July 8, 2020

Office of the Assistant Secretary for Health (OASH)
200 Independence Avenue, SW, Room 716G
Washington, DC 20201

Submitted electronically to: OASHcomments@hhs.gov

RE: Request for Information—Long-Term Monitoring of Health Care System Resilience

Dear Office of the Assistant Secretary for Health,

OCHIN is grateful for the opportunity to respond to this request for information focusing on methods to improve health care resiliency. As COVID-19 has magnified gaps in health care, we are happy to share our learnings during this time, and how we can improve our response as a nation when the next pandemic comes upon us.

OCHIN is a 501(c)(3) not-for-profit community-based health information technology (HIT) collaborative, and a national leader in promoting high-quality health care in historically underserved areas across the country. We are a system of over 500 health centers, including Federally Qualified Health Centers (FQHCs), correction facilities, Ryan White Centers, tribal communities, and public health agencies. Resiliency of our system and health centers is always a consideration when employing technology and expanding methods of care delivery and information storage. Some of these health centers have dealt with disaster first-hand, experiencing floods and fires, requiring quick changes in workflows, build of alternate care sites, and improved data delivery methods. However, these experiences, as well as this pandemic have shone light onto current disparities and the need for expanded policies that will help increase resiliency in the future.

Barriers and Opportunities for Health System Resilience

1. What have been the most significant barriers to assessing, monitoring, and strengthening health system resilience in the U.S.?

Some of the most significant barriers to assessing, monitoring, and strengthening health system resilience during COVID-19 have been inequities in health policies and funding. These have resulted in the piecemeal system with support and capabilities extended to some providers and patient groups, and not others. Inequities also stem from lack of needed infrastructure built and deployed in rural and underserved areas.

During a pandemic, these inequities become amplified, increasing barriers to access and reducing the flow of critical data. In response to COVID-19, many providers across the nation quickly rolled out telehealth services to ensure their patients could still receive the care they needed. Coverage of a growing modality of health care delivery, previously embraced by commercial providers and payers, was temporarily extended to Medicare and Medicaid providers and their patients.
Providers serving urban areas were generally able to utilize telehealth capabilities and continue serving those patients able to access broadband connectivity. However, for rural providers and those serving Medicaid or uninsured patients, this process presented more of a challenge. The preliminary issue is physical connectivity in rural communities. When a patient does not have broadband connectivity within their home, they are required to travel to an area with a hotspot. This could be somewhere as close as a library parking lot, but that is assuming the patient already possess a smartphone to be able to utilize this connectivity. Where this technology is not available, organizations have had to get creative. It is difficult for the health system serving these communities to be resilient when connectivity often considered a necessity is unavailable, and even when it is, affordability can be a problem.

For many public health organizations, as well as labs and nursing homes, which continue to play a significant part in this outbreak, their inability to acquire interoperable technology systems and technological support further hinders requisite data movement. Contact tracing becomes increasingly difficult and burdensome without the proper technology, further slowing down an efficient response to COVID-19 and putting more of the population at risk.

2. What policies and programs can be improved to mitigate the risk of COVID-19 and avoid negative impacts on patient outcomes?

- National patient identifier
  - Patient matching remains a serious issue that disproportionately impacts minority populations as a result of manual errors such as misspelled names and housing inconsistency. Use of a national patient identifier would eliminate the enormous rates of duplicate patient records that result in high administrative burden and reduce patient safety by splitting their record, leading to missed information critical for their care.

- Public health modernization
  - Public health reporting/national standards
    - To improve the interoperability of public health information, standards for data collection and movement must be nationalized and centrally connected. Public health departments must operate as health care providers in that the information they collect from patients and surrounding communities must be entered with a single standard into an interoperable system to be analyzed by the overseeing agency, such as the Centers for Disease Control and Prevention (CDC).
    - Case reporting and the investigative authority of public health must be clarified in plain language with the goal of increasing data movement and collection. Ambiguous language such as “minimal necessary” and “permitted purpose” has resulted in delaying or foregoing interoperability because of privacy concerns.

  - Improved technology
    - For public health agencies to reach functional interoperability, they must be provided funding and technical assistance to onboard to 2015 or better certified Electronic Health Records (EHRs). Similar programs must also
provide the same assistance to those encountering personal health information and delivering care, such as nursing homes, dental providers, and behavioral health providers. Having this capability allows providers to utilize telehealth delivery software and ensure their encounters can be accurately and instantly recorded into a patient’s single health record.

- It is also critical to upgrade lab systems, which are burdensome and antiquated. They require interoperable technology to improve reporting processes and reduce the spread of illness during a pandemic.

- Close inequity gaps around health policy
  - Telehealth
    - Commercial providers have had the ability to utilize telehealth with expanded policies around reimbursement at parity, while visits with Medicare and Medicaid patients are paid reduced rates for the same care. Paying lower than parity reduces the incentive to offer this technology, the financial inability to innovate, and access for this already underserved population. Having the ability to offer care through any modality, whether it is synchronous or asynchronous telehealth using email, live video, or even phone consultations, is critical not only during a pandemic, but to overcome everyday barriers. These options for care can help a patient avoid driving extensive distances, taking time off from work, or having to pay for additional childcare to visit with their provider. As transportation is one of the key social determinants of health, telehealth is critical for overcoming this divide.
    - Metrics must be put in place to ensure quality telehealth is delivered, and to provide clear data on the benefits of expanding this to all providers. This is especially critical in the movement towards value-based care.
  - Preventative services and primary care
    - By improving access to care for patients, they will be more likely to engage in preventative care with their providers built upon improved communication and stronger relationships. Ensuring primary care providers can utilize all modes of patient engagement as well as giving primary care providers the support they need, patients can receive care in their communities. Specialty eConsults, or electronic consultations between primary care and specialty care providers, give primary care providers the support they require to continue caring for their patients as well as to expand their scope of practice when referrals are not required. Further, it improves contact between a patient’s primary and specialty care provider, leading to a more coordinated care plan and better outcomes.
  - Support underserved populations
    - Patients under Medicare and Medicaid, and those who are in tribal communities, uninsured, or homeless are all put at a disadvantage by unequal health policies and inconsistent funding over decades. Archaic barriers must be removed, community care systems must be supported,
and providers caring for these populations must be given the same health policies as those given to commercial providers.

- Expand broadband infrastructure
  - Increased funding and agency cooperation to disburse funds for broadband must also be established. There are multiple agencies working to increase rural broadband connectivity, each with different populations or purposes they seek to serve (health care, education, etc.). To better utilize the available funding, agencies should be working together to connect every community across the nation, ensuring all providers and patients have broadband access from their homes. Funding to close the last mile by providing devices for rural patients and providers must also be prioritized. During COVID-19, compliance with local and state-wide lockdowns required home-bound providers to connect to home-bound patients, and in many cases, this was not a possibility due to lack of connectivity and technology.

- 42 CFR Part 2
  - With the CARES Act came a long-awaited change of tighter alignment of 42 CFR Part 2 with HIPAA. This allows substance use disorder (SUD) treatment records to be shared by a HIPAA covered entity, business associate, or program for the purposes of treatment, payment, and health care operations. Now that we have been given this ability, every provider must operationalize this change to ensure records can move more easily for the increased safety of behavioral health patients, and providers must be given the technological support to do so.

- Build out the workforce of tomorrow
  - Expanding modalities of care for primary, specialty, and behavioral and mental health providers will result in a change in the landscape of the workforce, and this transition must be supported.
  - We are also about to see a rise in patients either uninsured or using public services as a result of economic impacts of COVID-19. This surge will require stronger resources to prevent provider burnout.

- Improve behavioral and mental health
  - Access to continuous behavioral and mental health care is critical to seeing improved patient outcomes. This requires increasing funding, expanded modalities, and better access to rehabilitative and inpatient care. Allowing providers to deliver behavioral and mental health care using both virtual and telephonic visits has resulted in an uptick in its utilization. This data points to the need for improved access and coverage to serve patients in need of this care. These policies should be expanded permanently to allow providers to truly utilize these modalities and see the impact on their practices and outcomes of their patients. These policies will have an enormous effect on patients served by Medicaid, Medicare, and Indian Health Services.

- Fund research
• Funding for PCORI and ARCH is critical to truly understand the impact expanded policies can have on these populations, and what other inequities and gaps exist within the safety net.

• Study value-based pay structure
  o Safety net providers face numerous challenges in the effort to convert from fee for service structures to that of value-based pay. The world that virtual care has also now opened to health centers due to COVID-19 provides opportunities to study alternate payment models and designs for the future. New payment methodologies may drive resiliency into the system but need to be studied outside the framework of COVID-19 response. Additional time is needed with different modalities of care to allow a smooth transition and greater understanding of the impacts of a more complex patient population and how to define quality.

Key Indicators & Data Sources of Health System Resilience

1. What is your definition of health system resilience within the context of your organization? Does the definition of resilience need to be defined differently based on geographic region and/or the domain of healthcare being assessed?

For OCHIN, resiliency means the health care system is only as strong as the foundation upon which it is built. We have learned that broadband infrastructure doesn’t extend across the entire country, that data doesn’t flow equally between providers; there are some providers lagging far behind in their health information technology or who don’t have the technological support they require. There is a chronic lack of funding for those serving in public health capacities. These cracks in our foundation result in a lack of resiliency, leaving much to be desired. Resiliency must be defined based on the national population as a whole, and where there are gaps, we see a lack of resiliency.

OCHIN believes national standards for technology connections and data reporting are key to building a resilient public health system. Case reporting for COVID has shown us that disease reporting is fragmented and reporting standards differ in federal, state, and local jurisdictions. Further standardization across state lines for data movement are critical to provide real-time and actionable data to respond to a crisis.

Additionally, data is only as good as the systems that they are entered into and the knowledge of those entering it. The funding within the CARES act to modernize public health and the systems being used at state and local health departments and other underserved health care providers should be priority for these dollars. Many are old, antiquated record systems that lack the ability to share data or capture it in any interoperable way.

Support like the work provided by health center-controlled networks (HCCNs) to train staff on data entry and flow are critical. Organizations need consistent support for training and technical assistance on data to ensure that it is entered correctly and captured for reporting and study.

2. What key indicators or data sets are being used within your organization to assess health system resilience?
  • UDS and SDH
• The HRSA Uniform Data System (UDS) is the main metric OCHIN uses to capture performance of those we serve. However, we find social determinants of health (SDH) are a measurable symptom of existing inequities in our health care system. Communities lacking broadband connectivity, sometimes considered a super-determinant of health,\(^1\) and low-income families relying on public health systems tend to face the greatest barriers to accessing reliable and affordable health care. OCHIN members have currently screened over 500,000 individual patients for their specific SDH and we continue to help support the capture of this information for patients across the country. This data collection is difficult in busy and underfunded health centers and is made more difficult as there are no national standards for collection of data. Our members in North Carolina have different reporting requirements than our members in California, for example. We urge HHS to consider national standards for data collection. OCHIN believes we can support resilient communities further by integrating social services and health care delivery together, ensuring patients receive the services at the time for the best outcomes.

• Broadband

  o Rural areas without reliable broadband connections or connections into the home, as well as urban families unable to afford household connectivity cannot benefit from one of the latest innovations in health care—telehealth. During this pandemic, we saw providers and patients embrace telehealth, but those with disconnected communities had to improvise. Although they made incredible strides, such as setting up parking lot hotspots, patients were still forced to leave their homes, sometimes traveling great distances to meet with their providers. This is an additional burden reducing accessibility and often harming patient health.

• Funding

  o Public health programs are systemically underfunded and are often the first cuts made in times of economic uncertainty. Despite making progress through the ACA, not all states used the opportunity to expand, and even many states that have expanded still have a population that earns too much for Medicaid but too little to pay for regular health care visits. Historically low reimbursement rates for public health services is a disincentive for providers to participate and further complicate access.

  o Without improvement in funding mechanisms to expand broadband and improve our public health care system through additional national expansions and improved reimbursement rates, we will continue to face issues such as patients having to travel unreasonable distances for care, having difficulty finding participating providers, and relying on providers using out-of-date software that doesn’t meet the interoperability standards necessary to deliver safe, coordinated care.

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care. COVID-19 magnified these gaps in our system, and without a resolution they will continue to reduce our resiliency as a nation.

- Provider satisfaction
  - Provider satisfaction surveys provide great insight into the outcome of under resourced providers who are being stretched too thin. High volume care periods in response to flu season or, specifically, COVID-19, tend to lead to provider burnout when they do not have the support they require to handle their increased demand or lack other resources they require such as PPE, the availability of alternative care or communication methods, or the ability to ensure a referral is completed—an issue positively impacted by the availability of eConsults.

4. What selected health conditions should be used as indicators of healthcare availability, access, timeliness, and quality, in terms of treatment and preventive services?

One “condition” that could be an ideal marker for availability, access, timeliness, and quality, in terms of treatment is maternal and infant health. Despite being one of the wealthiest nations in the developing world and the highest rate of spending on hospital-based maternity care, women in the U.S. face the highest maternal mortality rate among other high-income countries.\(^2\) This rate is 3 to 4 times higher among African American mothers.\(^3\)

OCHIN recently submitted a set of comments to CMS regarding a request for information on how to improve maternal and infant health.\(^4\) Some of the issues we cited include rural hospitals closing at high rates, causing patients, including prenatal patients, to show up in FQHCs and Rural Health Centers (RHCs) seeking long term care. However, these ambulatory providers are ill-equipped to care for these patients because of their lack of technical support, proper software, and network of specialists to respond to high-risk prenatal patients. Improving broadband connectivity, providing technical support, upgrading software (e.g., electronic health record systems), and leveraging HCCNs can make an enormous difference for these patients’ outcomes.

Mental and behavioral health are also strong indicators of health care availability, access, timeliness, and quality. Access to and coverage for these types of care consistently lack behind access to primary care providers and even specialty care providers, despite health outcomes significantly reliant on one’s mental or behavioral health. Simply looking at the levels of utilization of these services and their consistency serves as a telling indicator of inequities in the system.

Diabetes is another health condition worthy of attention, as both preventative services and maintenance care are critical to improving patient outcomes. Community health centers with additional types of support, including cooking courses, nutrition counseling, and even exercise classes in combination with expanded telehealth services tend to show better maintenance rates


and reduced emergency care needs by improving patient engagement and supplementing purely medical intervention with critical education.

**Public-Private Data Sources**

1. *What data sources does your organization use to assess the resilience of the health system? What demographic populations are covered by these data systems? Do these data systems capture urban-rural and other geographic differences?*

   OCHIN is currently combining health record data with claims data to understand total cost of care for the patients and providers we serve. Access to state and federal data sets such as Medicare and Medicaid are critical to understanding how to improve patient outcomes and deliver better, lower cost care. Further, OCHIN is accessing, when available, state all payer claims data sets to study total cost of care for the OCHIN network in respective states and for individual centers we support. Until we have a full picture of cost and care, gaps still remain and threaten resiliency.

2. *How are you using these data sources to inform your public health response?*

   Our members are on the front lines of responding to the COVID crisis. In partnership with the CDC, OCHIN was one of the first in the country to adopt electronic case reporting across a multi-state region. This allows real-time COVID-19 results delivered to public health departments, both state and local, to obtain digital and automated reports directly from the health record without need of data entry or paper and faxing. This national standard is being implemented throughout the country, and states should be encouraged to enable its functionality.

**Public-Private Partnerships**

1. *Provide ideas of the form and function of a public-private partnership model to continually assess and monitor health system resilience and individual as well as population health outcomes?*

   As interoperability improves and national data exchanges are utilized, it is important that this data is monitored and analyzed to better understand where there are clear gaps in care. For example, if a patient is primarily presenting only in emergency rooms to receive care when their symptoms have become acute, it is critical to investigate to determine why they aren’t seeking care with a primary provider to monitor their health and prevent their symptoms from exacerbating. If they do have a primary care provider and lack access to a specialist, then we can determine that we must improve the ability for their primary to electronically consult with a specialist to perhaps help avoid a referral, or ensure the patient is engaged with the referral process to close the loop.

   In the goal of expanding care networks, especially in underserved areas, it is necessary to leverage national standalone HCCNs to help deliver necessary technical support, improved technology, and provider networks. Improving funding for these HCCNs and incentivizing participation in them can help fill many of the gaps we are seeing in rural and underserved areas primarily served by public health.

2. *What private and public sectors should HHS engage as part of such a collaborative effort?*
HHS should engage the USDA, the FTC, state and local public health jurisdictions, state health authorities, non-profit health care networks, multistate standalone HCCNs, national health information exchanges such as Commonwell, Carequality, and eHealth Exchange, the FCC, telehealth networks, and public health advocacy organizations to ensure a better understanding of where many of the issues facing care access, broadband, and interoperability intersect and result in gaps in care and failure in resiliency.

We appreciate your consideration of our comments. Please contact Jennifer Stoll at stollj@ochin.org should you have any questions.

Sincerely,

[Signature]

Jennifer Stoll
EVP, Government Relations and Public Affairs
OCHIN