Testimony of Michael Lardieri, LCSW

Hello, my name is Michael Lardieri and I am the Assistant Vice President for Strategic Program Development at the North Shore-LIJ Health System in New York. North Shore is the sixth largest health system in the nation consisting of 17 hospitals, over 350 ambulatory practices and over 35 behavioral health practices. There, I oversee the use of technology in integration of physical and behavioral health care including health information exchange, patient portals, telemedicine and the use of mHealth technologies. For the last 10 years, I have worked in developing and integrating electronic health records and other health information technology into behavioral health and primary care. Thank you for inviting me to speak here today as we discuss the important role of health information technology and interoperability.

We all know the history. In 2009, behavioral health providers were left out of the Meaningful Use incentive program, creating a division within health care we are still looking to close today. We know that since 2009, there have been continued efforts to bring coordinated care to our nation's high-risk, high-cost patient population and that health information technology is the bedrock of that coordinated care. Today, poorly coordinated transitions from hospitals to other care settings cost between $25-45 billion. Patients with mental illness and substance use cost nearly three times as much as patients without such an illness due in large part to untreated co-occurring chronic physical health conditions. While behavioral health providers have been excluded from financial incentives for adapting health information technology, it is clear that something must be done to better coordinate care and help this vulnerable population.

Right now, there are multiple systems that could support the coordination of behavioral health and primary care settings. First, is utilizing secure messaging components incorporated into Meaningful Use Certified EHRs themselves, called DIRECT Secure Messaging. DIRECT allows providers to send and receive information on a secure point to point connection between sending and receiving providers. The problem is that because they are not eligible for the Meaningful Use incentive program, not all behavioral health providers have 2014 MU certified systems, so they are not equipped for this type of communication.

Second, are health information exchanges (HIEs), which in my opinion, are the ideal vehicle for information sharing among disparate providers with disparate EHR systems. HIEs can provide a platform that can share a "community view" of the patients' treatment plan with those "wrap around" providers who do not have EHRs. This would allow these providers, who are an integral part of the treatment team, to view and add to a patient's treatment plan. HIEs, however, are not quickly implementing these services as there is little return on investment for them. And they are very busy incorporating feeds from EHRs.

To participate in HIEs providers must have technology that produces a Continuity of Care document (C-CDA). The ability to produce a C-CDA is the standard set by Meaningful Use as it provides guidelines for sending structured and unstructured data across systems. This type of standardization is essential to support interoperability. The problem is that these standards are evolving and there are many areas that are open for interpretation. Even little differences in the transmission of information could cause data to be rejected or incorrectly incorporated.

Integrated systems such as the North Shore –LIJ Health System I work in have developed internal HIE systems to meet the need for care coordination. The "Care Tool", which we use, provides the capability to extract information from multiple disparate systems used by our providers and share

the information for care coordination purposes across our system. We are able to successfully share internally within the Care Tool system, however, once we begin to share outside the system then we have the same barriers that other HIEs experience in managing consents.

Each solution discussed has its inherent problems and limitations. However, despite these hurdles, there are success stories that should serve as role models as we move toward fully integrated and coordinated care. First, let's look at Rhode Island and New York City, two leaders in information sharing. Both the Rhode Island and the NYC HIEs have adopted a two-step process where the patient allows information to be shared from the provider to their HIE - CurrentCare in Rhode Island and Healthix in New York City - and then allows a separate release of information for the HIEs to share with providers within the HIE. But similar to other solutions, this system is still hampered by the restrictions imposed by federal regulations, namely 42 CFR Part 2 which governs sharing of substance use information.

In Kansas, they have developed a workaround to share information in their system by having all information go through the HIE and requiring the provider to "break the glass" to view any behavioral health information. If a provider requests information and there is behavioral health information in the system, the requesting provider is presented with a log-in screen, told they do not have the required consent to access the information and are directed to receive consent at the point of care. Once the consent is obtained, the provider can "break the glass" to obtain the information. Again, while this system is effective, it is still difficult to navigate, does not fit into provider workflows and does not support providers reviewing information upon referrals like they do in medical or health home settings.

Congress can advance these efforts and success stories and support legislation that fixes a faulted system. It can support legislation that includes mental health and substance use providers into the financial incentive program and work with them to bring about methods that promote, and not inhibit interoperability. By furthering the use and reach of electronic health records, Congress can help bring truly coordinated care to a population of patients that need it most.

Thank you for your time. I am happy to answer questions and speak further after the presentations are finished.