NEW YORK eHEALTH COLLABORATIVE

Implementation and Usability Hearing
Office of the National Coordinator
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Written Testimony
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Key Points:

1) New York is a large diverse state of 19.6 million people with 14 million people living less than 200 miles from Manhattan. The healthcare system is highly fragmented:

   a) 240 hospitals
   b) 800 pharmacies
   c) 1100 imaging centers
   d) Nearly 1000 labs
   e) 65,000 licensed doctors with 18,000 in single doctor practices
   f) Over 150 EHR vendors with multiple products and versions

2) New York's Medicaid program, the nation's largest, spends nearly $53 billion to serve 5 million people, which is twice the national average when compared on a per recipient basis. At best, New York is in the middle of the pack when it comes to health care quality.

3) New York has embarked upon a multi-year strategy to end the state's Medicaid fee-for-service system and replace it with a comprehensive, high quality and integrated care management system that will lower costs and improve health outcomes.

4) High quality and integrated care management requires integrated healthcare IT systems to facilitate coordination and workflow. In a highly fragmented healthcare system like New York, this requires both public and private health information exchanges that work together to share patient records and provide the tools necessary for coordinated care.

5) Through an extensive workflow development and requirements gathering process with the New York Medicaid Health Homes, we need:

   a) Patient Record Look-up or Query Based Exchange: the ability for a provider or care manager to have access to all of a patients records through a simple query from either a connected EHR or a secure web portal.
   b) Direct Exchange: the ability for a provider to securely send a patient's records from their EHR to another provider's EHR to facilitate a transition in care.
   c) Notifications and Alerts: the ability to notify the care manager or other providers associated with a patient when that patient interacts with the healthcare system. Example: when a patient is admitted to the ER, notify the care manager and primary care provider.
   d) Care Plan Management: the ability for providers to share a common care plan for a given patient across different provider organizations and care settings.

e) Patient Engagement: the ability for a patient to have access to all of their clinical records in a single on-line location.

6) With ten community health information exchanges in operation since 2010, we have approximately 80% of the hospitals connected to an HIE, 25% of the population has given consent, and a few of our communities will have over 50% of all healthcare providers in their community connected by the end of the year. More and more data is going online daily and more and more data is being made available to providers – at great expense.

7) Rochester, one of our more mature health information exchanges with higher adoption rates is already seeing significant savings across their community:

   a. 55% reduction in 30-day hospital readmissions when the HIE is accessed by healthcare providers after hospital discharge

   b. 30% reduction in hospital admissions from emergency departments when the HIE is accessed

   c. 35% reduction in duplicate radiology testing when providers use the HIE to look up patient information as part of the care

   d. Practices show savings of 3 hours per day through administration efficiencies

   This is just the tip of the iceberg – as adoption grows and more data is available, additional efficiencies, cost savings and quality improvements can be measured across more and more communities.

8) Given the size and scale of the New York healthcare system, the costs of connecting all of the data sources are daunting without technical interoperability standards.

9) We worked with 19 other states and dozens of EHR vendors to put together the EHR-HIE Interoperability Workgroup in order to develop "plug-n-play" standards for both Patient Record Lookup and Direct. (www.interopwg.org) The objective being to enable the industry to create interoperable products whereby a provider can buy an EHR product that is fully interoperable with their local HIE (public or private) without requiring costly custom connectivity. This is plug-n-play.

10) We believe that we need to collectively move towards nationally adopting full plug-n-play Query Based Exchange standards, Directed Exchange standards, and Care Plan standards. The standards need to be developed with "plug-n-play" (no engineering integration required for connectivity) as a requirement and require robust technical interoperability testing. Coupled with a certification and logo program, this work will greatly enable broad use of HIE in the delivery of care, regardless of how a community may be formed.