Re: The Prepare for and Respond to Existing Viruses, Emerging New Threats, and Pandemics Act (PREVENT Pandemics Act), discussion draft

Dear Chair Murray and Ranking Member Burr,

On behalf of OCHIN, we appreciate the opportunity to comment on the discussion draft of PREVENT Pandemics Act. OCHIN is a national nonprofit health information technology and research network of locally-controlled members which includes nearly 1,000 community health care sites with 21,000 providers in 45 states, reaching more than 6 million patients. OCHIN provides our members technology solutions, informatics, evidence-based clinical research, and policy insights.

OCHIN applauds your bipartisan leadership and supports your efforts to build a sustainable national public health infrastructure that ensures at the local, state, and federal level essential public health services are effectively and equitably provided. Foundationally, the PREVENT Pandemics Act should include provisions that strengthen the involvement, infrastructure, and resources of the front-line primary care providers and local public health agencies, particularly in underserved communities. We are only as strong and safe as our community clinics and public health agencies as they are the first line of defense. OCHIN respectfully urges the Committee to modify the draft bill to explicitly require the representation, engagement, and direct funding for community health clinics, local public health agencies, and their networks in draft bill provisions identified in the appendix. This will ensure they are more fully integrated and become increasingly resilient and able to rapidly innovate to prevent, identify, and mitigate against public health emergencies while also delivering clinical and other public health services for underserved communities that are consistently the hardest hit and disparately negatively impacted.

For over two decades, OCHIN has advanced equitable health care solutions and health outcomes by leveraging the strength of our network’s unique data set and the practical experience of our members to drive technology innovation for patients and providers. In addition to federally qualified health centers (FQHCs) and other community clinics, including those in rural areas, we support local public health agencies, Tribal community providers, certified community behavioral health clinics (CCBHC), complex specialty mental health organizations, and school-based health programs. OCHIN is in a unique position to offer recommendations to address the health care disparities that were exacerbated by the COVID-19 public health emergency. Four out of 10 patients in the OCHIN network are non-white and at least a quarter are Hispanic/Latinx. Additionally, the OCHIN network serves a high volume of patients who are
covered by Medicaid (50 percent), are uninsured or underinsured, and who are medically complex, with one or more chronic health condition.

**OCHIN: COVID-19 RESPONSE DRIVING EQUITY**

As the Committee is aware, the new year began with an unprecedented surge in COVID-19 cases due to rapid spread of the latest, highly contagious, Omicron variant. The OCHIN network saw its highest spike since the beginning of the public health emergency, with more than 14,000 electronic health record documented new COVID-positive patients during the first week of 2022. That’s more than twice the number documented during the same week in 2021 (about 6,000 cases)—one reason that OCHIN has redoubled its own efforts to provide real-time pandemic support in response to the evolving needs of the hundreds of community-based health care organizations we serve nationwide. We welcome the opportunity to work with the Committee so that underserved communities have the resources, operational and clinical workforce trained to optimize use of new technology, and technological infrastructure to drive equity in health care and public health.

OCHIN’s recommendations are informed by the following:

- **In the first 30 days of the public health emergency**, OCHIN accelerated 75% of OCHIN Epic network members providing primary care onto virtual visits which has increased to 82% as of October 2021. This is in sharp contrast to many community-based health care providers who struggled to provide their patient population continued access during the first stages of the public health emergency. OCHIN’s advance planning ensured members had turnkey health information technology capacity to address the need.

- Over the course of the public health emergency OCHIN has been able to accurately track the impact of COVID-19 daily across our network of safety net providers and has been able to offer analytics on COVID-19 trends by demographics and social determinants of health including positive test rates, vaccination rates, telehealth utilization, and rise in behavioral and mental health needs to our members and policymakers.

- OCHIN worked with the Centers with Disease Control and Prevention (CDC) and other partners to develop electronic case reporting for COVID-19 positive patient tests. As a result, OCHIN members have triggered over 1.7 million electronic initial case reports (eICR) reports since April 2020 and delivered those reports to public health agencies in all 50 states. Currently, OCHIN has expanded eICR in Oregon to also report on additional CDC reporting requirements to validate exchange, which will be expanded state-by-state once the data validation is complete.

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1 Source: are for all clinics and patients seen in the OCHIN system since March 1, 2020; SA Encounter Volume Trending Tableau Dashboard; Salesforce, retrieved 11/10/2021.

2 OCHIN analyzed the COVID-19 positivity rates by race and ethnicity among community health center (CHC) patients and with other partners issued the report, “COVID-19 Racial Disparities Persist in Community Health Centers’ Vulnerable Population.” This report builds upon previous OCHIN research aimed at understanding the role of community health centers as frontline providers of COVID-19 testing and care. It also lays the groundwork for future research to examine the long-standing racial and other structural inequalities within our nation’s health care system and how community-based care providers can help curb the impact of COVID-19 and drive health equity nationally.
OCHIN network members have administered over 2.8 million COVID-19 vaccinations by bringing vaccines to where patients are and provided by known and trusted clinicians in underserved communities. Scaling these offerings was enabled by leveraging the technology and additional workflow re-engineering OCHIN rapidly provided to network members to overcome anticipated operational and technical vaccine roll-out challenges.

Within the first month of the public health emergency, OCHIN partnered with EPIC and the Washington State Health Care Authority to rapidly develop a new mobile electronic health record app that enables patient screening and triage outside of a typical health care setting for deployment in Washington state. It was designed so patients could use the tool to self-screen for COVID-19 symptoms and check in to a local emergency care site. Volunteers could use their own smartphones to help trained health care providers triage and care for members of their own communities when resources are scarce. And, state public health epidemiologists would be able to monitor the system’s incoming data to track trends county by county and direct patient follow-up. In addition, the tool’s unique integration with Epic’s Care Everywhere interoperability platform means that patients who are assessed in clinics or alternate sites would be able to link to their existing medical records, improving overall care coordination. Its portability also would allow providers to reach and screen the most underserved and hard-to-reach patient populations, such as homeless and rural communities.

OVERARCHING RECOMMENDATIONS

In order to modernize, eliminate conflicting or duplicative requirements, and seamlessly integrate public health and health care delivery at the community level to reflect 21st Century needs while staying ahead of rapidly evolving public health threats that disproportionately impact underserved communities, OCHIN offers the following recommendations:

- Ensure already authorized COVID-19 rescue and infrastructure funding are directly provided to local public health agencies, community clinics, and other providers including behavioral and mental health providers and nursing facilities, in order to modernize health information technology systems.

Since the Health Information Technology for Clinical and Economic Health (HITECH) Act, several generations of technological evolutions have occurred. Yet, small community-based providers have not had the significant resources needed to replace obsolete systems that do not enable automated exchanges with public health agencies, nor integrated virtual modalities such as telehealth, remote patient monitoring, and e-consults nor power population health analytics. Further, local public health agencies, nursing facilities, and behavioral and mental health providers were not included in HITECH. Funding for front line systems meets an immediate need to respond to COVID-19 as well as other public health crises and is a sound long-term investment since these are also the systems such practices need in order to implement new patient-centered, value-based delivery models.

- Require use of national digital health standards across programs and funding consistent with a national digital health data framework.

It is critical that the nation have a national digital health data framework that drives harmonization and standardization of medical and public health data and technical standards used by the Office of the National Coordinator for Health Information Technology, the Centers for Disease Control and Prevention, and other local, state, and federal agencies in the delivery of health care services such as
the Health Resources and Services Administration, the Centers for Medicare and Medicaid Services, and Indian Health Services, for example, along with community service providers. This will reduce the cost, complexity, errors, and burden of data capture, analysis, and reporting. The consequences of proliferating data and technical standards (for example, for social determinants of health (SDOH) and demographics) fall the heaviest on providers and public health agencies in underserved communities—which reinforces structural inequality and undermines our ability as nation to protect against pandemics and other natural disasters. Policies that limit interoperability of critical health information, such as 42 CFR Part 2 limitations, pose a significant threat to mental health and substance use disorder treatment in the normal course of health care delivery as well as during public health emergencies such as natural disasters and pandemics.

- **Modify the proposed health care workforce development programs to include funding to rebuild community clinic staff (operations and support staff) who are essential and need upskilling as we modernize technology and implement even more complex regulatory requirements (such as the No Surprises Act good faith estimate).**

Local health centers remain the frontline, and in some instances the only line of defense, as three public health emergencies have converged—COVID-19 along with the opioid epidemic and the mental health crisis. The community clinic operational and support staff workforce has been decimated. Community clinics are struggling to maintain capacity and cannot scale to meet growing demand - an alarming trend, since health centers play a critical role in reducing burden on local emergency departments, particularly in rural and underserved communities. The need for technology-trained support and operational staff will only grow with the adoption and implementation of modernized health information technology, which is urgently needed to transform clinical care delivery and improve public health capabilities at scale. In addition to ensuring community clinics are able to maintain access today, it is an effective strategy to reduce the administrative burdens of clinicians which drives burnout.

- **Ensure that national SDOH standards are utilized in all funded programs outlined in the draft bill and that pioneers and leaders of this work in the community clinic setting and their networks are eligible directly for this funding.**

Community clinics, primary care, and networks, like OCHIN, that include such providers along with local public health agencies, remain critical to the work of advancing SDOH evaluation, reporting, and effective intervention referral and coordination (with social service providers). OCHIN members have completed over 1 million documented SDOH evaluations and 30,000 more each month are documented. In addition, OCHIN continues to support the development of SDOH national standards including technical testing of new standards as well as pace-setting research among the nation’s preeminent SDOH and health disparities researchers. Efforts to drive permissive use of national standards directly undermines not only efforts to advance clinical care in underserved communities, but further hinders public health capabilities at every level to identify patient populations that are most adversely impacted.

We have all witnessed the impact of the COVID-19 pandemic on our communities and the nation. Working to create the infrastructure to prevent what has unfolded during COVID-19 in the future is urgently needed, one which OCHIN is committed to building. Please contact me at stollj@ochin.org to
work together to advance pandemic preparedness and evolve public health infrastructure and technology.

Sincerely,

Jennifer Stoll  
Executive Vice President  
External Affairs
APPENDIX

• Comprehensive Review of the COVID-19 Response (Sec. 101) OCHIN supports a national review of the COVID-19 response by a bipartisan taskforce that includes nongovernmental experts which will produce a report for the President and Congress. We appreciate that the draft bill provides that individuals with expertise in “public health, health disparities and at-risk populations, medicine and related fields” may be included, but we urge the Committee to provide that such individuals shall be included in each category. Further, given the central role of community health clinics for underserved communities during the public health emergency (including telehealth, vaccinations, and electronic case reporting), we urge the Committee to explicitly require the inclusion of representatives with first-hand experience across the nation of rolling-out the public health response among underserved communities and that are equipped with data and research to support the work of the Taskforce.

• Appointment and Authority of the Director of the Centers for Disease Control and Prevention (CDC) (Sec. 102) OCHIN supports the development of and regular update to a CDC Strategic Plan. OCHIN urges the Committee to specify that strategic priorities and objectives must go beyond those related to “enhancing global and domestic public health capacity, capabilities, and preparedness, including public health data, surveillance, and laboratory capacity and safety.” Instead, given the essential role of rapid communication enabled by technology—in particular health information technology—and the need for standardized digital data and interoperability, we urge the Committee to include a provision that directs the CDC in coordination with the U.S. Department of Health & Human Services Office of the National Coordinator for Health Information Technology (ONC) to establish and update the strategic plan with an explicit section on a national digital health information framework that ensures local, state, regional and national organizations have modern operable systems that are able to exchange information for timely, action oriented prevention and response.

• Supporting Access to Mental Health and Substance Use Disorder Services During Public Health Emergencies (Sec. 112) As the COVID-19 public health emergency has merged with the rapid rise in mental health needs and opioid crisis, it is essential that all existing flexibilities remain available even after the COVID-19 public health emergency ends to expand access to services for mental health and substance use disorder services. OCHIN strongly supports providing the Substance Abuse and Mental Health Services Administration (SAMHSA) with funding and maximum authorities to ensure continued access to mental health and substance use disorder services during the current public health emergencies and future ones. OCHIN urges the Committee to direct SAMSHA to issue final 42 CFR Part 2 regulations within 30 days of the bill’s enactment in order to advance the secure and interoperable exchange of essential medical information that directly impacts behavioral and mental health services, including those related to substance use disorders.

• Addressing the social determinants of health and improving health outcomes (Sec. 201) OCHIN strongly supports all of the Committee’s provisions related to social determinants of health and improving health outcomes but urges the Committee to clarify that collaboratives of community health centers and networks are also eligible directly for funding to advance this critical work. OCHIN and our network members have significant technical expertise and, on the ground-experience implementing SDOH screening and evaluation, data collection, navigation. OCHIN network members have documented over 1 million individual patient screenings for SDOH and complete 30,000 more each month. The screening, evaluation, and use of this information is complex, challenging, and hinges on preserving patient trust. This is a resource intensive process that requires adequate time, workflow design, patient engagement, and staff and clinician training. This work is further informed
by 40 OCHIN researchers who are focused on health equity and include some of the nation’s preeminent subject matter experts\(^3\) in SDOH. In addition, OCHIN technical experts have played a central role in the development of national SDOH domains and data element standards through the HL 7 Gravity Project which have been adopted by the Office of the National Coordinator for Health Information Technology to be a part of version 2 of the US Core Data for Interoperability (referred to as USCDI). OCHIN has also been engaged in supporting the advancement of SDOH quality measures. OCHIN also is undertaking technical testing of the USCDI SDOH adopted data elements and domains. In light of the foregoing, we also urge the Committee to clarify that this funding is available to fund research and demonstrations to increase the evidence-base with regard to effective interventions to address varied SDOHs in order to drive improved health outcomes as well as authorize funding to support testing and validating the standards (both technical and quality measures, for example). The latter are often unfunded (or significantly underfunded) which slows validation, adoption, and scaling of national standards and best practices.

- **Modernizing Biosurveillance Capabilities and Infectious Disease Data Collection (Sec. 211)** OCHIN strongly supports modernizing existing public health data systems and networks of the Department of Health and Human Services to reflect technological advancements. However, OCHIN urges the Committee to include explicit language that this modernization must extend throughout the health care and public health systems as the necessary data for surveillance and tracking involves data collected and transmitted from local providers and public health agencies to state and federal agencies. As a result, OCHIN urges the Committee to include language that clarifies that the COVID-19 rescue package provisions related to public health modernization and the recently passed Infrastructure and Investment Jobs Act infrastructure provisions authorize direct funding for community-based provider and local public health agency interoperable health information technology systems that leverage national standards.

- **Supporting Public Health Data Availability and Access (Sec. 213)** The current draft would amend the public health data systems modernization provisions in current law by directing the CDC Director to disseminate public health data standards within two years to improve the exchange of public health data and reporting to public health data systems. Consistent with the draft, OCHIN supports close collaboration between ONC and the CDC in this process of developing standards to avoid conflicting or duplicative standards that support various forms of interoperability. (As noted, OCHIN has been a key partner in developing, testing, and scaling use of CDC electronic case reporting (eCR); see, for example, OCHIN promoting eCR and the OCHIN quote on CDC website promoting use of eCR.) Consistent and harmonized standards are essential to promote interoperability, use of data for clinical care and public health, and lower costs. All are critical for community clinics and other providers in underserved communities with limited resources and staffing. OCHIN urges the Committee to ensure that the eligible entities to enter into the data use agreements (subsection (c)) and grants (subsection (e)) contained in Sec. 213 include networks of community health clinics and other community providers as our members and network have demonstrated that they provide essential public health data that is needed for early detection as well as targeted resources for vulnerable or highly impacted communities and we have played a prominent role in supporting standards development, testing, and rapid utilization throughout the OCHIN network while promoting such standards with the CDC and other partners.

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\(^3\) OCHIN investigators hold leadership positions as members of the SIREN Network Research Advisory Committee, the Epic Population Health Steering Committee’s SDH subcommittee, and an OCHIN investigator is a co-author on the groundbreaking 2019 National Academies report on integrating social care into health care settings.
• Improving recruitment and retention of the frontline public health workforce (Sec. 221) and Awards to support community health workers and community health (Sec. 222) OCHIN strongly supports the draft bill’s provisions that invest in public health workforce and community health workers, but urges the Committee to include workforce development and training provisions for community clinic operational and support staff (including health IT staff, billing, credentialing, and other administrative support staff) that can fund networks of community clinic professional development and training programs at the intersection of community, health care, and technology.