Care Spending

Dear Representative Burgess:

[Civitas Networks for Health \(Civitas\)](#) appreciates the opportunity to provide feedback on the August 25, 2023, request for information (RFI) from stakeholders on solutions to improve patient outcomes while reducing federal health care spending issued on behalf of the House Budget Committee's new Health Care Task Force. Civitas is a national nonprofit collaborative comprised of more than 165 member organizations—health information exchanges (HIEs), regional health improvement collaboratives (RHICs), and providers of services to meet their needs—working to use data frameworks, information infrastructure, and multi-stakeholder, cross-sector approaches to improve health for individuals and communities. We educate, promote, and influence both the private sector and policymakers on matters of interoperability, quality, coordination, and cost-effectiveness within the health system, while also supporting multi-site, grant-funded programs and projects around the country.

Civitas is proud to be an essential voice for our members and the communities they serve at a critical time in the development of America's health data frameworks, when rapid advances in the availability and use of medical information are colliding with systemic challenges and the imperatives to improve health system efficiency, security, and accountable governance. In the course of navigating these dynamic and sometimes conflicting circumstances, Civitas members have become leaders in the development of a new and innovative paradigm known as the Health Data Utility Model (HDU) that holds great promise for effectively managing the demands of this new landscape. The HDUs emerging around the country represent an evolution rather than a revolution in the structure of health information networks and value-added capabilities, combining the multi-directional data transmission infrastructure of incumbent statewide and regional HIEs with a wider array of quality improvement, analytics, community health and social service functions that in many areas have been advanced by RHICs and related quality improvement organizations of varying sizes.

The resulting nonprofit organizations—or partnerships of nonprofit organizations—which comprise an HDU can take advantage of scaling efficiencies across well-defined geographies to better serve their communities as information networks, secure data stewards, platforms for the integration of new technologies, and public health assets. HDUs' nonprofit status, local stakeholder governance (typically overseen by boards with representatives of different providers, patient advocates, and community organizations) and official recognition by public authorities (in state laws, regulations, or contracts) have positioned them as neutral system arbiters vis-à-vis

corporate electronic health record platforms (EHRs) and other technology vendors, whose products are “plugged in” to the HIE architecture to perform specific functions at different sites, but who do not own or control the HDU at large. The service territory structure of HDUs also enables them to achieve greater levels of financial self-sufficiency through payer and provider fee schedules, as well as through the use of public formula funds (e.g., Medicaid, block grants) and larger contracts. Analogies from outside the health space are long-established models of nonprofit, public-serving utilities like electric cooperatives and water authorities that are thoroughly connected to wider infrastructure networks while maintaining sufficient autonomy to respond to their customers’ needs, or the role of state and local roads in the national surface transportation network.

Examples of Civitas member organizations that can be characterized as emerging HDUs based on their current capabilities and various aspects of their operations include Texas’ HIETexas and C3 Health Information Exchange; Georgia Health Information Network (GaHIN), CyncHealth in Nebraska; Contexture in Arizona; and West Virginia Health Information Exchange (WVHIN). These and other emerging HDUs are characterized by a wide range of operations within their geographic service areas, most of which span urban, suburban, and rural communities—and all of which generate significant efficiencies for patients, providers, and the wider health system. The most common operational attributes of HDUs are described below:

Multi-directional, synchronous exchange of patient medical records between primary, specialty outpatient, and hospital clinicians. This is the modernized version of the original point-to-point legacy model for health information exchange, which now includes collection, aggregation, and transmittal of patient data in different formats from multiple entry points simultaneously and tailored to the needs of specific users. The largest emerging HDUs handle millions of secure clinical record transmittals and ADT (admissions, discharge, and transfer) notifications per month for millions of individual patients in statewide or regional service areas. While multi-directional data sharing at scale represents a massive and necessary advance in technology over earlier more discrete exchange technology (to say nothing of fax machines and pre-digital health information management) it has become especially important in rural service areas to negate distance barriers and bring disparate patients and providers together. The most illustrative and compelling use cases are often exercises in leveraging records from large numbers of patients and providers that would otherwise be impossible to assemble on a practical timescale, such as the statewide organ donor matching and coordination activities performed by the emerging HDUs in Missouri, Colorado, California, and elsewhere.

Connectivity between different types of healthcare providers. A hallmark of the emerging HDU model is the integration of technology, technical supports, and value-added applications across a broad and expanding range of provider facility types within the same serve area. In recent years, hospitals of different sizes (from critical access hospitals to academic medical centers) and independent primary care practitioners have been joined by—and in some cases, outnumbered within the HDUs own networks by—skilled nursing and long-term care facilities, urgent care clinics, ambulatory surgical centers, federally-qualified health centers (FQHCs) and look-alikes, rural health centers (RHCs), hospital outpatient departments, independent clinical laboratories, and psychiatric residential treatment facilities. These sites have in turn been joined by non-physician practitioners including physical and occupational therapists, psychologists, and

licensed clinical social workers. The leading edge of provider recruitment into HDU functionality in most states is pharmacies, many of which already share limited prescribing information with HIEs per state prescription drug monitoring programs (PDMPs) as an opioid abuse countermeasure, but most of which are only beginning to unlock the full potential of incorporating all prescriptions into HDU datasets as a result of new state laws and regulations.

Technical protocols and standardization to promote an open health data landscape and inclusive advancement. Emerging HDUs, HIEs and RHIC organizations have been leaders by necessity in the adoption of platform-agnostic data standards and processes (such as HL7 FHIR and API-based specifications more generally) that ensure as many stakeholders within their service areas as possible can participate in information exchange for their own benefit, and for purposes of securely contributing valuable datasets to further quality improvement and public health applications. Because Civitas members tend to have statewide or comprehensive regional service areas that typically include a mix of urban, suburban, and rural health ecosystems, they act as levelers for chronically underserved and rural participants who might otherwise be forced to play catch-up (more so than they already do). Moreover, many Civitas members have prioritized direct and ongoing technical assistance to high-need facilities within their service areas, providing education for system onboarding, project-specific support, and training that integrates data management into the routines of community health workers and other key personnel (particularly notable examples exist in Georgia, Ohio, and Vermont).

Resources and tools to enable effective and systematic quality improvement. Building on the work of state and regional RHICs nationwide, HDU partnerships have increasingly made quality improvement a major part of their portfolios as they recruit a wider array of providers and leverage expanding volumes of health data—and the federal health enterprise has been a key partner to this end. Eleven Civitas members have active contracts under Medicare’s longstanding Quality Improvement Organization (QIO) Program through 2024. Seven of them (Telligen, Alliant Health Solutions, Mountain-Pacific Quality Health, Quality Insights, Comagine and Metastar/Stratis Health within the Superior Health Quality Alliance) are among the 14 Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) nationwide tasked with implementing Program activities in their assigned multi-state respective regions, while four others (Iowa Healthcare Collaborative, New Jersey Innovation Institute, New York e-Health Collaborative, and Rhode Island Quality institute) serve as Network of Quality Improvement and Innovation Contractors (NQIICs) within state borders.

Quality improvement can vary significantly by provider and project type, with activities ranging from assessment of patient outcomes for specific medical procedures and large-scale evaluations of clinical best practices to the development of performance measures, workforce training, and community engagement. The common emphasis is better outcomes and lower costs, driving efficiency and bending the cost curve away from entrenched bureaucratic inertia and toward the promise of value-based care. This transition is particularly important for underserved areas, which account for markedly disproportionate shares of the nation’s highest-risk and most expensive patients. In rural areas, the problem is compounded by more small practitioners with fewer resources and less administrative bandwidth to handle the reporting requirements associated with Medicare’s flagship quality improvement programs (Shared Savings Program, QPP) and CMS innovation pilots despite being among the providers who stand to gain the most from them.

Localized social service referral networks and systemic integration of social determinants of health. HHS has defined “social determinants of health” (SDOH) as “economic and social conditions which influence the health of people and communities.” These conditions include housing, food, and utility insecurity; transportation needs, education and health literacy, household income, geographic distance to care, justice system involvement, and toxic environmental exposure (among many others). Their relative prevalence or absence in different communities is largely responsible for a broad array of socioeconomic indicators, impacting not only access to care, but the ability of individuals to sustain the benefits of medical care when they do receive it—and therefore lower utilization rates, particularly for expensive acute and inpatient hospital services. Everyday SDOH effects on healthcare provision in underserved communities are hard to overstate, as every nurse trying to explain drug interactions or critical access hospital with patients stranded in the ED for lack of a ride home can attest.

Addressing patients’ social needs can be a complex and protracted process, but in all cases the process begins by finding appropriate modes of care and staying in contact with those providers. This is where emerging HDUs have demonstrated their value, by incorporating public and private social care providers into health information exchange and data-integrated technical assistance networks alongside clinical providers. The HDU model refers primary care patients who are food-insecure to local food banks (and to local charity transit services to get to the food banks) in the same way it refers them to cardiologists or substance abuse clinics, and is able to gather similarly useful (de-identified) data points for quality improvement and public health analytics purposes. On the patient level, this makes records more comprehensive and practical for both clinicians and social service organizations, while compounding efficiencies on the level of the local and regional systems. As partners within the HDU framework, Civitas’ RHICs have taken SDOH activities several steps further by creating multi-pronged care coordination efforts organized around specific needs in their geographies, such as maternal mortality in Ohio and pediatric care in Kansas.

Each of these core HDU functions directly reduces labor time, administrative burdens, process redundancies, and opportunities for human error that collectively cost the health care system hundreds of billions of dollars annually, while enabling patient-centered clinical interventions that improve outcomes and pave the way toward more sustainable models of care delivery. Studies of HIE operations at scale and the widespread adoption of HDU-enabled use cases in recent years conducted in and out of government have demonstrated the value of these activities in dollars and cents—savings that are realized not only by patients and providers participating in integrated health networks, but by taxpayers who otherwise foot the bill for wasted resources. The following examples represent just a snapshot of the progress that has been made and continues to be documented nationwide:

- In Nebraska, Civitas member CyncHealth has worked with a broad cross-section of providers, pharmacies, public and private payers, community-based organizations, and policymakers to build one of the most comprehensive examples of the HDU model in use anywhere. Among the system’s core transmittal and value-added capabilities is diagnostic image sharing that includes X-rays, CTs, MRIs and associated data in standardized formats, paired with applications that can perform advanced sorting and analytic functions. In partnership with researchers from Creighton University and the Washington Health Alliance, CyncHealth

created a system for retroactively identifying unnecessary and wasteful imaging within a statewide study cohort of patients experiencing lower back pain (LBP)—both an extremely common diagnosis (experienced by nearly two-thirds of adults as some point) and a common source of imaging orders from clinicians. Out of nearly 1,000 cases with LBP and imaging that have been recorded in CyncHealth’s statewide patient index, 51% of the imaging orders were found to be “wasteful” and another 35% were “likely wasteful,” based on the patient’s eventual diagnosis or duplicative orders from other practitioners. With early imaging for low-risk LBP is strongly correlated to increased costs of care in the first year after a patient sees a doctor (nearly \$20,000 more than a conservative diagnostic approach, according to the *American Journal of Managed Care*), CyncHealth’s analytics are a powerful quality improvement tool to help Nebraska providers to do their part in cutting the estimated \$360 million that Medicare spends annually on unnecessary LBP imaging.

- In Oklahoma, Civitas member MyHealth Access Network was one of 28 organizations in 21 states participating in CMS’ Accountable Health Communities Model (AHC) pilot program from 2018-2021, which found that MyHealth’s HIE-mediated patient navigation services resulted in a 9% reduction in avoidable emergency room visits within a statewide cohort of Medicare Fee-for-Service (FFS) beneficiaries over four years. Navigation that combines synchronous data sharing capabilities linking primary, specificity, and acute care in real time with an established community-based SDOH referral system and individualized case management by trained community health workers is an asset for all patients, but from an actuarial standpoint is particularly important for the high-need, high-risk and correspondingly high-cost populations that disproportionately comprise FFS enrollees. Using the most recent publicly-available CMS data on Oklahoma FFS enrollment, estimated rates of potentially avoidable ED visits in the state, and Medicare payment averages for ED visits, the projected cost savings from expanding the same HIE patient navigation services to all 484,500 Oklahomans would total \$15.4 million over the four years of the AHC performance period (or \$3.8 million annually).
- In Erie County, New York (Buffalo and its surrounding municipalities), Civitas member HEALTHeLINK connects local primary care providers and clinical laboratories to the Erie County Department of Health (EDOH) through an integrated and expanding set of notification systems and analytic tools that are available across HEALTHeLINK’s western NY regional service area. Among the many demands on the limited time and resources of the epidemiologists who manage EDOH is surveillance of sexually-transmitted infections (STIs), which is not particularly new or exciting but remains a critically important part of basic community health. A 2017 study conducted by researchers at EDOH, Women and Children’s Hospital of Buffalo, and the University of Buffalo demonstrated that in the first year after joining the HIE 2012, not only did reported treatment rates in Erie County increase substantially for chlamydia and gonorrhea (by over 15% for both STIs), but they increased without adding work hours for EDOH staff. The personnel efficiencies realized as a function of time saved during the processes of obtaining patient records, matching them to laboratory test results, and confirming provider treatment thanks to HIE services totaled over \$8,500 in salary and benefits per year just for the epidemiologists managing chlamydia and gonorrhea cases (excluding the wide array of other disease tracking and case management activities performed by EDOH epidemiologists that HEALTHeLINK facilitates).

- In the Bronx—by many metrics the most chronically unhealthy, underserved, and medically complex jurisdiction in New York City and the state as a whole—provider participation in the HL7-formatted event notification service offered by Civitas member Bronx Regional Health Improvement Organization (Bronx RHIO) reduced the 30-day hospital readmission rate for Medicare FFS beneficiaries in a study cohort of over 2,500 patients by 2.9% over 53 months. While 2.9% may not seem substantial, the study’s authors at Weill Cornell Medicine and Indiana University estimated that based on median Medicare reimbursement rates for Bronx hospitalizations, Bronx RHIO’s event notifications saved \$1.25 million in inpatient hospital bills that the 2,500 patients would otherwise have incurred over the same period. Scaling the findings up to all 69,000 current FFS enrollees in the Bronx yields \$34.5 million in projected Medicare savings over length of the study, or \$7.8 million annually.

Thank you again for the opportunity to comment. Please do not hesitate to reach out to Civitas if we can be a resource as we work together to achieve a community-governed, interoperable health data system to improve public health and health care outcomes.

Sincerely,



Lisa Bari
CEO, Civitas Networks for Health
lbari@civitasforhealth.org