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Introduction:

My name is Jim Jirjis, and I have been invited to offer my perspective on public health reporting throughout the COVID-19 pandemic, and on public health reporting more broadly, because of my experience and involvement with such work as the Chief Health Information Officer of HCA Healthcare. I want to express my appreciation for the Administration's attention to this issue and the invitation to share what I hope will be helpful insight.

I thought it would be helpful to start by sharing some context for the size and scale of our organization as I think it provides us with a unique vantage point on issues like this. HCA Healthcare operates more than 2,000 sites of care across 20 states and the United Kingdom, spanning a broad spectrum in terms of acuity. As you can probably imagine, our geographic diversity has increased the diversity of public health agencies with whom we work. We have made it a priority to accommodate public health reporting requests as an organization, but even with the resources and experience we've been able to bring to the table, it has been no small feat.

Challenges and Opportunities:

I would like to highlight some opportunities we have identified as we consider the challenges of conducting public health reporting activities throughout the COVID-19 pandemic; however, unless we wish to miss the forest for the trees, we must acknowledge that these challenges and opportunities extend to public health reporting activities of any flavor.

First, there are many entities vying after the same data, but there are few mechanisms in place for them to obtain the data without effecting their own, one-off request. If there were a way for nationally-reported data to be filtered down to other jurisdictions, where appropriate, the result would be significant savings in terms of time/resources that would otherwise be spent standing up and managing a separate data feed. A centralized structure could help facilitate better data and a better process. A learned intermediary that accepts data from required reporters could pass necessary information on to different reporting programs or agencies without having providers on the ground reporting to many different systems.

Beyond the data flow, there are also process variations to consider. Since many, if not most, public health agencies are government-sponsored, there are often very unique hoops to jump through from jurisdiction to jurisdiction. Some entities require contracts while others prohibit them. Some will take the data any way they can get it while others have wildly specific requirements (often tied to the way their integration engine "likes" to ingest the data or somewhat arbitrary error acceptance thresholds). A

common framework applied consistently would dramatically reduce the amount of guess-work and re-work involved in each individual endeavor.

While standards for many flavors of public health reporting exist, it is not uncommon to see public health agencies "tweak" the standards to suit their architecture or research interests. While it is easy to understand the motivation behind this, the approach is simply not scalable. We need a standard that can truly serve as a standard; one that is respected as such.

With the advent of CMS's Meaningful Use Program, healthcare providers were pushed to connect to public health agencies to report a few different types of data. Although the providers were incentivized to do so, the recipient public health agencies were not. As a result, there have been times it felt like we were pushing a string. Ensuring access to and consistency of resources is critical to reducing jurisdictional differences.

Lastly, requests for the manual collection of data should be closely managed. Where possible, our health IT should do the work for us. Of course, there are going to be times when manually counting and reporting supply are important; however, we should be disciplined in determining when to ask and when to stop asking this kind of work of our healthcare workers. Every minute is precious in a crisis.

Closing:

The ideal state is simple yet complicated: Do more with less.

Point-to-point connections are extremely expensive and burdensome to all parties involved. However, tapping into a multi-purpose data set, curated by a learned intermediary providing a governance structure for both process and technology, is a far more scalable solution. Think of the approach ONC and The Sequoia Project have taken toward the Trusted Exchange Framework and Common Agreement, centralizing the standardization efforts for the benefit of participants who agree to forego some of the flexibility they would otherwise have in order to enjoy easier access to the data they desire.

I want to wrap up my comments with the motivations I think we should all be using to fuel this endeavor.

The COVID-19 pandemic has highlighted our opportunities. It has increased the visibility of some very real issues that might have otherwise continued to fly under the radar. It is now our obligation to demonstrate progress on behalf of our patients and the communities we serve.

We also have to acknowledge that the very existence of these opportunities means that there is waste in the system. That means making these improvements will free up otherwise restricted resources to do more good for more people—and isn't that our overall mission?

Improving our foundational infrastructure will enable us to learn more and learn it faster when facing similar crises in the future. The COVID-19 pandemic has certainly reinforced the notion that fortune favors the prepared. We know the hill we have to climb now, and I appreciate the breadth and depth of experience that this group can bring to bear to make a positive impact on our nation's overall security and health.

Public Health Observations from a Multi-State Healthcare System

Main Points. HCAHealthcare is in 20 states and experienced the challenges and burdens 6%
185 hospitals, 2000 sites of care 280K employees
35 million annual encounters
20 states
25% admissions 50% ER visits are Medicaid or uninsured
Scale allows is to expand healthcare services and use data to improve care in the learning health system

Experience in COVID. Afferent and Efferent
Many to Many problem
20 states, 20 ways of doing things enormous coordination and work effort:
- Wide range of variation in Public health interface readiness (MU)
- Contracting
- interface testing
- Varying technologies, approaches, interpretations, etc. "If you seen one Public health department IT approach, you've seen one"

Interpretation: if a particular data field is not accepted: require us to scrub and resubmit
If public health staff is on vacation or away we have no feedback mechanism to know if our submissions were received and thus we are compliant with federal policies
Additional or slightly different requirements between states and between states and fed
Some requirements require manual counts…people walking through hospitals counting gloves, etc. So ensuring that Staff effort is taken into account or a plan to increase automation

Summary of issues:
- ***redundancy***
- ***IT variation***
- ***process variation***
- ***lack standards adherence***
- ***implementation variation***
- ***resource constraints***
- ***lack of incentive to align***
- ***lack of specificity and completeness in terminology standards from testing machines (for example lab testing machine story, including public health phone calls)***

Modernization elements:
Need an ***easy on ramp for providers to interact with either a learned intermediary or a system akin to TEFCA that reduces the variation, cost, time and effort. (Process, terminologies, exchange standards, etc)***
Like TEFCA it is not only technology but ***also process consistency***
Need **public health funding** for the technology and operations
Need alignment of **incentives** for public health departments to ***adopt and align***

Benefits:
Faster collection of insights to support response to public health issue and crises
Will reduce costs for public health reporting outside of pandemic situations

Need investment in Public health capabilities, and also incentive for them to adopt the modern solution described above