TESTIMONY RE: THE PENNSYLVANIA HEALTH INFORMATION TECHNOLOGY ACT (SB 8)

Honorable Members of the Senate Communications and Technology Committee:

This testimony is submitted on behalf of the Delaware Health Information Network ("DHIN") with respect to the proposed SB 8, to be known and cited as the Pennsylvania Health Information Technology Act. As the first state-wide Health Information Exchange (HIE) in the nation, and a near neighbor of the Commonwealth of Pennsylvania, DHIN's experience may be useful in your deliberations.

The Delaware Health Information Network was statutorily created as a not-for-profit instrumentality of the State of Delaware and as the state-designated health information exchange under Delaware law. From its beginnings in 1997 until 2010, DHIN was "incubated" within the Delaware Health Care Commission under the umbrella of the State. Funding to support DHIN operations was almost evenly divided between federal grants, capital funding through the State bond bill, and private contributions from member organizations.

In 2010, SB231 amended the legislation to spin DHIN out from under the State as a stand-alone not-for-profit organization with expectations that it function in a traditional corporate model with an employed (vs contracted) Executive Director and management team and a sustainable business model. DHIN continues to have oversight by a public-private board appointed by the Governor and representing all the key constituencies and stakeholder groups such as physicians, hospitals, health plans, employers, consumers, and key State agencies. In September 2011, DHIN submitted to the Governor and General Assembly of Delaware a business plan for sustainable operations which has been approved and successfully implemented. From this point forward, the State's financial participation in DHIN will be as a customer of services that DHIN provides, not as a provider of capital funding, and fees for participation will be the same for State and private users of each service.

Membership in DHIN has grown steadily since it first became operational in 2007. Today, all of Delaware's acute care hospitals, the major national reference laboratories, and regional pathology and radiology groups send data into the DHIN. Users of this data include all of Delaware's skilled nursing facilities, 86% (and growing) of Delaware's physicians, physician assistants, and advanced practice nurses, all Federally Qualified Health Centers (FQHCs), as well as a growing number of pharmacies, home health agencies, hospice, assisted living, and other health care entities.

Through the DHIN, test results are electronically sent from a laboratory to the physician that ordered them and are simultaneously available to other providers treating that patient. DHIN also enables information on a patient who is admitted, transferred or discharged from a hospital to be sent to their primary care physician. This information from pathology reports, admission and discharge summaries and transcribed reports includes diagnoses, procedure or operative reports, allergies, reason for visit, admission, or transfer, as well as patient demographics, next of kin, and insurance information. Through the DHIN this information is available by query as needed for improving the management of a patient's care. Collectively, these data types provide a rich trove of clinical information to inform decision making in the ambulatory environment and to support coordination of patient care across multiple providers and facilities.

DHIN has both qualitative and quantitative data validating the value proposition. Numerous anecdotal reports confirm the value of DHIN to patients in supporting transitions of care. Consider the elderly and mildly demented patient discharged from hospital to home and presenting back to her primary care provider. Her daughter accompanied her to this appointment, dreading the ordeal of explaining what happened during the hospitalization, and was delighted to discover that the primary care physician already had the critical information from the hospital and was able to pick right up on an appropriate plan of care. Or consider the patient who presented for evaluation of a lump in her neck – impossible to think past the fear of hearing that dreaded word, "cancer," and give an accurate and coherent past and family history. With the information available through the DHIN, fact-gathering is streamlined and the physician can concentrate on reassurance and next steps. Many, many more concrete, specific examples could be cited of real people with real stories of improved quality of care and improved experience of care due to the ready availability of relevant background clinical information through the DHIN.

The Division of Public Health has benefited through the electronic transmission of syndromic surveillance and reportable labs through the DHIN. A real world outbreak of "swine flu" was swiftly detected and a public health response prepared because of real-time transmission of this data from hospital emergency departments.

Hospitals, laboratories, and other data senders have been able to recognize substantial monetary savings due to electronic results delivery through the DHIN. When a provider "signs off" accepting DHIN as the report of record (meaning they are satisfied with the timeliness, accuracy, and completeness of the data they receive through the DHIN), the data sender is able to turn off paper and other traditional methods of results delivery. Based on DHIN's fee structure, this results in an 86% savings on the cost of results delivery for each "signed off" practice. DHIN's data senders have avoided several million dollars in the cost of results delivery, and this figure continues to grow as confidence in DHIN grows among Delaware's providers. At the present time, slightly over half of providers who have enrolled in DHIN have "signed off."

Physicians and other health care providers receive numerous benefits from DHIN. A typical practice with an electronic health record (EHR) may have multiple interfaces to one or more hospitals and one or more reference laboratories. Costs to the practice for each of these may range from $5,000-$10,000 and sometimes more, depending on the EHR vendor and the complexity of the interface. DHIN has negotiated steep discounts with the EHR vendors to develop a single interface from the EHR to the DHIN that accurately transmits data from all of the DHIN data senders into the EHR. Estimated cost savings of $18,500 - $28,500 per participating practice have resulted, with the

potential for millions in savings across the state if all practices connect their EHR to the DHIN in this manner.

Practices also report that DHIN saves them time and frustration in seeking for and collating data needed for patient care. DHIN has actually become a verb, with office staff trained to "DHIN the patient" before they are seen by the provider. Some practices have reported being able to reduce their support staff or repurpose staff for more productive tasks because DHIN saves so much time in information management.

DHIN has dramatically delivered on the promise of reducing the duplication of costly studies. For select high cost and high volume tests, the ratio of test results per unique patient sent through the DHIN in June 2011 as compared to June of 2009 was 30 percent lower for radiology exams and 33 percent lower for lab results. Along with the qualitative data collected in focus groups with DHIN member practices, this validates that providers do in fact check for the existence of previous results before ordering new studies, and as more providers and more data senders have joined DHIN, the net resulting decrease in duplicate studies has been dramatic, with an estimated cost savings based on Medicare reimbursement rates of $6.5 million for just this select group of exceptionally high cost labs and radiology studies. Furthermore, reducing the amount of exposure to radiation by avoiding repeat radiology studies has a patient safety benefit as well as a cost reduction benefit.

There is every reason to believe that the Commonwealth of Pennsylvania could reap the same benefits that DHIN has provided to the citizens of Delaware. These benefits do not occur over night. It takes time and committed work and cooperation to grow the services and participation in an HIE to the point where these benefits accrue.

If I may respectfully point out one area in which I believe the proposed Pennsylvania Health Information Technology Act is weak, it would be in the area of immunity from liability. As currently worded, the Act provides protection to providers and their employees, agents, and representatives. (Chapter 9, section 901.) A "health care provider" is explicitly defined in Chapter 1, Section 102 as "a person licensed by the Commonwealth to provide health care or professional clinical services." This leaves data senders, such as hospitals and laboratories, and the HIE organization(s) without explicit immunity. Without such statutory protection, these organizations will need to carry liability insurance if they choose to participate in health information exchange. In a fledgling industry, it can be difficult to determine the type and amount of such coverage needed, and it can adversely impact the financial sustainability of an HIE organization to include such coverage in their cost structure. It also does not address the potential for clinical information exchange across state borders.

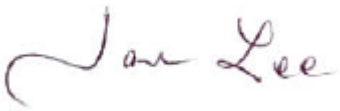
A key principle of health information exchange is that the data should follow the patient. Patients frequently cross state lines in seeking medical care. Accidents or illness occur on vacation or while traveling for business. Some patients have homes and spend significant amounts of time in more than one state. The number of unique patients in the DHIN database exceeds the population of Delaware by 30% and includes over 50,000 residents of Pennsylvania. Conversely, a single hospital in Philadelphia has reported over 30,000 residents of Delaware in their hospital database. The value of being able to exchange information so that the data follows the patient and is available at the point of care, wherever that may be, is self-evident.

I respectfully recommend that the language of the Pennsylvania Health Information Technology Act be revised to provide both civil and criminal immunity for all HIE participants, both the data

senders and data users, as well as the HIE organization, so long as they are duly licensed and/or incorporated in the state in which they principally practice or conduct business, follow accepted national standards of health information exchange and protection of privacy and confidentiality of data, comply with the laws of the State or Commonwealth in which data will be collected and/or used and the rules and regulations of the HIE or HIEs involved, and the information exchange is intended to support patient care. Good faith should be presumed until proven otherwise, with malice required to be shown by a complainant.

As a physician of 30 years, I have personally and repeatedly experienced the frustrations of missing, lost, or inaccessible clinical information in my efforts to provide high quality care to my patients. I am deeply committed to eliminating the information stovepipes and barriers to exchange of relevant clinical data across time and organizational boundaries. It is my honor and privilege to add my voice to others advocating for the passage of the Pennsylvania Health Information Technology Act.

Sincerely,



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