HIE Lessons Learned: NYS Health IT Strategy

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General Points of Agreement

• Need to advance broad adoption and use of health information technology
• Agreement on definitions and implementation of common standards
• Alignment of payment incentives for use

ADVANCING THESE OBJECTIVES REQUIRES COORDINATION OF POLICY AND IMPLEMENTATION ACTIVITIES
Broad Goals for NY’s Health IT Strategy

• Build health information infrastructure to support state health reform goals
  – Support clinicians and consumers with information at point of care
  – Advance care coordination
  – Strengthen public health surveillance and response
  – Enhance quality and outcome measures

OVERALL STRATEGY IS ABOUT SYSTEMS CHANGE, NOT JUST HEALTH IT
NYS Commitment to Fund Health IT – Investment in Capital Infrastructure to Support Health Reform

- **HEAL 1** – formation of regional health information organizations (~ 20 projects = ~$50 million)
- **HEAL 5** – ($106 million = 19 projects)
  - Development of statewide network infrastructure
  - Development and support of the NYeC state wide collaborative process
  - Implementation of EHRs in physician practices
  - Support of EHR implementation for clinical use cases including medication management, quality reporting, clinical decision support, connecting NYers to clinicians and connectivity to NYS DOH to improve public health
  - Support of evaluation through HITEC
- **HEAL 10 and 17** – (total $240 million)
  - EHR implementation to achieve improved care coordination through support of the patient centered medical home (latter includes funding support for behavioral health and LTC providers)
  - Continuation of the NYeC state wide collaborative process
  - Further development and support of the SHIN-NY infrastructure
  - Continuation of HITEC evaluation
What We (and Many Others) Have Learned

**Build and maintain an inclusive, transparent collaborative process**
- Common problems are identified and resolved through the collaborative process
- Stakeholders support what they create

**Adopt a “Top-down, Bottoms-up Approach”**
- Alternative approaches (i.e., top-down control, laissez-faire) may be “cheaper” or “easier” in short term, but more costly and problematic in long term

**Link policy and implementation and build incrementally**
- Aspirations and practical considerations must be balanced

**Acquire skills to address technical and policy challenges**
- Challenges are large, complex
- Deployment at this scale is unprecedented
- New, unexpected issues continually emerge and must be assessed, options identified, and recommendations developed
### NYS Health IT Strategy – Work in Progress

<table>
<thead>
<tr>
<th>Category</th>
<th>HEAL 5 Achievements</th>
<th>HEAL 5 Gaps</th>
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</table>
| Governance & Sustainability | • Developed integrated statewide / regional SCP governance structure  
  • Created mechanisms to ensure compliance with SPG, including vendor contract language  
  • Initial shared work on RHIO business plans | • Low RHIO participation rates in certain sectors including private physician practices, LTC, MH  
  • Need for a longer-term accountability model that will live beyond HEAL program  
  • Long-term solutions to RHIOs’ sustainability issues |
| Policy                    | • Developed comprehensive set of privacy and security policies and procedures       | • Certain providers elected not to follow statewide consent guidance  
  • Gaps in policies due to focus on HEAL 5 implementations  
  • Need to advance policies and legal agreement for RHIO-RHIO exchange |
| Technical Infrastructure   | • Created SHIN-NY architecture and set of specifications  
  • Demonstrated concept of MMM shared service | • Multiple regional implementations of certain core services creates inefficiency  
  • Need to develop a production-level MMM shared service and other shared services  
  • Fully vetted technical specifications for RHIO-RHIO exchange |
| HIT Adoption              | • Developed comprehensive set of EHR functional requirements                        | • CHIxP protocols not driven down to EHRs in a standard way, resulting in costly regional variation |
| Public Health             | • Developed specifications for Universal Public Health Node                        | • Need to develop UPHN into a production-level service |
| Consumer Engagement       | • Funded several projects to implement CNYers use case and empower consumer with information | • Projects had limited breadth and recognized need for further attention to consumer-related policy issues |
High Performance Case Studies: Delivery System Level*

• Ideal health care system attributes
  – #1 is information availability and continuity
  – Care coordination and transitions
  – System accountability

• Observations
  – Cost and effort offset by efficiencies
  – Build or buy; physician involvement key to effective implementation in either case
  – Long term strategic investment in population health management and clinical improvement strategies

* McCarthy and Mueller, Commonwealth Fund, July 2009
<table>
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<tr>
<th></th>
<th><strong>HEAL 10</strong></th>
<th><strong>HEAL 17</strong></th>
<th><strong>Medicare ACOs</strong></th>
<th><strong>Beacon</strong></th>
<th><strong>APCP (Medical Home)</strong></th>
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<tbody>
<tr>
<td><strong>EHR Adoption</strong></td>
<td>Required</td>
<td>Required</td>
<td>No statutory requirement</td>
<td>EHR adoption and MU among at least 60% of PCPs</td>
<td>Adoption of health IT to support primary care</td>
</tr>
<tr>
<td><strong>HIE Requirements</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>No statutory requirement</td>
<td>Integrate with state and local efforts</td>
<td>No explicit requirement</td>
</tr>
<tr>
<td><strong>Practice-Level Support for HIT</strong></td>
<td>Yes – for implementation and to support clinical transformation</td>
<td>Yes – for implementation and to support clinical transformation</td>
<td>No statutory requirement</td>
<td>Varies by project but can explicitly budget for this</td>
<td>Varies by project</td>
</tr>
<tr>
<td><strong>Interoperability</strong></td>
<td>Central component of project</td>
<td>Central component of project</td>
<td>No statutory requirement</td>
<td>Utilize federal interoperability specifications consistent with MU</td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Personal Health Records</strong></td>
<td>Required</td>
<td>Required</td>
<td>Not a central component but could be included</td>
<td>Not required but important for patient management</td>
<td>Not required but important for patient engagement</td>
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Proposed Key Attributes of Collaborative Care Communities Definition

- Multi-stakeholder governance structure
- Defined clinical and cost reduction objectives and a commitment to measurement of same
- Use of health IT consistent with State and Federal standards and requirements
- Minimum provider participation requirements
- Requirements relating to public reporting
Medicaid and Health IT Coordination

- Participation in governance
- SMHP requirements – initial focus on implementing MU incentives but also need to address collection of quality data and role in delivering or consuming HIE services
- Medicaid as a focal point for shared HIE services – MMIS, enhanced admin funds; optimal strategy for aggregation of administrative claims and clinical data?
- Medicaid as payer – payment incentives for eRX, PCMH, reducing hospital readmissions
Closing the Loop: Establishing State Regulatory Authority for HIE

• The commissioner shall make such rules and regulations as may be necessary to implement federal policies and disburse funds as required by the American Recovery and Reinvestment Act of 2009 and to promote the development of a statewide health information network of New York (SHIN-NY) to enable widespread interoperability among disparate health information systems, including electronic health records, personal health records and public health information systems, while protecting privacy and security. Such rules and regulations shall include, but not be limited to, requirements for organizations covered by 42 U.S.C. 17938 or any other organizations that exchange health information through the SHIN-NY.