**eHealth Council**
**May 29, 2009**
**1:30 PM CT – 4:00 PM CT**


- **Lincoln—**Nebraska Educational Telecommunications, 1800 N. 33rd, Board Rm., 1st Floor, Lincoln, NE
- **Omaha—**UNMC, Wittson Hall—Library of Medicine, Room 8016A
- **North Platte (tentative)**- Educational Service Unit #16, Distance Learning Rm., 1221 W 17th  St. North Platte, NE or Great Plains Regional Medical Center, Pawnee Room
- **Alliance—**Box Butte General Hospital
- Members at hospitals and public health departments may also establish connections.   Please call 471-4130 to set up a test a couple of days prior to the meeting.


 **Meeting Documents: Click the links in the agenda or click here for all documents**


**Tentative Agenda**

**1:30**      **Roll Call**
             **Notice of Posting of Agenda**
             **Notice of Nebraska Open Meetings Act Posting**
             **Approval of March 16, 2009 minutes***


             **Public Comment**

**1:35**      **Updates and Reports**

             **Updates on Recovery Act Funding for Health IT**
             HIT ARRA Implementation Plan--ONC
             What States Should Be Working On
             ONC Memo to NTIA


             **eHealth Plan Work Group Update**
             Recommendations include:

             - Aligning with federal HIT Plan
             - Looking at New Hampshire's plan as a model

             **E-Prescribing Work Group Update**
             E-Prescribing Work Group Recommendations*

             **HIE Meeting Update**
             HIE Recommendations*

             **Public Health Work Group Update**
             Public Health Charge and Membership

             **HISPC Update**

             - Legislative Update
               Nebraska HISPC
             - HISPC State Challenges

- HISPC Webinars-- **http://privacysecurity.rti.org/Default.aspx?tabid=101**

**Telehealth Update**

**Membership**
Resignation of Jim Krieger

**2:15      Tying Health IT Implementation to Quality Measures**
- Monica Seeland, Nebraska Coalition for Patient Safety
- Dale Mahlman, Nebraska Medical Association
- Dave Palm, Dept. of Health and Human Services
- Joyce Beck, Thayer County Health Services
- Kevin Conway, Nebraska Hospital Association

**3:00       Further Discussion of  Updates and eHealth Plan**

**3:30      Discussion Health IT Needs of Dentistry and Teledentistry**

Dr. David Brown and others, University of Nebraska Dental College

**4:00        Adjourn**

Meeting notice posted to the NITC and Public Meeting Website on May 22, 2009.  The agenda was posted on May 27, 2009.

# eHealth Council
## March 16, 2009

## Meeting Minutes

**Members Present:**
Vivianne Chaumont
Kimberly Galt
Dan Griess
Donna Hammack
Steve Henderson
Alice Henneman
Ron Hoffman, Jr.
Wende Baker (for C. J. Johnson)
Harold Krueger
Jeff Kuhr
Ken Lawonn (via phone –joined 15 minutes late)
David Lawton
Keith Mueller
John Roberts (phone)
Nancy Shank
September Stone
Delane Wycoff (phone )
Harris Frankel  (phone—alternate for Delane Wycoff)

## Opening Business

**Roll Call, Notice of Posting of Agenda, Notice of Nebraska Open Meetings Act Posting, Approval of Minutes**

Dan Griess called the meeting to order at 9:30.  There were 16 members present. The meeting announcement and agenda were posted on the NITC website and on the Nebraska Public Meeting Calendar on March 9, 2009.  A copy of the Nebraska Open Meetings Act was available on the wall.

**Keith Mueller moved to approve the August 13, Oct. 2, and Dec. 2 minutes as presented.   Kim Galt seconded the motion. Roll call vote:  Chaumont-Yes, Galt-Yes, Griess- Yes, Hammack-Yes, Henderson-Yes, Henneman-Yes, Hoffman-Yes, Baker-Yes, Krueger-Yes, Kuhr-Yes, Lawton-Yes, Mueller-Yes, Roberts-Yes, Shank-Yes, Stone-Yes**, **Wycoff-Yes.  Motion carried.**

## Public Comment

There was no public comment.

## Health IT Stimulus Funding

Lt. Governor Rick Sheehy discussed stimulus funding opportunities for health IT.   $300 million has been allocated for state grants to promote health IT.  At this point, few details are known.  Nebraska could receive $34 million for implementation or planning.   In order to qualify for this funding, the State of Nebraska will need to submit a plan for eHealth.   The eHealth Council is charged with developing the plan.   Lt. Governor Sheehy stressed the importance of transparency.   The State of Nebraska has

created a website (www.recovery.nebraska.gov) to provide information on funding received by the state. The eHealth Council will probably play a role in monitoring grant funds.  Plans will probably be due in 2009 and funds will be distributed in 2010.

Lt. Governor Sheehy also said that he will work with the offices of Senator Johanns or Senator Nelson to urge the Treasury Department to act on applications for 501(c)3 status for health information exchanges.

Lt. Governor Sheehy urged the eHealth council to take a broad view when developing a state plan and look at a time frame of up to five years.

Nancy Shank suggested that the eHealth Council could help spread the word about funding opportunities. She also suggested that the eHealth Council could be the state-designated entity to disperse funds.   Lt. Governor Sheehy said that was a possibility, although some issues would have to be resolved.

Kim Galt asked about the approval process for the plan.   The plan would be approved by the eHealth Council, the NITC, and the Governor.

Keith Mueller commented that it may be wise to also look at other non-health IT funding programs such as broadband.  Lt. Governor Sheehy commented that he will be meeting with the Public Service Commission next week to discuss broadband.

## Needs of Surveyors

Helen Meeks discussed the needs of surveyors to access information.   When conducting surveys and inspections, staff members need access to information.   They need to look at records to determine if deficient practices have occurred.   They may need to take away copies of evidentiary information.   CMS is talking to states about access to electronic information.     Surveyors may need staff assistance available and may need to print copies.    Ms. Meeks suggested contacting her office to resolve issues that may arise during a survey.     She mentioned the importance of training staff to use electronic records.

## Membership

Terms of the following members have expired:

- o   Steve Henderson
- o   Senator Annette Dubas
- o   Congressman Jeff Fortenberry
- o   Dr. Delane Wycoff
- o   John Roberts
- o   Harold Krueger
- o   Jeff Kuhr
- o   Ron Hoffman, Jr.
- o   Nancy Shank
- o   Henry Zach

Henry Zach declined serving on the eHealth Council another term, leaving an opening on the eHealth Council.  All other members up for renewal indicated a willingness to serve another term.  Joyce Beck, the CEO of Thayer County Health Systems, was suggested as a nominee to fill Henry Zach's position.

Wende Baker was previously nominated to replace C.J. Johnson as the representative of SNBHIN. There was no quorum at the meeting, however, so her nomination still needs to be approved.

**Nancy Shank moved to the nominations of Steve Henderson, Senator Annette Dubas Congressman Jeff Fortenberry, Dr. Delane Wycoff, John Roberts, Harold Krueger, Jeff Kuhr, Ron Hoffman, Jr., Nancy Shank, Wende Baker, and Joyce Beck. Kim Galt seconded the motion. Roll call vote: Chaumont-Yes, Galt-Yes, Griess- Yes, Hammack-Yes, Henderson-Yes, Henneman-Yes, Hoffman-Yes, Baker-Yes, Krueger-Yes, Kuhr-abstain, Lawton-Yes, Mueller-Yes, Shank-Yes, Stone-Yes, Wycoff-Yes. Motion carried.**

## Updates and Reports

**HISPC**

**Legislative Update—As of March 12, 2009.** Neb. Rev. Stat. 71-8403 stipulates that authorizations for release of medical records are valid for a maximum period of 180 days. At a hearing before the Health and Human Services Committee, Brenda Decker proposed an amendment to LB288 (the Health and Human Services Clean Up Bill) to eliminate the 180-day restrictions. LB288 (Health and Human Services Clean Up Bill) has been designated as a priority bill by the Health and Human Services Committee. It still has not been placed on general file and no amendments have been filed, though.

The eHealth Council and E-Prescribing Work Group also identified a potential barrier to e-prescribing in a Nebraska statute that requires pharmacists to keep paper copies of prescriptions. A change to this statute which would allow pharmacists to keep copies of prescriptions in a readily retrievable format was included in LB220. Lt. Governor Sheehy provided a letter supporting the provision to the Health and Human Services Committee. LB 220 is on General File.

**Nebraska HISPC.** The Nebraska HISPC has published a report on its activities over the past year. The report is available at
http://www.nitc.nebraska.gov/eHc/meetings/documents/2009March/REV_DRAFT_HISPCII_Summary_Report.pdf .

**HISPC Multi-State Collaboratives.** Participants in the nine multi-state collaboratives addressing health information security and privacy issues met in Washington, DC on March 4-6. Materials produced by the collaboratives will be available from the website of the Office of the National Coordinator (http://www.hhs.gov/healthit/) after March 31. Nebraska has participated in the Adoption of Standards Collaborative.

The Office of the National Coordinator has just announced an extension of 3-4 months to the HISPC contracts with participating states. Possibilities include using other collaboratives' materials and continuing the work of the collaborative in which Nebraska participated. Nebraska has been invited to participate in a dialogue between the upper Midwest states (ND, SD, IA, NE, MN, WI) to address privacy and security barriers to HIE. Council members indicated support for using HISPC continuation funding to provide assistance in consumer education efforts. Council members also indicated support for entering into discussions with the upper Midwest states.

**Telehealth**

Donna Hammack reported that discussions continue with the FCC on the definition of rural which is used to determine eligibility for funding from the rural health care fund. The current definition would exclude several Nebraska hospitals from receiving funding. Hospitals eligible under the old definition have been temporarily receiving funding under a grandfather clause. An OAT grant is being submitted to refresh technology and to expand teletrauma and clinical services. A Congressional appropriation of $100,000 was also made.

**PHR Work Group**

The PHR Work Group has proposed the following conclusions and recommendations.

   **Conclusions**

- Significant progress is being made in PHR interoperability standards and in the development of privacy and security protections.

- PHRs which are interoperable with other types of electronic medical records offer more value and convenience to consumers by reducing the need to personally enter data and by improving the timeliness, availability and accuracy of data.

- PHRs with financial management functions may offer further value to consumers by providing cost and benefit information to support decision making.

- PHRs which are interoperable may offer more value to health care providers. PHRs populated by data from providers may be viewed as being more reliable by health care providers.

- PHR adoption will require consumer education and incentives. Consumers may be more receptive to PHR adoption in conjunction with certain events such as the birth of a child, enrollment in college, the diagnosis of a chronic disease, or the need to manage care of a parent.

- Health care providers may also require education in incorporating PHRs into patient care and assistance in making adjustments in the practice workflow.

- PHRs as part of a broader health management program can help consumers reduce their health risks, better manage their health, and reduce their health care expenditures.

- PHRs as part of a broader health management program can help employers reduce their health care related costs.

**Recommendations**

o The State of Nebraska should explore making immunization data from the state's new immunization registry available to consumers through PHRs.

o Efforts should be made to encourage Nebraska's health information exchanges to offer PHRs or to make patient data available through third-party PHRs in the future.

o The utilization of PHRs in conjunction with a broader health management program for State employees should be periodically evaluated as a potential way to reduce health care costs. Continued developments in PHRs may reduce implementation costs and increase the ROI.

o The utilization of PHRs in conjunction with a broader health management program for Medicaid recipients should be periodically evaluated as a potential way to reduce health care costs. Continued developments in PHRs may reduce implementation costs and increase the ROI.

o The eHealth Council should look for opportunities to partner with other organizations in educational efforts targeting consumers and providers on the use of PHRs.

o Continued research on the benefits of PHRs and the ROI for PHRs should be done.

Kim Galt suggested revising the second recommendation to include other providers and to be less prescriptive about the role of health information exchanges in providing PHRs.


**Steve Henderson moved to remand the second recommendation to the PHR work group for revision and to approve the other recommendations.   Kim Galt seconded the motion. Roll call**

**vote:  Galt-Yes, Griess- Yes, Hammack-Yes, Henderson-Yes, Henneman-Yes, Hoffman-Yes, Baker-Yes, Krueger-Yes, Kuhr-Yes, Lawton-Yes, Mueller-Yes,  Shank-Yes, Stone-Yes,  Motion carried.**

**E-Prescribing**

Kim Galt reported that the E-Prescribing Work Group has identified a number of issues related to e-prescribing and is drafting recommendations.

**Public Health Work Group**

Anne Byers, David Lawton, and Ann Fetrick drafted a charge and potential list of members for a Public Health Work Group.   The group was supportive of the charge and membership list.  Kim Galt suggested broadening the membership to include EMS and other facilities.

## Action Plan Development

Anne Byers reported that it is time for the Council to begin considering action items to be included in the statewide technology plan developed annually by the NITC.  She suggested the Council's primary action item focus on the development of a state plan for health information exchange.    Health information security and privacy is another area that should be considered for inclusion in the statewide technology plan.

Ms. Byers presented draft principles and strategies as a starting point for the discussion on the development of the state plan for health information exchange.    Keith Mueller suggested including a statement that technology should support work processes--rather than making work processes more cumbersome technology should simplify and improve work processes.  Kim Galt suggested including a statement on the need for health information to protect patient safety.   Keith Mueller suggested including a strategy on the development of telecommunications infrastructure.

The Council agreed to form a work group to develop a state plan for health information exchange.  Representatives of the state's four health information exchanges will be invited to participate.  David Lawton and Nancy Shank volunteered to serve on the committee.  Keith Mueller or a representative of UNMC will also participate.

The Council asked Anne Byers to prepare a charge to the work group and a timeline.   Ms. Byers suggested starting out with six-month time frame.   That could be adjusted if necessary to meet deadlines for stimulus funding opportunities.

The meeting was adjourned.

Minutes taken by Anne Byers, Nebraska Information Technology Commission

# Health Information Technology
## American Recovery and Reinvestment Act (Recovery Act) Implementation Plan
### Office of the National Coordinator for Health Information Technology

## A. Funding Table

| | Total Appropriated<br>*(Dollars in Millions)* |
|---|---|
| Privacy and Security* | $ 24.285 |
| National Institute of Standards and Technology (NIST) | 20.000 |
| Regional HIT Exchange | 300.000 |
| Unspecified | 1,655.715 |
| Total, Health Information Technology | $ 2,000.000 |

*Note: This dollar figure, $24,285,000, includes an estimated $9.5 million for audits by the Office for Civil Rights and the Centers for Medicare & Medicaid Services. This estimate is subject to change. Updated Figures will be reported to Recovery.gov.

## B. Objectives:

The Health Information Technology for Economic and Clinical Health (HITECH) Act provisions of the Recovery Act of 2009 create a historic opportunity to improve the health of Americans and the performance of the nation's health system through an unprecedented investment in health information technology (HIT). This initiative will be an important part of health reform as health professionals and health care institutions, both public and private, will be enabled to harness the full potential of digital technology to prevent and treat illnesses and to improve health. This is a remarkable and far-sighted commitment that the Office of the National Coordinator for Health Information Technology (ONC) is honored to lead and support.

The ONC is acutely aware that to fulfill its obligations under the Recovery Act it must act swiftly but thoughtfully. It must meet tight deadlines created by statutory requirements of the law while assuring that ONC's decisions and actions support the law's fundamental, long-term purposes: improving health and health care through the best possible applications of HIT. Meeting the long-term goals of the Recovery Act will require careful thought and planning while delivering to the American people quick action and effective investment of committed funds.

This operating plan outlines immediate actions to meet statutory requirements and to begin the huge task ahead. Over the next several weeks, ONC will hold hearings and meetings to develop and vet plans and procedures.

## C - E. Activities, Characteristics and Delivery Schedules:

American patients and their caretakers will be the ultimate beneficiaries of the following activities aimed at achieving the President's health IT initiative to accelerate the adoption of health IT and utilization of electronic health records. All of the activities discussed in this section support the current two Federal Health IT Strategic Plan goals:
1. Inform Health Care Professionals: Provide critical information to health care professionals to improve the quality of care delivery, reduce errors, and decrease costs.
2. Improve Population Health: Simplify collection, aggregation, and analysis of anonymized health information for use to improve public health and safety.

- Privacy and Security Spend Plan*: Recovery Act Subtitle D - Utilizing fully competitive contract awards, HHS will implement time-sensitive, mandatory regulatory and enforcement requirements in Subtitle D, providing contract assistance to meet statutory deadlines requiring promulgation of a variety of regulations and guidance, conduct multiple studies, and submit a number of Congressional reports; enhance enforcement of the Health Insurance Portability and Accountability Act *(HIPAA)* Privacy and Security Rules by carrying out the extensive changes that Subtitle D makes to the existing HIPAA complaint investigation and enforcement scheme. This funding will enable the Centers for Medicare and Medicaid Services (CMS) and the Office for Civil Rights (OCR) to carry out mandated audits, make modifications in their case and document management systems, and train State Attorneys General in their new enforcement role. The Recovery Act also required that, no later than April 17, 2009, ONC was to issue guidance on technologies and methodologies that render protected health information unusable, unreadable, or indecipherable to unauthorized individuals. This guidance was published in the Federal Register. A fully competitive contract award will be utilized to support the review and disposition of public comments. Final guidance will be published after a public comment period

Milestones:

**Regulations, Guidance, Reports and Studies**

| DESCRIPTION | DATES(S) | PURPOSE | RESPONSIBLE AGENCY |
|---|---|---|---|
| For breach notification purposes, issue guidance specifying the technologies and methodologies that render protected health information unusable, unreadable, or indecipherable to unauthorized individuals | April 18, 2009; annual updates | Required guidance under Section 13402 | ONC in collaboration with OCR and CMS |
| Issue interim final regulations to implement breach notification for HIPAA covered entities and business associates | August 18, 2009 | Issue regulation under Section 13402 | OCR and FTC |
| Issue regulations to modify the HIPAA Enforcement Rule to implement revised penalty structure | February 18, 2010 | Issue regulation under Section 13410 | OCR in collaboration with CMS |
| Issue regulations to extend certain HIPAA Security Rule provisions to business associates | February 18, 2010 | Issue regulation under Section 13401 | CMS |
| Issue guidance on technical safeguards to carry out security | February 18, 2010; annual updates | Required guidance under Section 13401 | CMS in collaboration with ONC |
| Report to Congress on breaches for which notice was provided to the Secretary | February 18, 2010 and annually thereafter | Issue report to Congress under Section 13402 | OCR |
| Issue regulations to extend certain HIPAA Privacy Rule provisions to business associates | February 18, 2010 | Issue regulation under Section 13404 | OCR |
| Issue regulations to modify the HIPAA Privacy Rule's provisions regarding right to request restrictions, minimum necessary, access | February 18, 2010 | Issue regulation under Section 13405 | OCR |
| Issue regulations to modify the HIPAA Privacy Rule's provisions regarding marketing and fundraising | February 18, 2010 | Issue regulation under Section 13406 | OCR |

| Issue regulations to clarify that certain entities are HIPAA business associates | February 18, 2010 | Issue regulation under Section 13408 | OCR |
|---|---|---|---|
| Report to Congress on HIPAA Privacy and Security Compliance | February 18, 2010 and annually thereafter | Issue report to Congress under Section 13424 | OCR and CMS |
| Study and report to Congress on privacy and security requirements for entities that are not HIPAA covered entities or business associates | February 18, 2010 | Issue report to Congress under Section 13424 | ONC in collaboration with OCR, CMS and FTC |
| Issue guidance on the HIPAA Privacy Rule's requirements for de-identification | February 18, 2010 | Issue guidance as required under Section 13424 | OCR in collaboration with ONC |
| Study the HIPAA Privacy Rule's definition of "psychotherapy notes" with regard to including certain test data and mental health evaluations | February 18, 2010 | Conduct study as required under Section 13424 | OCR in collaboration with SAMHSA |
| Issue regulations to modify the HIPAA Privacy Rule's accounting of disclosures provisions | June 18, 2010 | Issue regulation under Section 13405 | OCR |
| Issue guidance on what constitutes "minimum necessary" for purposes of the HIPAA Privacy Rule | August 18, 2010 | Issue guidance as required under Section 13405 | OCR |
| Issue regulations to modify the HIPAA Enforcement Rule to implement willful neglect provisions | August 18, 2010 | Issue regulation under Section 13410 | OCR in collaboration with CMS |
| Issue regulations to modify the HIPAA Privacy Rule to generally prohibit exchanging health information for remuneration without individual authorization | August 18, 2010 | Issue regulation under Section 13405 | OCR |
| Issue regulations to modify the HIPAA Enforcement Rule to implement provisions for sharing civil money penalties or settlements with harmed individuals | February 18, 2012 | Issue regulation under Section 13410 | OCR in collaboration with CMS |

**Enforcement**

| DESCRIPTION | DATES(S) | PURPOSE |
|---|---|---|
| OCR Case Management Upgrade – Issue Task Order | Third Quarter 2009 | Upgrade Case Management System to incorporate HITECH changes. |
| CMS Case Management Upgrade – Issue Task Order | Third Quarter 2009 | Upgrade Case Management System to incorporate HITECH changes. |
| Training for State Attorneys General | Third Quarter 2009 | Training on Section 13410(e) of the Act. |
| Issue Audit Task Order – OCR | Second Quarter 2010 | Compliance with Section 13411 of the Act. |
| Issue Audit Task Order – CMS | Second Quarter 2010 | Compliance with Section 13411 of the Act. |
| Completion of Projects | 1 October 2011 | |

- National Institute of Standards and Technology (NIST): Recovery Act Authorizing Language - HHS will transfer $20 million to NIST for continued work on advancing health care information integration through activities such as technical standards analysis and establishment of conformance testing infrastructure.

Milestones:

| | Start | End |
|---|---|---|
| Discussions between HHS and NIST to outline work requirements | 03/31/2009 | 05/15/2009 |

| Draft agreement to codify outcomes, deliverables, schedule and reporting requirements | 05/16/2009 | 06/30/2009 |
|---|---|---|
| Fully execute agreement | 07/01/2009 | 07/15/2009 |

- Standards Rulemaking: Recovery Act §3004 (B) (1) - No later than December 31, 2009, HHS shall adopt and publish an initial set of standards, implementation specifications, and certification criteria. The rulemaking for this initial set of standards, implementation specifications, and certification criteria may be issued on an interim, final basis. Fully competitive contract awards will be utilized to support the impact analysis.

  Milestones:

  | | Start | End |
  |---|---|---|
  | Complete Draft Rule/ Regulatory Impact Analysis | 05/01/2009 | 08/26/2009 |
  | Submit for HHS Clearance | 08/26/2009 | 09/25/2009 |
  | Clear OMB (up to 90 day process) | 09/25/2009 | 12/24/2009 |
  | Publish in Federal Register | 12/24/2009 | 12/31/2009 |

- Update Federal Health IT Strategic Plan: Recovery Act §3001 (c) 3, (A), (B), (D) - ONC will develop a draft update, receive input from stakeholders, review the impact on other projects, adjust the operating plan as needed, and publish the strategic plan on the HHS website. Strategic planning expertise will be engaged utilizing fully competitive contract awards.

  Milestones:

  | | Start | End |
  |---|---|---|
  | Receive input from Federal and private-sector stakeholders to inform path forward | 05/18/2009 | 08/30/2009 |
  | Review impact on other projects | 09/01/2009 | 09/30/2009 |
  | Adjust operating plan, as needed | 10/01/2009 | 10/15/2009 |
  | Submit for clearance | 10/15/2009 | 12/15/2009 |
  | Publish revised plan on HHS Website | 12/15/2009 | 12/31/2009 |

- Define "Meaningful Use of an EHR": Recovery Act §4101- The Recovery Act authorizes that incentive payments may be made to eligible professionals and hospitals that are using EHRs in a meaningful way. Specific understanding of what constitutes meaningful use will be determined through a process that will include broad stakeholder input and discussion. HHS is developing milestones for major phases of the program's activities with planned delivery dates.

- Recovery Act Public Communications: Recovery Act §3001 (c) (3) (A) (B) (D) - ONC will establish mechanisms for communications with the public, which would include creating a website like healthreform.gov. Through a fully competitive process, ONC will award a contract(s) to provide support in determining the best methods of broad communication and establish the resulting infrastructure. HHS is developing additional milestones for major phases of the program's activities with planned delivery dates.

Considerations to Address Moving Forward - There are a number of complex issues that must be considered to fully implement the requirements of the HITECH Act and the intent of the Recovery Act. There is foundational work required to support the large investment that will be made through the Medicare and Medicaid Incentives programs at the Centers for Medicare & Medicaid Services (CMS). With the arrival of the new National Coordinator, decisions about how to best address standards development and harmonization, the certification and testing processes, privacy and security policy development, issues around governance, workforce training, and education for health care providers and consumers will be made.

Additionally, a notification for funding availability for the regional extension center grants will be published by the end of FY 2009. Awards are anticipated to be made in early FY 2010.

**F. Environmental Review Compliance**:
The activities described in this Implementation Plan do not trigger the requirements of the National Environmental Policy Act (NEPA), National Historic Preservation Act (NHPA) or related statutes.

**G. Measures:**
ONC has performance measures in place that relate to overall Recovery Act activities. These outcome, output, and efficiency measures support the President's health IT initiative to accelerate the adoption of health IT and utilization of electronic health records.

Through the revision of the Strategic Plan, ONC will revise existing and develop additional performance measures that will more specifically support the individual programs funded with Recovery Act dollars. These measures will be tied to the goals and objectives of the revised Federal Health IT Strategic Plan and will, on a more granular level, gauge progress toward the intended outcomes of each program. Although current measures are reported annually, Recovery Act-specific measures are under development and will be reported quarterly.

HHS is working to develop cross-cutting outcome measures for health information technology activities across the Department. Initial outcome measures will be developed by December 1, 2009. Some of these new measures will be reported quarterly to help HHS track progress toward the program's goals and objectives.

Current performance measures include the following:

**Office of the National Coordinator for Health Information Technology**

| # | Measure | FY | Target | Result |
|---|---------|-----|--------|--------|
| 1.3.2 | Increase physician adoption of EHRs *(Outcome)* | 2010 | TBD | Feb 2011 |
| | | 2009 | 25% | Feb 2010 |
| | | 2008 | 24% | 21% Target improved but not met |

| # | Measure | FY | Target | Result |
|---|---------|-----|--------|--------|
| | | 2007 | 18% | 14%<br>Target improved but not met |
| | | 2006 | N/A | No survey conducted |
| | | 2005 | Baseline | 10% |
| 1.3.3 | Increase the percentage of small practices with EHRs *(Outcome)* | 2010 | TBD | Feb 2011 |
| | | 2009 | 12% | Feb 2010 |
| | | 2008 | 8% | 13%<br>Target met |
| | | 2007 | 5% | 9% |
| | | 2006 | Baseline | 4% |
| 1.3.4 | Percent of physician offices adopting ambulatory EHRs in the past 12 months that meet certification criteria *(Outcome)* | 2010 | TBD | Feb 2011 |
| | | 2009 | 35% | Feb 2010 |
| | | 2008 | 25% | No survey conducted |
| | | 2007 | Baseline | 27% |

**Office for Civil Rights Privacy Measures**

| # | Measure | FY | Target | Result |
|---|---------|-----|--------|--------|
| 1.1.5 | Percentage of privacy cases resolved per privacy cases received *(Output)* | 2010 | 103% | Nov 2010 |
| | | 2009 | 100% | Nov 2009 |
| | | 2008 | 93% | 99.7%<br>(Target Exceeded) |
| | | 2007 | 88% | 87.4%<br>(Target Not Met) |
| | | 2006 | 81.20% | 91.8%<br>(Target Exceeded) |
| | | 2005 | 74.20% | 79.7%<br>(Target Exceeded) |
| 1.1.9: | Percentage of privacy complaints that require formal investigation, resolved within 365 days *(Output)* | 2010 | 40% | Nov 2010 |
| | | 2009 | 45% | Nov 2009 |
| | | 2008 | Set Baseline | 42.3%<br>(Baseline) |
| 1.1.10 | Percentage of privacy complaints that do not require formal investigation, resolved within 180 days *(Output)* | 2010 | 63% | Nov 2010 |
| | | 2009 | 66% | Nov 2009 |
| | | 2008 | Set Baseline | 67%<br>(Baseline) |

**H. Monitoring/Evaluation:**
All Recovery Act programs will be assessed for risk and to ensure that appropriate internal controls are in place throughout the entire funding cycle. These assessments will be done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123, "Management's Responsibility for Internal Control."

As programs are developed, ONC will also develop performance metrics and reporting requirements within the contract or grant language to ensure that adequate progress is being made toward the defined goals of the program.

Spending of Recovery Act dollars requires coordination with the Office of the Inspector General (OIG), which has been tasked with analyzing the spending plans to assess the risk potentials associated with the proposed contract and grant expenditures. The risk assessments are both internal and external. Internally, the OIG will assess and, when appropriate, test the necessary management controls that need to be in place to adequately manage the proposed contracts and grants inclusive of the program development and execution stages and the administration of the programs. Externally, the OIG will perform any audits necessary to insure that intended grant recipients are financially stable and have auditable financial systems; they will also ensure that contractors' financial systems are auditable.

**I. Transparency:**
ONC and other agencies administering HITECH funded activities will be open and transparent in all of its contracting and grant competitions and regulations that involve spending of Recovery Act funding, consistent with statutory and OMB guidance.

ONC and other agencies administering HITECH funded activities will work closely with Federal partners to codify agreements that will support the reporting of all Recovery Act activities in compliance with Section 2.9 of the OMB February 18, 2009 Guidance. MOU language will be developed with the relevant agency outlining the expectations for information to be gathered, frequency of reporting, ability to assure that the data are reliable, timely and complete. ONC will post this information in the required Websites beginning July 10, 2009. For projects that are directly funded by ONC, language will be incorporated into contracts and other awards specifically spelling out the requirement for reporting data, as described above.

ONC and other agencies administering HITECH funded activities will ensure that recipient reporting required by Section 1512 of the Recovery Act and OMB guidance is made available to the public on Recovery.gov by October 10, 2009. ONC and other agencies administering HITECH funded activities will inform recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. ONC and other agencies administering HITECH funded activities will provide technical assistance to grantees and contractors and fully utilize Project Officers to ensure compliance with reporting requirements.

**J. Accountability:**
To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, ONC and other agencies helping to administer HITECH funded activities will build on and strengthen existing processes. Senior ONC officials in the Office of the Executive Director will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, and ensuring transparency. The personnel performance appraisal system will also incorporate Recovery Act program stewardship responsibilities for program and business function managers.

Accountability in terms of business functions will be monitored and documented through performance plans. Recovery Act awardees will be required to provide quarterly reports on progress. Following a thorough review of the progress reports, selected site visits will be taken if progress in meeting stated goals is delayed.

**K. Barriers to Effective Implementation:**
Staffing levels in ONC must be increased. With the current staff of 30 FTE, plans are to use all available human resources vehicles to increase the level of staffing. This will include term appointments for projects with short-term needs; details as permitted by Recovery Act legislation; a limited number of permanent positions for long-term projects; and other temporary and contractual agreements.

In order to ensure success of the HIT initiative, ONC will need to engage and ensure buy in from stakeholders in both the private and public sectors. ONC will engage stakeholders throughout the development process. ONC and other agencies helping to administer HITECH-funded activities will continue to increase communications and will develop consistent, measurable goals by which project execution will be measured, linking the planning process and the execution of the project plans in detail. Currently, there are many ways for stakeholders to get involved in ONC's deliberations, including:

- Listening to and participating during the public comment periods at the Health IT Policy Committee and the Health IT Standards Committee meetings.
- Commenting on draft program descriptions.
- Providing expert input and information to inform a report.

ONC and other agencies helping to administer HITECH funded activities will include in all funding announcements the requirement to accelerate work wherever possible. In addition, all grantees and contract awardees will be required to report quarterly to both ONC and through Recovery Act channels. ONC will also reflect the use of multi-year funding in the risk management plan and will include risk mitigation strategies. Furthermore, to ensure effective coordination of Federal health information technology activities, HHS will continue discussions with HHS partners such as OCR and CMS and others throughout the federal government such as VA, DoD, OPM, and SSA.

**L. Federal Infrastructure Investments**:
The activities described in this Implementation Plan are not related to building requirements or construction environmental impact issues.

# BACKGROUND ON ARRA'S HEALTH IT PROVISIONS AND STATE ACTIONS

## State Grants for Health Information Exchange and EHR Adoption Support

HHS will provide "**States** or **qualified State-designated entities**" with funding for planning and/or implementation "for the support of the physical and organizational infrastructure for HIE statewide."

- The potential amount for these grants is unstated. Funding is available for 5 years or until expended.
- There is a required match starting in 2011 and increasing.
- Potential funded activities include:
    1. Enhancing participation in statewide and nationwide exchange
    2. Providing TA for the development of exchanges
    3. Addressing the needs of safety net providers
    4. Promoting the use of EHRs for quality and public health purposes
    5. Educating consumers

## State Loan Program

This section states HHS will provide grants to **states** and tribes to support loans to any eligible health care provider to cover the costs of purchasing an EHR.

- Grantees must develop a loan fund from which to make and guarantee loans. Interest rates must be market-based, and interest payments return to the loan fund.
- The state must establish requirements and accountability mechanisms, and providers must agree to submit reports on select quality measures.
- The potential amount for these grants is also unstated. States can charge interest on these loans, but any collected interest must be reinvested in the fund.
- Providers can use funds to cover the direct purchase of equipment and software, as well as investments in training personnel, and improvements to security and utility of the EHR in their office environment.

## Medicaid Incentives for Providers to Purchase and Implement EHRs

These incentives are designed to support the purchase and use of EHRs by Medicaid providers. {NOTE: Medicare will also provide incentives, but providers must take one or the other}

- States will manage and be accountable for the Medicaid reimbursements.
- Program will not start earlier than 2011.
- States must secure routine attestation from providers demonstrating meaningful use of the EHR in their practice. Standards for meaningful use are being developed,
- CBO estimates an increase in spending for the Medicare and Medicaid programs of $32 billion (2009-2019).

## Things states can do now

The success of these efforts to move toward system-wide electronic health information exchange will rely heavily on states. Although timing and grant requirements are not available, there are things that states can, and probably should be doing now to prepare for implementing these programs and other related efforts.

- Prepare or Update the State Roadmap for Health IT
- (Re)Engage Stakeholders
- Establish a State Governance Structure
- Prepare Other State Agencies to Participate in HIEs
- Implement Privacy Strategies and Reforms
- Determine the HIE Business Model
- Create a Communications Strategy
- Establish Opportunities for Health It Training and Education.

MAY 1 4 2009

## MEMO

| | |
|---|---|
| **To:** | Anna Gomez<br>Deputy National Telecommunications and Information Administration Administrator<br><br>Cheryl Cook<br>Deputy Under Secretary for Rural Development, USDA |
| **From:** | David Blumenthal, MD, MPP  DB<br>National Coordinator |
| **CC:** | Susan Crawford, National Economic Council<br>Jonathan Claffey, USDA Rural Development<br>David J. Villano, USDA Rural Development<br>Michelle Carey, NTIA<br>Edward Smith, NTIA<br>Anthony Wilhelm, NTIA<br>Scott Deutchman, FCC<br>Julie Veach, FCC |
| **Subject:** | NTIA and USDA Broadband Funding Notices – health information technology criteria |

I appreciate the opportunity for my staff to participate in the broadband coordination meetings led by Susan Crawford of the National Economic Council and involving the Federal Communications Commission (FCC), the National Telecommunications and Information Administration (NTIA), and the U.S. Department of Agriculture (USDA).

The provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) related to broadband and health information technology (health IT) provide excellent opportunities to modernize our health care system in order to improve the health of all Americans, bring down costs and ensure sustained long-term economic growth. In addition, health IT is a critical part of the President's strategy to reform our health care system.

One of our top priorities in the implementation of ARRA is to connect health care providers so that they can improve the quality and efficiency of health care by sharing health information with each other. One of the challenges we face is the lack of broadband access across many geographies where health care providers provide services. Since broadband is needed to serve many stakeholders interests, it would be appropriate for all funding applicants to consider how to meet the education, awareness, training, access, equipment, and support needs across stakeholders in given geographies. To ensure the inclusion of health care stakeholders needs, the plans to address medical and health care providers should be a required part of any proposed application for funding under the Broadband Technologies Opportunity Program (BTOP) in ARRA. While there will likely be common approaches to expanding broadband access in a given state or region, if medical and health care providers have specific needs related to education, awareness training, equipment or support in order to be connected to the Internet via broadband, the Notice of Funding Availability under BTOP should allow for applications and awards directly for these purposes. As discussed previously with NTIA and USDA, their funding notices should clearly describe the medical and healthcare providers eligible for broadband funding. Definitions are needed for "medical and healthcare providers" as stated in Section 6001 (b)[1]. We recommend you use the definition of health care provider defined in the HITECH Act (now Title XXX of the PHS Act) Section 3000 (3) " Health Care Provider".

We anticipate that health IT infrastructure spending under ARRA to advance the wiring of health care providers will be allocated in part to states and regional extension centers. States or state-designated entities that qualify for and are awarded grants for health IT (as specified under Section 3013) will be developing statewide plans for health information sharing which should be informed by a map of broadband service capability and availability across a given state. Regional extension centers will be providing technical assistance to providers who adopt electronic health records and share health information. To support their efforts, we request the NTIA's ARRA-required nationwide inventory map of existing broadband service capability and availability include the following medical/healthcare entities:

- Hospitals
- Medical and health care providers in unserved and underserved areas [2]
- Long-term care facilities
- Community health centers [3]
- State Public Health Departments including all satellite offices

We request the following be included in NTIA and USDA funding eligibility criteria/application review criteria.

- The number of medical/healthcare providers that currently use or plan to use electronic health records (EHRs) certified by an organization recognized by the Secretary of the U.S. Department of Health and Human Services.

- If the geographic region includes local or satellite state health department offices, then the names and exact geographic locations of such offices and a commitment to provide broadband connectivity to them.

- How applicants will coordinate broadband access with State agencies and/or State-designated entities as defined under ARRA Section 3013 that are awarded State grants to promote health information exchange and health IT.

- Description of statewide coordination for exchanging health information across medical providers, health care providers and public health entities that takes into account broadband access.

We request the funding notices require grantees provide the following quarterly reports:

- Number and locations of all medical and health care providers that have access to broadband, including broadband capacity and speed.

- Number and locations of all public health department offices, including satellite offices that have access to broadband, including broadband capacity and speed.

---

[1] Section 6001(b) states that the purposes of the program are to—

    (1) Provide access to broadband service to consumers residing in unserved areas of the United States;

    (2) provide improved access to broadband service to consumers residing in underserved areas of the United States;

    (3) provide broadband education, awareness, training, access, equipment, and support to—

        (A) Schools, libraries, medical and healthcare providers, community colleges, and other institutions of higher education, and other community support organizations and entities to

        facilitate greater use of broadband service by or through these organizations;

[2] H.R. Rep. No. 111-16, at 776 (2009) (Conf. Rep.)

[3] Health Centers are community-based and patient-directed organizations that serve people with limited access to health care. These include low-income patients, the uninsured, those with limited English proficiency, migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing. See web site of the HHS Health Resources and Services Administration at http://www.hrsa.gov/about/factsheets/bphc.htm

Department of Health & Human Services
Office of the National Coordinator for
Health Information Technology

# The ONC-Coordinated
# Federal Health Information Technology
# Strategic Plan:  2008-2012

# SYNOPSIS

**June 3, 2008**

# The ONC-Coordinated
# Federal Health Information Technology
# Strategic Plan:  2008-2012

## *Using the Power of Information Technology to Transform Health and Care*

## Table of Contents

## About the Office of the National Coordinator
## for Health Information Technology

On April 27, 2004, President Bush issued Executive Order (EO) 13335 "to provide leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care," establishing the position of a National Coordinator for Health Information Technology (IT) within the Office of the Secretary of Health and Human Services. Acknowledging the role of multiple executive branch agencies in addressing the vision of this nationwide architecture, the National Coordinator was charged with ensuring coordination of federal health IT policies and programs and of relevant executive branch agency outreach and consultation with public and private entities.  Thus, the National Coordinator provides the leadership necessary to support national progression to a health IT architecture envisioned to:

- Ensure that appropriate information to guide medical decisions is available at the time and place of care;
- Improve health care quality, reduce medical errors, and advance the delivery of appropriate, evidence-based medical care;
- Reduce health care costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information;
- Promote a more effective marketplace, greater competition, and increased choice through the wider availability of accurate information on health care costs, quality, and outcomes;
- Improve the coordination of care and information among hospitals, laboratories, physician offices, and other ambulatory care providers through an effective architecture for the secure and authorized exchange of health care information; and
- Ensure that patients' individually identifiable health information is secure, protected, and available to the patient to be used for non-medical purposes, as directed by the patient.

The Office of the National Coordinator for Health IT (ONC), since 2004, continues to advance the national health IT agenda to achieve President Bush's target for the majority of Americans to have access to electronic health records (EHRs) by 2014.

# Message from the National Coordinator for Health Information Technology

Looking toward the future, we can envision a health care system that is centered on each and every individual patient. Clinicians will have at their fingertips all of the information needed to provide the best care; individuals will have access to this and other information that can help them engage and insert their values in the decision-making process about their health and care; and, secure and authorized access to health data will provide new ways that biomedical research and public health can improve individual health, and the health of communities and the Nation.

Underpinning that system is the ability for patients and providers to electronically share accurate health care information securely while protecting patient privacy. This concept of a connected system of information is referenced as the interoperable health IT architecture and is characterized by widespread use of electronic health records (EHRs) and health information exchange everywhere.

In order to reach the goal of most Americans having access to EHRs by 2014, adoption of interoperable health IT systems needs to remain at the forefront of national priorities.

The Department of Health and Human Services (HHS) has made significant progress in building the foundation for this interoperable health IT architecture – the Nationwide Health Information Network – over the past four years. We must, however, maintain momentum and demonstrate to the general public the value of this work.

The ONC-Coordinated Federal Health Information Technology Strategic Plan (the Plan) sets forth a number of goals, objectives, and strategies that, for the first time, brings together all federal efforts in health IT in a coordinated fashion. It will guide the advancement of health IT throughout the federal government for the next five years.

I would like to personally thank ONC and ONC's many partners in federal service who contributed to the development of this Plan. Together with our colleagues in the private sector, we will assure that health IT can enable patient-focused health care and improve population health. In doing so, we will be using the power of IT to transform health and care.

Robert M. Kolodner, MD
National Coordinator for
Health Information Technology

## Goals and Organization of the Plan

The Plan has two goals, Patient-focused Health Care and Population Health, which are defined as follows:

*Patient-focused Health Care:* Enable the transformation to higher quality, more cost-efficient, patient-focused health care through electronic health information access and use by care providers, and by patients and their designees.

*Population Health:* Enable the appropriate, authorized, and timely access and use of electronic health information to benefit public health, biomedical research, quality improvement, and emergency preparedness.

Each goal has four objectives and the ***themes of privacy and security, interoperability, adoption, and collaborative governance*** recur across the goals, but they apply in very different ways to health care and population health. The goals, as they are organized around the core themes, are summarized below:
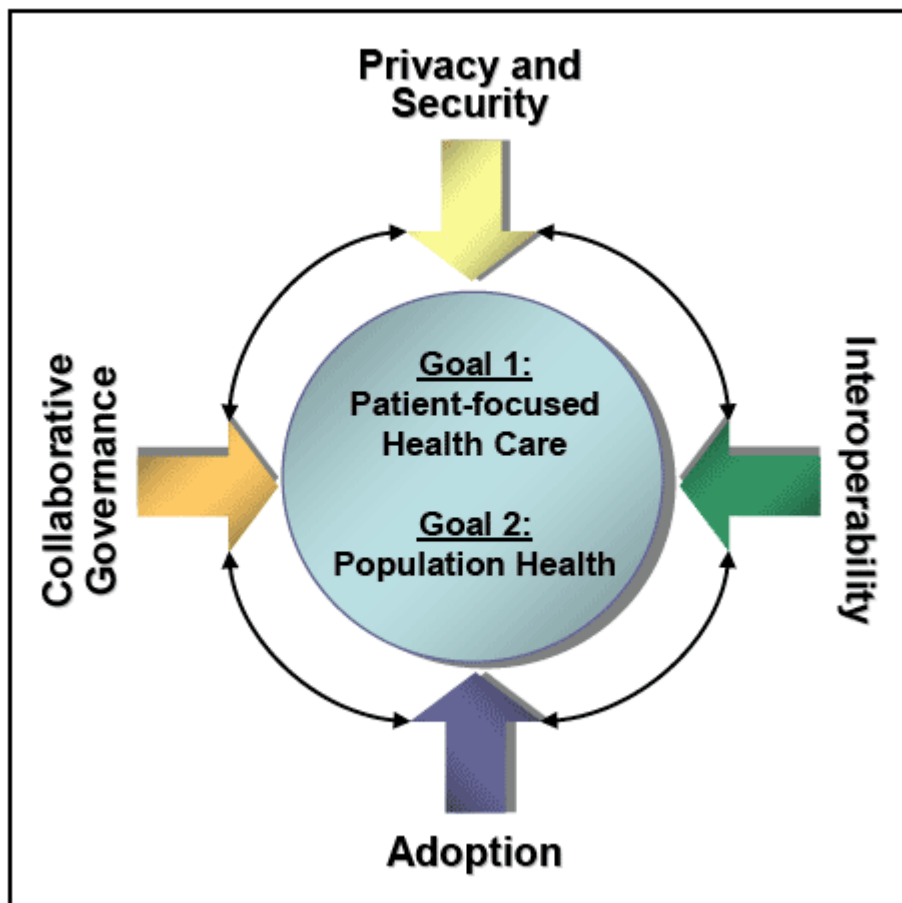
The Plan articulates strategies that describe the work needed to achieve each objective. As a group, the strategies are characterized by:

- Commitment to the engagement of multiple stakeholders across the public and private sectors;
- Concern for reliability, confidentiality, privacy, and security when exchanging, storing, and using electronic health information; and
- Focus on the consumer of health care as a critical participant in achieving the two overarching goals of the Plan.

The goals, objectives, and strategies of the Plan portray the totality of what must be done, *in a coordinated manner distributed across the federal government*, to achieve an interoperable health IT architecture for the nation in support of patient-focused health care and population health. To emphasize the collaborative nature of this initiative, a major component of the Plan is a compilation of relevant federal agency projects, as well as partnerships between those federal agencies and other stakeholders, that are already underway in pursuit of one or more of the specific objectives.

In developing the Plan, ONC worked with other federal agencies to solicit input and assure that the full breadth of federal activity was reflected. ONC will periodically update the Plan and actively engage other federal agencies in re-evaluating the strategic objectives and strategies, and in tracking progress toward these goals and objectives. Health IT has and will continue to rapidly evolve, and the federal government will need to remain flexible with its strategies to move forward in this changing environment.

A summary of the strategic goals and objectives is provided in Table A. Charts 1 through 4 address the key strategies and timeframes for each objective.

**TABLE A: Summary of Health IT Strategic Goals and Objectives: 2008-2012**

| | Privacy and Security | Interoperability | Adoption | Collaborative Governance |
|---|---|---|---|---|
| **Goal 1. Patient-focused Health Care** | **Objective 1.1:** Facilitate electronic exchange, access, and use of electronic health information, while protecting the privacy and security of patients' health information. | **Objective 1.2:** Enable the movement of electronic health information to support patients' health and care needs. | **Objective 1.3:** Promote nationwide deployment of electronic health records (EHRs) and personal health records (PHRs) and other consumer health IT tools. | **Objective 1.4:** Establish mechanisms for multi-stakeholder priority-setting and decision-making. |
| **Goal 2. Population Health** | **Objective 2.1:** Advance privacy and security policies, principles, procedures, and protections for information access in population health. | **Objective 2.2:** Enable exchange of health information to support population-oriented uses. | **Objective 2.3:** Promote nationwide adoption of technologies to improve population and individual health. | **Objective 2.4:** Establish coordinated organizational processes supporting information use for population health. |

## Privacy and Security

The success of a nationwide, interoperable health IT architecture in the United States will require a high degree of public confidence and trust. Health information exchange must maintain privacy and security.

**Chart 1 – Privacy and Security**

| Privacy and Security | | | | | | |
|---|---|---|---|---|---|---|
| **Goal 1: Patient-focused Health Care** | | | | | | |
| | Strategies | 2008 | 2009 | 2010 | 2011 | 2012 |
| *Objective 1.1 – Facilitate electronic exchange, access, and use of electronic health information, while protecting the privacy and security of patients' health information.* | 1.1.1: Develop a confidentiality, privacy, and security framework. | ▓ | | | | |
| | 1.1.2: Identify best practices to ensure confidentiality, integrity, and availability of information. | ▓ | ▓ | ▓ | | |
| | 1.1.3: Facilitate state-based efforts for protected exchange of health information. | ▓ | ▓ | | | |
| | 1.1.4: Increase stakeholder trust of health IT through education. | ▓ | ▓ | | | |
| | 1.1.5: Address apparently inconsistent statutes and regulations for exchange of electronic health information. | ▓ | ▓ | ▓ | ▓ | |
| **Goal 2: Population Health** | | | | | | |
| *Objective 2.1 – Advance privacy and security policies, principles, procedures, and protections for information access in population health.* | 2.1.1: Employ the privacy and security framework for population health information. | ▓ | | | | |
| | 2.1.2: Address apparently inconsistent statutes or regulations for exchange of population health information. | ▓ | ▓ | ▓ | ▓ | |
| | 2.1.3: Facilitate state-based efforts for protected exchange of population health information. | ▓ | ▓ | ▓ | ▓ | |
| | 2.1.4: Increase stakeholder understanding of current federal privacy and security laws. | ▓ | ▓ | ▓ | ▓ | |

## Interoperability

To effectively exchange health information, health IT systems and products must use consistent, specific data and technical standards.

**Chart 2 – Interoperability**

| Interoperability | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Goal 1: Patient-focused Health Care** | | | | | | | |
| | **Strategies** | **2008** | **2009** | **2010** | **2011** | **2012** | |
| Objective 1.2 – Enable the movement of electronic health information to support patients' health and care needs. | 1.2.1: Advance use of specified data and technical standards for interoperability. | ██ | ██ | | | | |
| | 1.2.2: Identify core capabilities for networks to exchange health information. | ██ | ██ | | | | |
| | 1.2.3: Foster the business case for exchange of health information. | ██ | ██ | | | | |
| | 1.2.4: Increase the volume of standardized exchange of health information to enhance its value. | ██ | ██ | ██ | | | |
| | 1.2.5: Promote processes for testing implementation of recognized standards and policies. | ██ | ██ | ██ | | | |
| | 1.2.6: Encourage provision of electronic personal health information in standardized form. | ██ | ██ | ██ | ██ | ██ | |
| | 1.2.7: Increase the number of competitive health information service providers. | ██ | ██ | ██ | ██ | ██ | |
| | 1.2.8 Use standards to empower use of health information beyond direct patient care delivery. | ██ | ██ | | | | |
| **Goal 2: Population Health** | | | | | | | |
| Objective 2.2 – Enable exchange of health information to support population-oriented uses. | 2.2.1: Advance standards to support the merging of comparable population health information. | ██ | ██ | | | | |
| | 2.2.2: Enable flexible models for exchange of population health information. | ██ | ██ | | | | |
| | 2.2.3: Assess providers' and networks' implementation of standards. | ██ | ██ | ██ | | | |
| | 2.2.4: Promote availability of population health information in electronic form. | ██ | ██ | ██ | | | |
| | 2.2.5: Provide population health information needed for emergency response. | ██ | ██ | ██ | | | |

## Adoption

Standards and policies that will enable the widespread adoption and ongoing use of health IT must be developed.  The widespread use of health IT will allow patients to receive better health and personalized care.

**Chart 3 - Adoption**

| Adoption | | | | | | |
|---|---|---|---|---|---|---|
| **Goal 1: Patient-focused Health Care** | | | | | | |
| | **Strategies** | **2008** | **2009** | **2010** | **2011** | **2012** |
| Objective 1.3 – Promote nationwide deployment of electronic health records (EHRs) and personal health records (PHRs) and other consumer health IT tools. | 1.3.1: Remove business obstacles for provider use of EHRs. | ██ | ██ | ██ | | |
| | 1.3.2: Make EHRs easy to buy and implement. | ██ | ██ | | | |
| | 1.3.3: Increase value of EHRs through technology. | ██ | ██ | ██ | | |
| | 1.3.4: Promote certified health IT products as essential to clinical care. | ██ | ██ | ██ | | |
| | 1.3.5: Develop the workforce for health IT product development and use. | ██ | ██ | ██ | | |
| | 1.3.6: Identify ways for PHRs to link to useful health and care applications. | ██ | ██ | | | |
| | 1.3.7: Advance PHR and consumer health IT tools. | ██ | ██ | ██ | | |
| | 1.3.8: Minimize provider liability when using health IT. | ██ | ██ | ██ | ██ | |
| | 1.3.9: Remove barriers to treating patients outside of provider offices. | ██ | ██ | ██ | ██ | ██ |
| **Goal 2: Population Health** | | | | | | |
| Objective 2.3 – Promote nationwide adoption of technologies to improve population and individual health. | 2.3.1: Optimize exchange of EHR and population health information among users. | ██ | ██ | ██ | ██ | ██ |
| | 2.3.2: Minimize provider burden for population health reporting. | ██ | ██ | ██ | ██ | ██ |
| | 2.3.3: Electronic exchange of population health data among various stakeholders. | ██ | ██ | ██ | ██ | ██ |

## Collaborative Governance

It is essential that collaborative governance occurs across the public and private sectors and involves all individuals and organizations with a stake in health-related activities.

**Chart 4 – Collaborative Governance**

| Collaborative Governance | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Goal 1: Patient-focused Health Care** | | | | | | | |
| | **Strategies** | **2008** | **2009** | **2010** | **2011** | **2012** | |
| Objective 1.4 – Establish mechanisms for multi-stakeholder priority-setting and decision-making. | 1.4.1: Establish an entity to advance nationwide exchange of health information. | ███ | ███ | | | | |
| | 1.4.2: Assure consumer representation in stakeholder governance. | ███ | ███ | ███ | ███ | | |
| | 1.4.3: Promote active and appropriate participation by all relevant government agencies in multi-stakeholder governance entity activities. | ███ | ███ | ███ | ███ | | |
| **Goal 2: Population Health** | | | | | | | |
| Objective 2.4 – Establish coordinated organizational processes supporting information use for population health. | 2.4.1: Advance data stewardship models for exchange of population health information. | ███ | ███ | ███ | | | |
| | 2.4.2: Implement quality measures in ways compatible with different models for exchange of health information. | ███ | ███ | ███ | ███ | ███ | |
| | 2.4.3: Connect clinical care and public health through exchange of electronic health information. | ███ | ███ | ███ | | | |
| | 2.4.4: Connect clinical care and research through exchange of electronic health information. | ███ | ███ | ███ | | | |
| | 2.4.5: Create accountability for implementing exchange of electronic health information. | ███ | ███ | ███ | ███ | | |
| | 2.4.6: Develop, implement, and oversee health data sharing strategy across federal agencies. | ███ | ███ | ███ | ███ | ███ | |

**How Health Information Technology Can Help Transform Health and Care: Defining Success**

Over time, as information begins to move among EHRs and PHRs, individuals will connect with their clinicians, clinicians will connect with other care providers, and health-related communities will connect with each other to enable the improvements in health and care that everyone wants. As these connections are made, the Nationwide Health Information Network, or NHIN, will evolve fully and provide communities across the entire nation with the ability to securely exchange electronic health information.
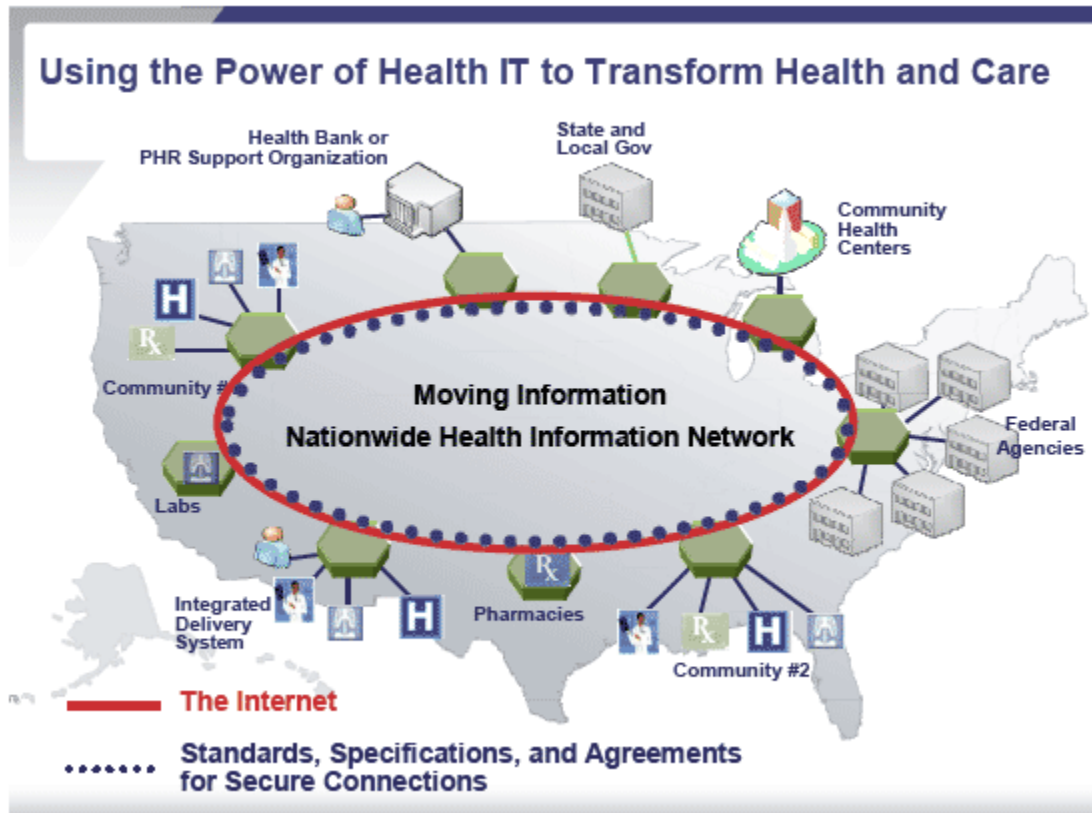


Ultimately, we will know we have achieved success when:
- Health IT becomes common and expected in health care delivery nationwide for all communities, including those caring for underserved or disadvantaged populations;
- Your health information is available to you and those caring for you so that you receive safe, high quality, and efficient care;
- You will be able to use information to better determine what choices are right for you with respect to your health and care; and
- You trust your health information can be used, in a secure environment, without compromising your privacy, to assess and improve the health in your community, measure and make available the quality of care being provided, and support advances in medical knowledge through research.

EHRs and PHRs will be the key technologies over the next several years to enable this transformation in health and care. The outcomes anticipated as a part of the health IT architecture will allow authorized access to comprehensive individual health information for patient care, consumer self-management of health, and a wide range of research, quality, emergency response, and public health initiatives. Beyond these health IT tools, the health IT architecture requires health information exchange networks to support secure and reliable information exchange within and across communities. Both the tools and the network must use recognized interoperability standards to make this work.

## Health Information Technology as a Top Federal Priority: Work to Date

Today, many of the critical pieces are in place to realize the goals of the Plan, but there is still a great deal of work ahead in order to achieve full success. We, the federal government, working with state and local governments and the private sector, have established the critical processes – the foundation for successful health IT – to move the Nation towards an interoperable health IT architecture. This architecture will be supported by federal efforts which will guide interoperability, adoption, and collaborative governance for the exchange of electronic health information, and ensure the privacy and security of health information. Critical activities already underway include, but are not limited to:

- *Privacy and Security:* We are working at the federal level to promote a collaborative approach to crafting solutions that maintain the privacy and security of patient information while enabling appropriate exchange, access, and use of electronic health information. Only when individuals trust that there are security mechanisms in place and the privacy of their data is at all times respected and protected, will they allow their data to be shared. We are also working at the state level to encourage and facilitate the secure exchange of electronic health information which protects individuals' privacy.

- *Interoperability:* We are recognizing interoperability standards at the federal level so information exchange through the use of EHRs and EHR-to-PHR information exchange can happen reliably and securely. We are advancing the use, by federal agencies and their contractors, of health IT systems and products that meet recognized interoperability standards. We are also working to connect various health information exchange organizations through the NHIN to start sharing data with each other.

- *Adoption:* We are supporting a process for certifying EHRs to assure that they meet specific criteria for critical functions and security, and ultimately incorporate the federally recognized standards to achieve interoperability. We are also working on other approaches to increase adoption and use of health IT, such as incentives for use of EHRs to improve the quality of care.

- *Collaborative Governance:* We established a federal advisory committee which includes members of both the public and private sectors, to recommend priorities necessary to accelerate the advancement of health IT. We are assisting in the establishment of a new public-private entity, to have broad based participation from

the public and private sectors that will continue to advance the use of common standards and policies and will provide a governance structure for health IT.

## Accelerating the Momentum: Achieving the Tipping Point

Malcolm Gladwell, renowned author of *The Tipping Point*, explained the tipping point as the "level for which the momentum for change becomes unstoppable." As with any new technology, truly widespread use of health IT will not occur immediately. Adoption of health IT among physicians is slowly rising – from 10 percent in 2005 to 14 percent in 2007. In 2009, the first set of health information exchanges will share real data, in real time, through the NHIN. As all of the health IT initiatives that are underway grow and continue to produce results, there will be a shift in how individuals interact with the health care system.

The processes currently underway will enable the technology – products and networks – to advance far enough to make the vision of a nationwide health IT architecture a reality. However, this effort is not just about technology. It is about a change in the way the nation views health and care. We envision that our current activities will begin to create this change:

- As information moves securely through the NHIN, individuals will gain the necessary trust to allow their data to be shared;
- Sufficient numbers of recognized standards will exist to cover basic health information exchange needs;
- Certified products will be available so providers can make purchases with confidence; and
- Appropriate governance will be in place to ensure that all stakeholders have a voice in how the nation moves forward with health IT.

Individuals will begin to expect that interoperable health IT will be used to manage their health and care, and providers will begin to view health IT as essential to what they do.

## Moving Towards Health Information Technology: Anywhere, Anytime

Significant work is underway in the public and private sectors to advance interoperable health IT. The completed Plan brings together, for the first time, the catalog of current federal activities focused on health IT and a strategy for moving forward. These numerous efforts, along with those of the private sector, must continue and must be coordinated for the nation to accelerate the use of interoperable health IT and achieve the goals for patient-focused health care and population health. As the health IT architecture takes shape, the movement of data, with appropriate safeguards and privacy protections, will enable improvements in quality of care, increased access to information for better care management, and added opportunities to advance population health – community by community.

The nation will approach the tipping point during the timeframe of this Plan. While continuing work will be needed to fully embrace health IT throughout the United States,

the nation will see a rapid acceleration in the use of interoperable health IT and, in time, individuals will have access to their health information – anywhere, anytime.

# A Strategic Plan for Health Information Technology and Exchange

# Table of Contents

# Executive Summary

The acquisition and deployment of Health Information Technology (HIT) and Health Information Exchange (HIE) throughout the healthcare system(s) in New Hampshire offers a unique opportunity to make substantial progress in improving the health of our citizens. **The direct benefits include: improved patient safety and healthcare quality, enhanced public health, healthcare cost reduction, access to care, and consumer engagement and empowerment.** It is vitally important that the State of New Hampshire have a strategic vision for both the implementation of information technology and a system of connectivity that will provide for the free exchange of information among providers throughout the state. HIT and HIE is a core pillar of our healthcare system.

The purpose of this document is to develop a roadmap for both the industry and public policy makers to achieve a fully deployed and integrated system of HIT and HIE. The genesis of this report is a Vision and Principals Statement that was developed by the New Hampshire Citizens Health Initiative and adopted in 2007 (**Appendix B**). The HIT and HIE Working Group re-affirmed this Vision and Principals Statement, and the Vision Statement below forms the basis of the Working Group's proceedings:

## *Vision Statement*

*Private and Secure. A patient's personal health information will be secure, private and accessed by healthcare providers only with patient consent or as otherwise authorized by law.*

*Promotes Quality, Safety and Efficiency. HIT and HIE will serve as vehicles to promote quality, enhance patient safety, increase efficiencies in healthcare delivery, expand access and improve public health.*

*Electronic. All healthcare providers will use a secure, electronic record to store and access patients' personal health information.*

*Patient Accessible and Portable. All patients will have access to a secure, electronic and portable health record.*

*Equitable. HIT and HIE will be a vehicle to support equitable access to healthcare services through out the state.*

To achieve the vision of a transformed healthcare system with easy access to important clinical information, the HIT and HIE Working Group has identified five core strategies:

1. **Ensure that all providers of healthcare have access to electronic tools, irrespective of organizational size, financial capacity, or location.** Computerization of health records often referred to as electronic medical records (EMRs) has come slowly to the healthcare industry. However, most practitioners have adopted some forms of computerization. It is essential that all providers from the largest integrated hospital and physician systems to private practitioners, community health centers, nursing homes, and home health and hospice agencies adopt, acquire, and implement electronic medical records into their operations. This will allow for the eventual sharing of clinical information across the healthcare system and with patients and their families.

2. **Promote information exchange that enables healthcare providers to access and exchange clinical information and data across geographic and organizational boundaries.** The use of electronic tools and storage of patient data in an electronic file is valuable to clinicians only if the data is meaningful, easily retrievable at the point of care, can be provided by all entities generating the data, and can be shared with clinicians and consumers. Too often, clinicians operate within information silos using systems that include only their own patient data. It is essential that a system (or systems) of interconnectivity be efficiently deployed in an interoperable manner to provide information no matter where the patient seeks care.

3. **Develop a framework for engaging and empowering patients to access their health records and participate in their health management.** Computerization of electronic health records provides an important opportunity to engage patients more actively in the management of their health. There is a world of medical information available to consumers on the internet, yet few New Hampshire residents have direct electronic access to their own electronic health records. Technology exists that provides a way for patients to have access to their personal health records (PHRs). Engaging consumers in the maintenance and management of their health is a transformational opportunity to enhance patient/provider communication, improve outcomes, more closely monitor care, enhance consumer responsibility for their care, and improve efficiency of the delivery system.

4. **Support a privacy standard that protects patient health information while identifying and promoting the benefits of sharing clinical information between healthcare providers.** Protecting patient privacy and maintaining the public trust is a critical element to the successful deployment and optimal utilization of an electronic records system and the appropriate exchange of patient data. This protection must be balanced with enabling the transfer of clinical information in order to improve clinical quality and patient outcomes. Both provider and patient education efforts must take place in order to complete the privacy picture.

5. **Create a sustainable state-level entity to convene stakeholders, coordinate planning, monitor progress and report annually to the Governor, Legislature and the healthcare industry on the advancements of these initiatives.** To achieve the goals articulated in this report it is essential to establish a clearly recognized convening and coordinating structure. This structure will provide the leadership to achieve the goals and will require an annual monitoring and reporting of progress. This function should be a shared public/private undertaking that assures balanced input from all stakeholders.

While significant investments have already been made in the acquisition and deployment of health information technology, there is significant variation in the financial and technological capacity of various provider systems to achieve these goals. In general, large hospital systems, hospital-owned physician networks, and community health centers have the critical mass to successfully deploy the technology. Critical access hospitals, small or independent physician practices and post-acute healthcare providers (nursing homes, home health and hospice health agencies) are often disadvantaged in implementing these core strategies by their size, financial capacity, and access to both IT resources and financial capital.

There is significant opportunity for the state, the private sector, employers, consumers, and other stakeholders to work together to ensure full deployment of HIT and HIE in the coming years. The remainder of this document spells out the opportunities for New Hampshire, provides an overview of activities outside our borders, and identifies specific action plans, policy recommendations, and details of a proposed Successor Group.

# OPPORTUNITY STATEMENT FOR NEW HAMPSHIRE

At its core, HIT and HIE efforts are about providing New Hampshire's citizens with a safe, high quality, cost-effective, and consumer-friendly healthcare system. The potential benefits of HIT and HIE to both consumers and the healthcare system as a whole presents a compelling list of reasons for a coordinated, focused, public/private initiative that will organize and prioritize steps to achieving this vision and provide for maximum utilization of limited financial resources:

- **Patient Safety and Healthcare Quality:** According to the Institute of Medicine, more than 100,000 deaths occur in this country annually due to medical error. Countless others occur that do not result in deaths. These errors are often the result of inadequate information available to the clinician, such as medication history. Additionally, higher quality patient care is possible through adherence to scientifically proven treatment protocols and guidelines. Information technology deployment is essential for the efficient management of this information and operational processes.

- **Public Health:** There are significant benefits to population health through integration of clinical information systems with public health information systems. Efforts such as syndromic surveillance, epidemiological studies, and determination of populations who require or would benefit from public health programs can be supported by HIT and HIE.

- **Healthcare Cost Reduction:** One of the key drivers for investment in HIT and HIE is to assist in reducing healthcare costs, primarily via increasing operating efficiencies and reducing duplication. The elimination of paper records and files, ending manual transmission of prescriptions, enhancing access to patient demographic and health coverage information, and transmission of lab results, problem lists, and radiology results electronically can all increase operating efficiencies as well as improve care. The availability of clinical information at the point of care can reduce the need for re-ordering tests and procedures which increase the cost of care.

- **Access to Care:** Technologies such as telehealth/telemedicine have the power to provide care to populations where specific medical services are unavailable. Currently, home health, radiology, dermatology, and behavioral health services are being provided through the use of these technologies to some communities in New Hampshire. With improvement in telecommunications infrastructure and appropriate reimbursement, these technologies will continue to proliferate.

- **Consumer Engagement and Empowerment:** There is much discussion about the "engaged healthcare consumer". In order to become engaged, the consumer needs access to cost, quality, and clinical information. This may be via a patient portal to their electronic health record, or via information delivered by a health plan or the New Hampshire Department of Health and Human Services.

Payment reform, quality and outcomes reporting, patient centered medical homes, disease registries, improved care management, telehealth, health system transparency, and public health disease surveillance are all examples of efforts that are dependent on all healthcare providers having access to technology across the continuum of care delivery. Without HIT and HIE investment, the potential of these efforts will not be fully realized.

While the healthcare industry as a whole has made significant investments in technology for diagnostic, clinical and treatment purposes, it has been relatively slow to adopt health information technology and health information exchange as a health management tool. It has only been in the last decade that substantial investments have been made for the adoption and deployment of electronic medical records.

The integration of these records into the operational environment and work flow of physician offices and hospital systems is a time consuming and challenging undertaking which requires investment of human and financial resources. The connecting of these isolated silos of data into a coherent system of data exchange within existing organizational structures has begun in the past five years. Transporting this data across organizational and geographic boundaries is at an early stage of development in many parts of the state.

Many of New Hampshire's healthcare providers, across a broad spectrum of care delivery, have made significant investment in HIT. These investments serve a foundational and vital role in the state's efforts to increase HIT adoption, and ultimately to achieve advanced levels of HIE.

# The Case for HIT and HIE Investment

HIT and HIE has the promise of addressing multiple issues within New Hampshire's healthcare landscape:

- **Technology Adoption:** Increasingly, New Hampshire is moving to a system of haves and have-nots with regard to the purchase and implementation of HIT. The larger, integrated delivery systems, multi-specialty practices, and community health centers have the critical mass needed to purchase, implement, and maintain EMR and ePrescribing platforms. Many other providers have also made investments in home health monitoring technology and other forms of telehealth. Smaller private practices (less than five clinicians) are having a more difficult time choosing, implementing, and paying for systems as technology purchasing is not their core business and the systems are expensive. There is a significant opportunity for HIT adoption in nursing homes, home care, specialty practices, community behavioral health centers, and other care settings not covered through integrated delivery systems, multi-specialty practices, and community health centers. It should be recognized that simply having limited technology, such as EMR, is not sufficient. It must be implemented with functionality and interoperability that is consistent across provider entities.

- **Internal HIE:** There is much HIE work to be done by our hospital institutions to integrate internal operating and clinical systems. An example of internal HIE is the integration of a hospital's inpatient clinical system with their outpatient EMR platform. Additional HIE may need to occur with other platforms such as lab and PACS (radiology) systems. In contrast, some multi-specialty practices and all of New Hampshire's community health centers have implemented their core EMR and billing systems and are now ready to work on HIE within and across communities.

- **Patient Mobility:** Based upon data from the New Hampshire Comprehensive Healthcare Information System (NHCHIS), it is evident that New Hampshire patients move freely across state borders as well as across communities within the state (**Appendix C**)—17% of care to New Hampshire residents is delivered outside of New Hampshire while between 29% and 69% of the residents in New Hampshire communities leave their community for care. Additionally, some New Hampshire healthcare organizations serve significant numbers of out-of-state residents which require coordination with out-of-state providers. This movement necessitates solutions for improved information flow across care communities and across borders so that a patient's full medical record can accompany the patient within the marketplace. This is consistent with work occurring at the federal level surrounding the development of state-level HIEs and the Nationwide Health Information Network (NHIN). This issue could also be addressed through a state-level patient portal strategy.

- **Equitable Distribution of Resources:** As articulated by the New Hampshire Telehealth Program, there is significant opportunity in New Hampshire to further advance the deployment of telehealth technologies (video conferencing, home health monitoring, store and forward technologies, etc.). However, adequate and dependable reimbursement from payers is an issue and needs resolution. The deployment of telehealth technologies will not only improve quality of medical care delivered to New Hampshire's rural areas, but will also improve the distribution of scarce resources (ie, child psychiatry, dermatology) to these areas (**Appendix D**).

- **Public Health Systems:** The New Hampshire Department of Public Health (DPH) has multiple IT systems that require updating and consolidating per their recent Centers for Disease Control (CDC) Public Health Information Network (PHIN) analysis conducted by an outside firm (**Appendix E**). There is a distinct opportunity for New Hampshire's DPH to expand their existing HIE platform to address these issues.

It is important to note that New Hampshire, as a whole, has made significant strides in adoption of HIT. However, there is wide variation in the level of investment and rate of adoption based upon organizational size, human and financial resources, access to capital and geographic location. This gap between the "haves and the have nots" needs to be closed to assure equal access for all New Hampshire residents to an optimal system of care.

There are market *and* policy actions that can be taken to support and complement current hospital and community investments in HIT. Policy actions may include legislative actions, Executive Orders, purchasing practices for state and local employee health benefit plans, and Medicaid reimbursement and medical management policies.

It is essential that a concept for statewide HIE functionality be developed to provide for the interconnectivity of disparate HIT systems. Although many hospitals and physicians currently exchange necessary patient information, there is no effort or coordinated approach underway to develop and implement a statewide network. There is significant activity centered on the development of local (hospital centric) Network Neighborhoods. A Network Neighborhood is a set of local healthcare provider entities (usually grouped around a hospital system) with electronic linkages that tie internal and external information flows together. *Figure 1* provides an example of such a network.

These community-specific Network Neighborhoods may be linked together in order to form regional or state-wide HIEs. *Figure 2* depicts not just the linking of the various community Network Neighborhoods, but also ties into non-clinical functions such as public health, insurers, and consumers. These are all important stakeholders in the HIE vision for the state.

While recognizing the importance of HIE to New Hampshire, the HIT and HIE Working Group did not achieve consensus on the form and structure of an HIE function that would serve the entire state. The Working Group discussed two primary options for HIE. The first being a state-level entity and the second being interlinked Network Neighborhoods. Both options will ultimately allow for state-level interconnectivity, but the latter more readily recognizes the investments made by local care providers to date. Whether initially state-level or not, successful HIE requires many things to be successful: a high level of participation by providers, privacy and interoperability standards, sufficient capital for infrastructure development and sustainability, the development and maintenance of a patient and provider record locator service, and adoption of a governance structure to support the operations.

It is important to recognize that if multiple HIE efforts are undertaken, they will need to have the capability to link together in order to benefit all geographic areas of New Hampshire as well as to be coordinated with the Nationwide Health Information Network (NHIN) efforts. While New Hampshire is not currently bound to federal mandates regarding HIE, it would be prudent for New Hampshire to make investments that align strategically with the federal vision. It is also anticipated that additional federal funding may be available in future years, depending on the resolution of the current and near term federal fiscal crises.

The Working Group has identified many promising areas of opportunity where HIE pilots could be created. These pilots might eventually lead to the formation of an HIE entity serving the entire state if the pilot initiatives are harmonized. These pilots are discussed in the Action Plan on pages 10 and 11.

*Figure 1*



*Figure 2*
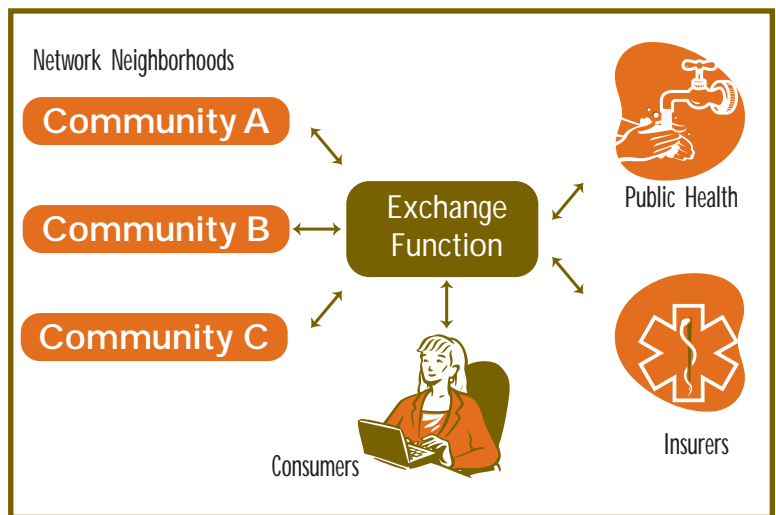
# The Current Landscape: Federal, Regional, Local

The advancement of health information technology (HIT) in the past decade has been significant. More Americans now have access to providers that use electronic medical records, electronic prescriptions, telehealth, and electronic exchange of information, which in turn is helping to improve clinical quality, reduce costs, and improve access.

At the same time, many providers and healthcare stakeholders are struggling to provide the capital needed for investment in HIT. The federal vision to create a system of interconnected HIEs is impeded by a lack of start-up capital, fiscal sustainability, privacy and security standards, and technical standards.

The current landscape has multiple areas of opportunity and significance that relate directly to this document. There are efforts being undertaken at the federal, regional, and state level that are directly related to, and in support of, one another.

## At the federal/national level

There are many initiatives currently operating at the federal level in support of HIT and HIE activities. New Hampshire has participated in some of these activities and will likely participate in future ones either as a result of federal mandates or as opportunities naturally align. This is not a full list of all federal HIT and HIE activities, but comprises those of significance to New Hampshire:

- The U.S. Department of Health and Human Services created the Office of the National Coordinator (ONC) in 2004. ONC is tasked with developing the standards for functionality and interoperability of information technologies that support the federal vision for an interconnected Nationwide Health Information Network (NHIN). These standards include business processes, electronic medical record certification, health data exchange interoperability, and privacy and security (ie, CCHIT, HITSP, AHIC, HISPC). It is expected that the incoming White House administration will continue to support these efforts.

- In June, 2008, the ONC released the first federal Strategic Plan for HIT and HIE entitled "The ONC-Coordinated Federal Health Information Technology Strategic Plan 2008-2012" (Appendix F). The high level ONC framework is provided in Figure 3. Sustainability of these efforts is implied, although not reflected by the diagram. In December 2008, ONC released a privacy and security framework document and the US Department of Health and Human Services released HIPAA privacy rules guidelines.

*Figure 3*



- Both the Institute of Medicine and U.S. Health and Human Services Office of the National Coordinator have stated that for healthcare quality to improve, investments must be made in efforts that will bring the population (public) health system and the personal care (medical) system together. To that end, ONC states that HIT and HIE is one vehicle to accomplish this.

- The Public Health Information Network (PHIN) is a national initiative of the US Centers for Disease Control to improve the capacity of public health agencies to use and exchange information electronically by promoting the use of standard messaging formats and vocabularies as well as by defining technical requirements. The standards and technical requirements are determined by adopting existing best practices (i.e., HL-7 messaging) related to efficient, effective, and interoperable public health information systems that support both routine public health activities and emergency preparedness and response. The CDC serves as the facilitator of the PHIN community and the steward for PHIN resources.
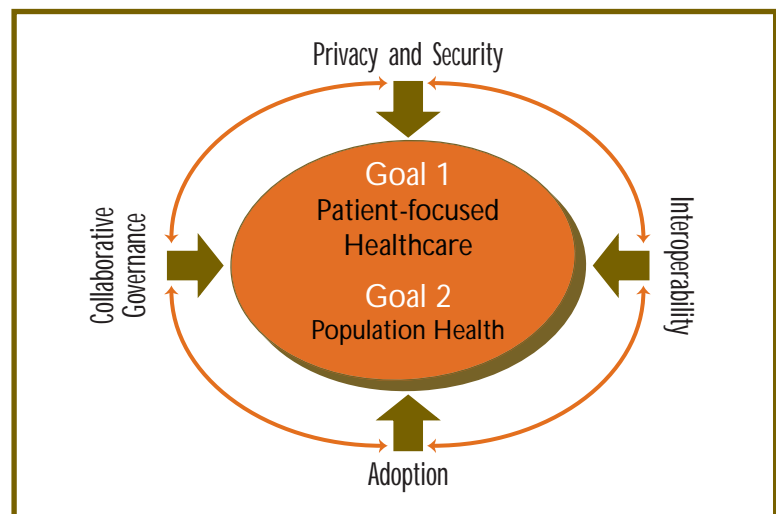
- The Centers for Medicare and Medicaid Services (CMS) is supporting incentives for HIT and HIE in areas such as pay-for-performance quality metrics, electronic prescribing adoption, and electronic medical record adoption.

- The National Governor's Association's State Alliance for e-Health has been a driving force in assisting states with developing clarity regarding multiple HIT and HIE efforts and released a report "Accelerating Progress: Using Health Information Technology and Electronic Health Information Exchange to Improve Care" (**Appendix G**).

## AT THE REGIONAL LEVEL

There are multiple HIT and HIE efforts occurring in New England. The working group has reviewed these efforts, along with other states such as Michigan and New York, as part of this process. Regional efforts vary widely in their scope, funding, and operations. They are listed here in order for the reader to have a sense of what else is occurring within our region. Additionally, as New Hampshire moves forward on executing its HIT and HIE vision and as the National Health Information Network proceeds, it will be important to understand what New Hampshire's neighbors are implementing.

- Vermont has developed a state-level organization called Vermont Information Technology Leaders (VITL) that is focusing on increasing HIT adoption and is implementing a state-wide HIE to support Vermont's Blueprint for Health. VITL has developed a resource center to assist clinicians with HIT adoption. The Legislature recently instituted a tax on health insurance claims to fund their efforts over the next five years.

- Maine has developed an HIE entity called HealthInfoNet. There is no separate HIT effort that is coordinated at the state-level. HealthInfoNet is working collaboratively with providers, employers, consumers, and the state to implement a working HIE within the next two years. Maine has chosen a repository model for their HIE. They receive minimal state funding and are primarily funded via grant monies and provider support. Their total budget is approximately $6.5M over two years.

- Massachusetts is working to implement both full EMR and HIE within three pilot communities. It is a $50M project funded by Blue Cross Blue Shield of Massachusetts. The pilots are expected to end next year. Funding beyond that point has not been determined.

- Rhode Island has developed an HIE via their Department of Public Health for clinical information sharing within their provider community. It has been accomplished with state funding and is managed jointly between the DPH and the RI Quality Institute.

## AT THE STATE LEVEL (NEW HAMPSHIRE)

Many entities in New Hampshire have made significant investments in HIT and HIE as a direct response to the need to continuously improve quality, create operational efficiencies, engage healthcare consumers, and implement innovative clinical models such as the nationally recognized Primary Care Centered Medical Homes (PCCCM). The following are key HIT and HIE efforts currently underway in the state:

- New Hampshire has a high level of electronic medical record (EMR) adoption within hospital-owned physician practices, community health centers, and some specialty practices. It is estimated that more than 65% of primary care clinicians have access to some form of EMR.

- Hospital based, integrated delivery systems and community health centers have invested significant resources to exchange clinical health information electronically (ie, lab data moving from a hospital to a health center), within their organizational environments. Dartmouth-Hitchcock has a long history of sharing patient information among its providers at its multiple operating sites and with its referring physician and affiliates.

- Hospital centric "Network Neighborhoods" like Elliot Health System are emerging to provide point to point connectivity between hospitals and non affiliated area providers (private physician practices, public health agencies, home health and hospice agencies, etc).

A Strategic Plan for Health Information Technology and Exchange

- New Hampshire was ranked in 2007 by RxHub as 14th in the nation for percentage of prescriptions filled electronically (ePrescribing). MA and RI are #1 and #2 respectively.

- New Hampshire providers and higher education institutions are preparing for the implementation of a Northern New England high-speed telecommunications network to support rural healthcare providers ($25M FCC grant to the New England Telehealth Consortium).

- The New Hampshire Telehealth Program (NHTP) has developed an assessment of the current state of telehealth programs in New Hampshire as well as future needs.

- The North Country Health Consortium in partnership with the University of New Hampshire has completed an assessment of HIE opportunities in New Hampshire's North Country.

- New Hampshire Division of Public Health Services (DPHS) engaged a consultant to evaluate the state's readiness to meet PHIN certification requirements. Based on recommendations provided by the consultant, DPHS is preparing a project plan for the implementation of CDC PHIN-compliant messaging and vocabulary services.

- Prior assessment surveys of technology adoption have been conducted in New Hampshire by the New Hampshire Hospital Association and by the University of New Hampshire. The Action Plan section of this report recommends that this prior work be updated on a bi-annual basis.

## PRIVACY AND SECURITY

Healthcare privacy and security is an extremely important topic in the deployment of HIT and development of HIE. There is existing national legislation such as HIPAA and CFR 42 Part 2, as well as state legislation that currently governs multiple aspects of privacy and security. Entities such as the U.S. Department of Health and Human Services, the U.S. Centers for Disease Control, and the National Governors Association are all working to address the implications of privacy and security in the era of electronic health information as well as to create recommendations for policy makers.

The HIT and HIE Working Group recognizes that the protection of personal healthcare information is of significant importance. It also recognizes that patient consent to have electronic information sharing among clinicians is critical to realizing the benefits to the patients and the healthcare system. The development of a common consent form and process for managing patient consent for all New Hampshire providers is an important step. There needs to be a balance between patient privacy and the ability to exchange clinical information to improve clinical quality and patient outcomes.

Finding the proper balance between protecting patient privacy and improving patient health through the timely exchange of information will require a full and open public discussion and constant vigilance.

# Action Plans

The following tables highlight a series of steps or actions to be undertaken by providers, payers, and policy makers to achieve the vision of an integrated health information system.

## Increased Health Information Technology (HIT) Adoption and Expansion

The following recommendations include technical solutions, goals for adoption, and methods/actions for achieving adoption. The items are ranked in terms of importance based upon the work of the HIT and HIE Working Group members.

### Hit Adoption and Expansion Opportunities

| RANK | TECHNOLOGY | ADOPTION GOAL[1] | METHODS/ACTIONS TO ACHIEVING GOAL |
|------|-----------|------------------|-----------------------------------|
| 1 | Electronic Medical Records (EMR) and ePrescribing (eRX) adoption | • 100% EMR adoption by 2014 for all New Hampshire providers<br>• 100% eRX adoption for New Hampshire providers by 2014 | • Development of financing mechanisms:<br> • Develop a strategy to accelerate EMR adoption, particularly among non-employed physicians by providing tax incentives<br> • Synchronize reimbursement for clinical, process, and efficiency outcomes (ie, P4P, medical home)<br> • Create a state-administered small grants program<br> • Create a state-administered technology revolving loan fund<br> • Coordinate existing financial incentives and develop new incentives from Medicare, Medicaid, and private payers<br> • State funding support for implementation of EMR at the Community Behavioral Health Centers<br>• Require CCHIT-certified EMR solutions to be adopted by providers<br>• Development of a resource center to assist providers identified in the gap analysis with selection and implementation of core technology |
| 2 | HIT and HIE Survey | • Bi-Annual Survey Process and Gap Analysis | • Conduct a baseline survey in 2009 of all healthcare providers re: EMR, eRX, telecommunications infrastructure, HIE, telemedicine, and identify adoption barriers<br>• Develop a gap analysis and a resulting plan of action |
| 3 | Portability of Patient Information | • 100% portability of patient information by 2014 | • Establish a strategy based upon provider EMRs as well as third-party Personal Health Records (PHR) providers such as Microsoft HealthVault, Google Health and Dossia<br>• Develop a consumer education and communication plan |
| 4 | Telehealth | • Provide comprehensive, coordinated telehealth services to underserved areas<br>• Incorporate telehealth into the Medical Home model | • Legislative requirement for payers to reimburse for telehealth services similar to Medicare<br>• Support a statewide telehealth program<br>• Formalize pilot programs at the state level within the Department of Corrections, the Bureau of Behavioral Health, and other key areas |
| 5 | Public Health Department Information Technology | • Compliance with PHIN Assessment by 2014<br>• Integration of the new Vital Records platform with longitudinal public health databases | • Development of integrated public health platforms at DHHS to support US CDC requirements |
| 6 | Telecommunications | • High-speed bandwidth delivered to all New Hampshire providers by 2014 | • Continued participation in New England Telehealth Consortium (FCC grant); includes development of regional healthcare network and group purchasing<br>• Establish partnerships with Fairpoint and other telecommunications providers to develop a provider needs assessment |

1. These goals tie directly to the Vision and Principles document developed in 2007.

# HEALTH INFORMATION EXCHANGE (HIE) PILOT OPTIONS

In lieu of a statewide approach to an HIE entity as described on page 6, the following table outlines a series of HIE pilot opportunities before New Hampshire's healthcare community. Some are regional and many could also be done from a state-level perspective such as a public health or Medicaid HIE. These were ranked in order of priority by the HIT and HIE Working Group although there is no preclusion for pilots working in parallel efforts.

## HIE PILOT OPPORTUNITIES

| Rank | Pilot Opportunity | Description / Core Purpose | Possible Actions to Take | Possible Funding Paths |
|---|---|---|---|---|
| 1 | Local Network Neighborhood Expansion | • Expansion of existing Network Neighborhoods in communities such as are beginning in Plymouth, Manchester, and the Seacoast | • Use the planning grant opportunities in Plymouth (Mid-State Health) and the Seacoast (CHAN) to seek HIE platform technologies<br>• Expand other, existing Network Neighborhoods, including those in competitive environments | • Provider sponsored<br>• Federal grant funding |
| 2 (tie) | Statewide Patient Portal | • Development of a free-standing patient portal (ie, not tethered to a provider or a health plan) that would serve the needs of all New Hampshire citizens<br>• Data would be populated at the request / control of the patient | • Enter discussions with leading Personal Health Record vendors to determine feasibility of such a strategy<br>• Engage consumers, employers, and providers in the strategy | • New Hampshire Citizens Health Initiative to underwrite feasibility strategy with its funding partners<br>• Funding for implementation TBD |
| 2 (tie) | Payer | • Development of a multi-payer database of clinical information to support chronic care management programs and patient identification efforts | • Develop a ROI study to quantify cost savings from reductions in medical expenditures. Utilize study to develop a Return on Investment (ROI) for network neighborhood HIE expenditures. | • Payers<br>• State (if state wanted to treat this as a public health or Medicaid initiative) |
| 3 | North Country Region | • HIE, EMR-Lite, and PHR Technology<br>• Serving CAHs, CHCs, Nursing Homes, and Home Health Agencies | • Develop business plan and RFP for vendor services based upon initial North Country survey process | • North Country Health Consortium to act as grant writer to HRSA and other sources<br>• Consortium members |
| 4 | Internal Hospital Exchange | • Improve interoperability of internal hospital systems (lab, ER, PACS, IP clinical, OP EMR) to prepare for cross-community connectivity<br>• Improve access to data in the ER setting | • Cost Benefit Analysis of internal effort vs. external HIE opportunity<br>• Evaluate use of patient portals and opportunity to develop a common approach across hospital systems<br>• Understand hospital systems clinical data priorities (included in the HIT and HIE gap analysis) | • Individual providers |
| 5 | Public Health | • System consolidation to support PHIN analysis<br>• Focus on syndromic surveillance, chronic care surveillance, and registry consolidation<br>• Expansion of AHEDD platform<br>• Ensure support for population health needs<br>• Ensure effectiveness of quality measurement programs | • Evaluate current public health data collection efforts/requirements and match with the state's priorities for population health<br>• Develop RFP for vendor services based upon PHIN analysis and certification<br>• Audit current quality measurement projects and match with current data availability to prioritize areas of focus<br>• Develop strategies to address chronic care condition management | • CDC<br>• State of New Hampshire |

# STATE-LEVEL SUCCESSOR GROUP

HIT and HIE is a complex subject requiring ongoing support and the HIT HIE Working Group fully understands that not all questions were answered by this report, and that more time is needed to fully refine the strategy and develop a complete implementation plan to support the recommendations herein. This work will require that one or more Successor Group(s) be created and it is suggested that a public-private partnership model be adopted.

The HIT HIE Working Group recommends that the work to be conducted in response to this report be broken into two phases. Phase 1 will hold responsibility for ensuring that a statewide provider technology survey and gap analysis be completed in order to drive the efforts of Phase 2. Phase 2 will hold responsibility for the following functions:

1. Convene stakeholders bi-monthly to set goals, establish priorities, and encourage cooperation and coordination, and measure and report progress.

2. Develop a road map to be presented bi-annually to the Governor, the Legislature, and the healthcare industry that is based upon the following actions:

    a. Completion of a survey of healthcare provider technology adoption and conduct a gap analysis report to identify progress and areas where continued technological deployment is required.

    b. Identification of barriers to HIT and HIE adoption based upon an environmental scan at the state, regional, and national levels, as well as the aforementioned survey and gap analysis.

    c. Creation of a set of recommendations for market and policy options to support HIT and HIE adoption.

3. Identify nationally recognized interoperability standards for HIT and HIE and promote said standards within the New Hampshire healthcare community (ie, HITSP, CCHIT, HL7).

4. Provide recommendations to policy makers on privacy and security that take into account local and national privacy and security efforts.

5. Develop and provide oversight for an HIT and HIE Resource Center that would conduct the following functions:

    a. Provide a website for providers to enable the sharing of best practices for HIT and HIE as well as information about resources available to New Hampshire providers.

    b. Provide a learning network for providers to transfer knowledge and streamline clinical and business processes.

    c. Provide an ongoing consumer and public education function in collaboration with other consumer and provider organizations.

    d. Coordinate with regional and national HIT and HIE efforts as appropriate.

6. Closely monitor the portion of the National Economic Stimulation Package that specifically addresses federal investments in HIT and HIE, and be prepared to shape a timely and effective plan for uses of those funds in New Hampshire, as well as any other Federal funds or incentives that may be available.

To achieve these functions, the Successor Group should be convened by the Office of the Commissioner of the New Hampshire Department of Health and Human Services and meet bi-monthly. It is recommended that the Successor Group be comprised of no more than fifteen (15) knowledgeable and energetic members with some familiarity of the work of past work groups and national and regional HIT and HIE activities. As the Successor Group's goal is to provide tools to transform the state's healthcare industry, there needs to be adequate representation from appropriate stakeholders including the following interests: Governor's

Office, New Hampshire Administrative Services (State Employee Health Plan), Consumers, Employers, Providers, Insurers, and the New Hampshire Citizens Health Initiative.

## POLICY RECOMMENDATIONS

The HIT and HIE Working Group debated at length whether this report should include specific policy recommendations beyond those of establishing the Successor Group. While numerous policy ideas were discussed and debated, there was not sufficient time or consensus to make specific recommendations. It was decided that further research and discussion of each would be required. With further development of the issues, future policy actions could accomplish the following:

1. **Authorize or require an activity** (i.e., requirement to develop a common consent to share information process for provider adoption; requirement of insurers to reimburse providers for telehealth services);

2. **Remove barriers or enable a specific function** (i.e., enabling legislation for a future statewide or regional HIE);

3. **Create a funding mechanism** (i.e., an assessment on health insurance claims to fund HIT and HIE activities including a resource center).

In addition to policy actions (legislation, Executive Orders, NH DHHS policies, and State Employee Health Plan purchasing policies), it is important to note that voluntary market actions (vision and missions statements, objectives, and operating principles) can also be taken that would harmonize with any possible policy actions.

## SUMMATION

While much has been accomplished by individual and group practitioners, hospital systems and ancillary healthcare providers to acquire, implement and share HIT and information at the point of care, there is no statewide view or consensus on how to interconnect these systems to provide for the electronic flow of patient information from an individual provider, practice, or system to another. There are significant gaps in the level of information technology adoption among providers based on size, location and financial capacity. There is a consensus in the industry that we must advance HIT and HIE in the most effective and efficient manner possible.

The cost and effort associated with raising all practitioners and providers to an acceptable level of HIT adoption and then creating a network of electronic connectivity is significant and there are many barriers and impediments to be overcome. However, the long-term benefits to the citizens of New Hampshire that result from improved quality of care, reduced medical errors, improved communication and consultation among practitioners, reduced duplication of tests, enhanced office and work flow efficiencies, increased access by patients to their medical records, and increased participation by patients in the care and management of their health far outweigh the cost of the investment.

If we truly hope to shape a system of healthcare for our citizens that is patient focused, efficient, cost effective, accessible and provides high quality and superior outcomes, we must make the collective effort to develop, acquire and implement a system of information technology and exchange that is visionary, robust and adaptive to change.

This effort will take the combined resources of federal, state and local government working in partnership with healthcare providers, payors and patients to make the investments necessary to achieve the vision.

# Appendices

Click on link below for each appendix:

A. Executive Order 2008–06

B. Vision and Principles

C. Study of Patient Movement

D. New Hampshire Telehealth Program White Paper

E. NH DHHS DPH PHIN Analysis Report

F. ONC-Coordinated Federal Health Information Technology Strategic Plan 2008–2012 Executive Summary

G. Accelerating Progress First Annual Report and Recommendations From the State Alliance for e-Health

H. Definitions/Glossary

# E-Prescribing Work Group
# Report and Recommendations
**May 29, 2009**

## Charge

- Determining the current status of e-prescribing, from both the prescriber and dispensing pharmacy point of view.
- Identifying barriers to e-prescribing.
- Study the start up and sustainability costs (e.g., hardware, software, and training costs), and potential sources of resources to support the essential needs of pharmacies in the state of Nebraska to participate and support e-prescribing.
- Making recommendations to promote the adoption of e-prescribing by all parties involved in the e-prescribing process.
- Identifying and disseminating best practices.

## Background

### Current status of e-prescribing

The use of e-prescribing grew significantly in the United States and Nebraska in 2008.  However, e-prescriptions still constitutes only a small percentage of new prescriptions and renewals.  Surescripts' 2008 *National Progress Report* (available at www.surescripts.com) found:

- By the end of 2008, there were 74,000 active prescribers (or 12.1% of all office-based prescribers), up from 36,000 at the end of 2007 and 16,000 in 2006.

- Nationwide, prescriptions routed electronically grew to 68 million (or 4% of eligible prescriptions) in 2008, up from 29 million (or 2% of eligible prescriptions) in 2007.  In 2007 in Nebraska, 0.48% of all eligible prescriptions were e-prescribed.  Eligible prescriptions do not include prescriptions for controlled substances and pre-authorized refills on existing prescriptions.

- By the end of 2008, increased participation by payers in e-prescribing enabled access to prescription benefit and history information for 65 percent of patients in the U.S.

- In Nebraska, approximately 61% of pharmacies accept e-prescriptions.  Approximately 82% of chain or other corporate owned pharmacies accept e-prescriptions.  Approximately 38% of independently owned pharmacies accept e-prescriptions (data from Surescripts website, accessed April 28, 2009).

A survey of 612 Nebraska physicians carried out by the Creighton Health Services Research Program and the Nebraska Medical Association in March 2008 (*Status of Health Information Technology in Nebraska* available at www.chrp.creighton.edu) found:

- 8.7% of respondent physicians report they e-prescribe; of these, 59% report daily use of e-prescribing.

- Of 53 respondent physicians who e-prescribe, a very large proportion still report using the following traditional methods to generate and deliver prescriptions to pharmacies:

    - 85.5% report patients taking handwritten prescription to the pharmacy;
    - 89.9% report telephoning prescriptions to the pharmacy;
    - 89.9% report faxing prescriptions faxed to the pharmacy.

- Physician attitude about the accuracy and completeness of e-prescriptions was positive to uncertain.

- Physician attitude about the efficiency of e-prescribing was mainly uncertain, but leaning negative.

## Barriers to E-Prescribing

**Costs.**  For both pharmacies and physicians, costs are a significant barrier to e-prescribing.

Pharmacies

**Transaction fees ($0.20 - $0.35 per transaction).**  Refills are free, so the transaction cost for prescriptions with multiple refills can be amortized over multiple dispensings.  As the number of e-prescriptions grows, the cost per transaction may eventually be reduced. Transaction fees are charged by the pharmacy's software vendor.  However, pharmacists argue that traditional methods of prescription generation and delivery have zero transaction fees for initial prescription fills and refill.  Approximately half of the transaction fee goes to Surescripts, the intermediary e-prescribing network developed by the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists Association (NCPA).  SureScripts merged with RxHub, a network founded by the nation's three largest PBMs.

**Software fees.**  Costs incurred by pharmacies include one time start-up fees to software vendor (~ $500) and monthly charges to software vendor ($30+ per month).  Surescripts reports there are 35 – 40 e-prescribing packages available for pharmacies.

**Additional optional fees.**  Viewing patient information through NeHII or another health information exchange may involve additional fees.

Fees mentioned above that are charged to pharmacies do not include costs incurred for pharmacy management software systems.

Physicians

**E-prescribing software.**  Surescripts reports there are approximately 350 e-prescribing systems available for physicians.  Examples include:

- A free stand-alone e-prescribing system is available through the National e-Prescribing Patient Safety Initiative (NEPSI).

- Through NeHII, physicians can subscribe to a bundle of services which include e-prescribing, an EMR lite, virtual health record, and the ability to push information to other providers for just over $50 a month.  Lower cost options are also available through NeHII.

- Full electronic medical record systems which integrate e-prescribing can cost from $25,000 to over $100,000 per physician.

- Sam's Club has begun offering electronic medical record systems for $25,000 per physician, and $10,000 per additional physician.

**Medicare Incentives.**  Costs for many physicians may be partially offset by Medicare incentives for e-prescribing.

- Physicians may be eligible to receive incentive payments on office fees charged for their Medicare Part B who are also enrolled in a Medicare Part D Prescription Drug Plan.

- Bonus incentives for Medicare Part B patients only are:

  o 2009 – 2010:  2%
  o 2011 – 2012:  1%

- Penalties for not adopting e-prescribing (Medicare Part B patients only):

  o 2012:  -1%
  o 2013:  -1.5%
  o 2014 and beyond:  -2%

- Estimates of incentive payments resulting from e-prescribing for Medicare Part B patients are in the $1,500-$1,600 range per physician per year during 2009 – 2010.

- Additional incentives of up to $44,000 will be available to qualifying physicians for "meaningful use" of full electronic medical record systems beginning in 2011.

**Changes to Work Processes.**  E-prescribing requires both physicians and pharmacists to make changes in their work processes, which can temporarily reduce productivity for some, cause others to return to traditional means of prescribing, and prevent others from adopting the technology.

**Controlled Substances:**  The DEA currently prohibits electronic transmission of controlled substances.  Consequently, physicians and pharmacies must maintain dual processes. Physicians are still required to write prescriptions for controlled substances.  This is can be a major work flow impediment in the physician's office.  Consequently, this can be part of the rationale that physician's use for not converting to e-prescribing.  Pharmacies must maintain a dual prescription filing systems - paper for controlled substances and electronic for all other prescriptions.   Dual filing systems for pharmacies can result in impediments to efficient work flow.

**Education, Training, and Prior Negative Experiences.**  Another barrier is a lack of education, training, and knowledge of the e-prescribing process.  Adequate training can reduce errors and frustration.  Discussions between pharmacists, physicians, and physician staff can improve understanding of the e-prescribing process and identify ways to improve the process.  Past negative experiences with e-prescribing can also be a barrier.

**Standards.**  Although much progress has been made in developing standards for e-prescribing and certifying e-prescribing systems, further development is needed in order to reduce e-prescribing errors.  The Certification Commission for Health IT (CCHIT) will begin certifying stand alone e-prescribing systems in 2009.  Additional criteria will be incorporated into the

certification process in 2010 and beyond.  Electronic medical record certification by CCHIT includes many e-prescribing functions.  Surescripts certifies both e-prescribing systems for physicians and pharmacy systems.  The Healthcare Information Technology Standards Panel (HITSP) has developed a number of standards for e-prescribing.

## Errors

E-prescribing is reducing some types of medication errors, but may not eliminate all sources of errors.  E-prescribing errors include but are not limited to:  1) wrong patient; 2) wrong drug; 3) wrong strength; and 4) wrong directions.  These errors have resulted in some pharmacists turning off the e-prescribing software function.   An informal survey of Nebraska pharmacists conducted by the Nebraska Pharmacists Association found that 75% of those responding currently use e-prescribing in some form, and that 65% of those responding that use e-prescribing experienced errors.   Sources of errors identified included software functionality, untrained personnel in physician offices using the system, input errors by physicians, not being able to request refills via e-prescribing software, and system communication errors.  A 2008 report from the Creighton Health Services Research Program funded through a Dyke Anderson Patient Safety Grant from the Nebraska State Board of Pharmacy (available at http://chrp.creighton.edu/) found that pharmacists reported both a reduction in some types of errors and new sources of errors due to e-prescribing.  Pharmacists reported that e-prescribing reduced legibility problems and provided more accurate and complete information.  New sources of errors included inaccurate information provided, system incompatibilities, and errors due to wrong drop down menu selections.  It is believed that some of these new types of errors are due to incompatibilities that exist between physician e-prescribing software and pharmacy dispensing software.

## Role of Intermediaries

The role and value of intermediaries generated considerable debate within the E-Prescribing Work Group.  The discussion brought attention to the concerns of independent pharmacists over transaction costs and e-prescribing errors due to incompatibilities that exist between physician e-prescribing software and pharmacy dispensing software.  The Nebraska Pharmacists Association (NPA) is opposed to the mandatory use of intermediaries or switches to facilitate e-prescription transactions.  The NPA believes the use of switches requires pharmacies to bear unnecessary e-prescription transmission costs.  The NPA recommends direct communication between prescriber and pharmacy to lower the cost of e-prescribing.  The NPA's position on intermediaries is in opposition to the positions of several national organizations.  The National Association of Chain Drug Stores (NACDS), National Council for Prescription Drug Programs (NCDPD), Surescripts, and eRx Network submitted comments supporting the use of intermediaries.  The majority of the members of the E-Prescribing Work Group had questions about the risks and complexity of establishing direct connections between pharmacies and prescribers.

4

# Recommendations

- Pharmacists, physicians, and the general public should be educated about the potential impact of e-prescribing with regard to:
    - Patient Safety – both recognized safety improvements and the newly emerging errors associated with the adoption of this technology;
    - Workplace efficiency in the pharmacy and physician's office – both improved efficiencies realized and new inefficiencies introduced in the local workplace context;
    - Workflow issues related to the migration of e-prescribing;
    - Costs to pharmacists and physicians of implementing e-prescribing.

- Training and education of physicians and pharmacists by professional associations, institutes of higher education and other venues about the proper use of e-prescribing technologies and processes in daily practice in order to reduce e-prescribing errors and optimize patient care quality should be encouraged.

- Pharmacist access to patient information should be encouraged either through NeHII or other health information exchanges.

- A forum to initiate a dialog among physicians, physician staff, pharmacists, vendors, and intermediaries on the e-prescribing process, costs involved, potential sources of errors, and best practices should be convened.

- The State of Nebraska should seek ways to provide resource support for participation in e-prescribing to independent pharmacies.

- Physicians should be provided information on incentive programs which support participation in e-prescribing and/or the implementation of EMRs.

- The integration of e-prescribing with the use of EMRs in physician offices should be encouraged.  Although stand-alone e-prescribing systems can be used effectively, research has shown that integration of e-prescribing with an EMR system often leads to greater improvements in quality of care.

- The eHealth Council should establish a sustainable mechanism to identify and disseminate best practices related to patient safety and quality improvement in e-prescribing.

- The eHealth Council and other stakeholders should work together to identify sources of e-prescribing errors and to address those sources.

- The State of Nebraska and other stakeholders should support efforts to remove regulatory obstacles related to the e-prescribing of controlled substances.

- Stakeholders in Nebraska and in the United States should encourage further development of e-prescribing standards to reduce errors.  This should include standards that require compatibility between prescribing software and pharmacy dispensing software.

- The State of Nebraska should explore connecting Nebraska's Medicaid program through its pharmacy benefit manager to Surescripts to provide benefit and prescription history information.

## Actions

- The Nebraska Medical Association and the Nebraska Pharmacists Association are tentatively planning an initial forum to discuss issues related to e-prescribing in June.

- The Nebraska Pharmacists Association will promote the use of the Pharmacy E-Prescribing Experience Reporting Portal (PEER Portal) at www.pqc.net/eprescribe to report e-prescribing errors.

- The eHealth Council and the e-Prescribing Work Group identified a potential barrier to e-prescribing in a Nebraska statute that requires pharmacists to keep paper copies of prescriptions.   The Nebraska Pharmacists Association worked to have legislation introduced which would allow pharmacists to keep copies of prescriptions in a readily retrievable format.   Lt. Governor Sheehy provided a letter supporting the provision in LB 220 to the Health and Human Services Committee.  LB 220 was amended into LB 195 and was passed by the Legislature and presented to the Governor on May 18.

## Members

- Mark Siracuse, E-Prescribing Work Group Chair, Creighton University
- Wende Baker, Southeast Nebraska Behavioral Health Information Network
- Deb Bass, Bass and Associates
- Joyce Beck, Thayer County Health System and Southeast Nebraska Health Information Exchange
- Kevin Borcher, Nebraska Methodist Health System & Nebraska State Board of Pharmacy
- Anne Byers, Nebraska Information Technology Commission
- Gary Cochran, UNMC
- Kevin Conway, Nebraska Hospital Association
- Joni Cover, Nebraska Pharmacists Association
- Eric Gall, RP
- Kimberly Galt, Creighton University
- Dave Glover, Family Practice Associates, Kearney
- Chris Henkenius, Bass and Associates
- Tony Kopf, Nebraska State Board of Pharmacy
- David Lawton, Nebraska Department of Health and Human Services
- Dale Mahlman, Nebraska Medical Association
- Marcia Mueting, Nebraska Pharmacists Association
- Carey Potter, National Association of Chain Drug Stores
- September Stone, Nebraska Health Care Association
- Clint Williams, Blue Cross and Blue Shield of Nebraska (also representing NeHII)

# Health Information Exchange Vision and Strategies
**Draft—May 27, 2009**

## Vision

**Stakeholders in Nebraska will cooperatively improve the quality of and efficiency of health care through a statewide, seamless, integrated patient-centered system of connected health information exchanges.**   Nebraska will build upon the investments made in the state's health information exchanges and other initiatives which promote the adoption of health IT.

## Strategies

**The State of Nebraska will support the development and expansion of health information exchanges to improve the quality and efficiency of care.**

**Actions:**

- The State of Nebraska, primarily through the NITC's eHealth Council, will support efforts to obtain funding for health information exchange, including coordinating and submitting applications for funding as appropriate.

- The eHealth Council will work with other stakeholders to publicize health IT success stories within the state and to inform stakeholders of the benefits of health IT.  Physicians in particular have been identified as key drivers in the adoption of health IT and health information exchange and should be targeted in educational efforts.

- The State of Nebraska will leverage its role as a payer in incentivizing the meaningful use of health IT by participating in the Medicaid Incentive program offered through the Recovery Act.

- The State of Nebraska will continue to address state laws which impact the exchange of health information within Nebraska and across state borders.

    The Legal Work Group of the Nebraska Health Information Security and Privacy Committee (HISPC) reviewed Nebraska's health information disclosure laws to identify laws more stringent than HIPAA.  Neb. Rev. Stat. 71-8403 stipulates that authorizations for release of medical records are valid for a maximum period of 180 days. The group recommended deleting the 180-day limit. HIPAA requirements would then apply, allowing patients to state an expiration date or expiration event.

    The eHealth Council and E-Prescribing Work Group also identified a potential barrier to e-prescribing in a Nebraska statute that requires pharmacists to keep paper copies of prescriptions. A change to this statute which would allow pharmacists to keep copies of prescriptions in a readily retrievable format was included in LB220.

**The State of Nebraska will support the development of interconnections among health information exchanges in the state and across state borders.**

**Actions:**

- The eHealth Council will work with the state's health information exchanges to determine requirements for connections among exchanges; to explore options including connecting through NeHII or through NHIN's open source Connect software; to issue an RFP;  and to evaluate proposals.

o   The eHealth Council will work with the state's health information exchanges to map the adoption of standards which would enable the integration of data from disparate sources into EMRs.  The migration to HL7 version 3 has been identified as a potential strategy.

o   The eHealth Council will continue to work with the state's health information exchanges to harmonize policies and procedures which impact the sharing of health information across exchanges.  The State of Nebraska and the state's health information exchanges have already made progress in this area.  The state's health information exchanges have shared policies and procedures.  Additionally, Nebraska participated in the national Health Information Security and Privacy Collaborative's Adoption of Standard Policies group which examined business practices related to authentication and authorization.

Additional Comments:

Encourage education and training in health IT, health information exchange, and EHRs.

Identify specific, measurable quality goals.

# e-Health Public Health Workgroup
## Charge and Membership
### Revised March 25, 2009

## Charge

**Time-Frame**: Begin ASAP, meet bi-monthly or monthly for, perhaps, 6 months, or as required to accomplish the mission.

Overarching goal is to position Public Health for e-Health development so that all key stakeholders can:
   (1) plan, act, and collaborate strategically and
   (2) communicate efficiently, effectively, and in a timely manner so as to
   (3) act in concert with local, state, and national public health and e-Health developments.

To accomplish this goal, we will:

1. Develop a shared vision for the integrated and secure exchange of public health data among public health entities, health information exchanges, personal health record systems, and private providers.

2. Gain a better understanding of public health information systems and health information exchanges in Nebraska, personal health record systems, electronic medical record systems, and how these systems could interact.

3. Identify and prioritize opportunities for exchanging public health data among public health entities, health information exchanges, personal health record systems, and private providers.

4. Identify barriers to the exchange of public health information. Prioritize barriers into several categories, those that are outside state control, those that may be affected by state initiatives, and those that can be addressed locally. Use this prioritization to develop next steps (see #5 below).

5. Recommend next steps for achieving the integrated and secure exchange of public health data among public health entities, health information exchanges, personal health record systems, and private providers.

6. Recommend a process for continuing development of the integrated and secure exchange of public health data among public health entities, health information exchanges, personal health record systems, and private providers.

**Membership**

**Nebraska Department of Health and Human Services**
- o Public Health Informatics & Biosecurity--David Lawton
- o Administration--Dr. JoAnn Schaefer
- o Public Health Data--Dave Palm and Colleen Svoboda (alternate)
- o Immunization Registry--Michelle Hood
- o Epidemiology--Tom Safranek
- o EMS—Doug Fuller
- o Licensure—Helen Meeks  and Joann Erickson (alternate)
- o Vital Stats—Stan Cooper or Mark Miller

**Local Health Departments or Districts**
- o Douglas County Health Department— Anne O'Keefe
- o Lincoln-Lancaster County Health Department—Bruce Dart and Kathy Cook (alternate)
- o Nebraska SACCO/Two Rivers Public Health Department—Terry Krohn
- o Three Rivers Public Health Department--Jeff Kuhr

**Health Information Organizations**
- o NeHII (Nebraska Health Information Initiative)—Kevin Conway
- o SNBHIN (Southeast Nebraska Behavioral Health Information Network)--Wende Baker
- o WNHIE (Western Nebraska Health Information Exchange)--Kim Engel and Kim Woods (alternate)

**UNMC College of Public Health**
- o Chair: Keith Mueller and Li-Wu Chen (alternate)

**Other Key e-Health Public Health Entities with Decision-making Authority**
- o Public Health Association of Nebraska--Rita Parris

**Providers and Provider Associations**
- o Nebraska Health Information Management Association—Kim Hazelton
- o Douglas County Community Mental Health Center—John Sheehan
- o UNMC—Dr. James Campbell

**NITC Staff**
- o Anne Byers

## Q: What is eHealth in New York?

**A:** eHealth is the use of a computer network, instead of paper, to store and manage your medical records. eHealth is also sometimes called "health information technology." In eHealth networks, you can make information about your health available electronically to doctors and other care providers you choose, which can help you get better care.

New York is rolling out a statewide eHealth network called the SHIN-NY (Statewide Health Information Network for New York) to improve the quality and safety of health care for New Yorkers.

The SHIN-NY is made up of smaller networks called RHIOs (Regional Health Information Organizations). RHIOs get and share information about patients from such places as hospitals, physicians, pharmacies, clinical laboratories, health insurers, and the Medicaid program.

## Q: What can eHealth do for me?

**A:** eHealth can help pave the way for safer, more convenient health care.

Medical records are reports about your illnesses, injuries, medicines and/or test results. If you've changed doctors, seen a specialist, visited a clinic, or checked into a hospital, your records are likely on paper and in different places. This makes it hard to get a complete picture of your health. eHealth can help to solve that problem for New Yorkers.

## Here's how eHealth can help you:

- When your records are easily available in one place on a computer, your doctors can get a more complete picture of your health, which helps them to make good decisions about your care.

- Your information is safe in a system that can only be used by the people who are caring for you, and only with your consent.

- Information that could save your life in a medical emergency is easy to get to in a hurry.

- You can skip wasteful and sometimes risky duplicate medical tests.

- You won't always have to fill out the same forms every time you visit a doctor, clinic, or a hospital.

- Backups of your records are made so they will still be available in the event of an emergency or natural disaster.

- You can better manage health records for yourself and your family.

## Q: Do I have a choice about eHealth?

**A:** Yes. You have the right to say "YES" or "NO" to participating in eHealth. Doctors and others involved in your care may see and share your health information through New York's eHealth network only if you say they can by giving your consent. Sharing your medical information using eHealth cannot happen unless you sign a consent form.

For most people, the potential benefits of eHealth outweigh the risks, but every person is free to make the choice that is right for him or her.

## ABOUT YOUR PRIVACY

Many people are worried about privacy and security when it comes to eHealth. Information can never be completely secure. This is true whether it's on paper or in a computer. But New York State is doing everything it can to make eHealth private and secure:

- Federal and state laws strictly protect the privacy and confidentiality of health information about you. New York State is requiring eHealth networks and everyone who uses them to follow the same rules to protect the privacy and security of records shared through this system.

- Only the people (such as doctors, nurses, and their staff) who are involved in your health care are allowed to access your health records using eHealth, and only if you sign a consent form. Others, such as employers and immigration agencies, won't have access to your information.

- Safeguards like passwords and other protections keep your records from being accessed without proper permission.

- You can request a list of everyone who has accessed your records using eHealth.

- If improper access does occur, you will be told, and New York State will make sure steps are taken to correct the problem so it won't happen again.

## Q: Can I get access to my own medical records through eHealth?

**A:** By law you already have the right to get a copy of your medical records from the healthcare organizations that made them. Some doctors, hospitals, and other healthcare organizations in New York can give you access to your medical records online or on a computer, not just on paper – but not all of them have that capability today. New York State is working to make it possible for everyone to get access to their medical records through eHealth networks.

In addition, many public and private organizations are developing eHealth tools that you may be able to use to keep and share your health information on a computer.

## Q: Where can I get more information about eHealth in New York?

**A:** **www.ehealth4ny.org**
A web site developed for the public by the Legal Action Center

**www.health.state.ny.us/technology**
The New York State Department of Health's Office of Health Information Technology Transformation

**www.nyehealth.org**
The New York eHealth Collaborative

Or call:

**877-690-2211**

ehealth4ny

## www.ehealth4ny.org

State of New York

Department of Health

# Better Information means Better Care

## A guide to eHealth for New Yorkers

# The Nebraska Coalition for Patient Safety (NCPS)

- Analyzes reported patient safety events
- Ensures compliance with the Patient Safety Improvement Act
- Shares critical alerts and notifications from national quality and safety organizations
- Communicates and promotes evidence-based best practices
- Establishes benchmark goals for statewide quality initiatives
- Partners with other Nebraska patient safety and quality organizations to avoid duplication of efforts
- Conducts educational seminars

To learn more about patient safety initiatives, visit:

- www.nhanet.org
- www.nebmed.org
- www.npharm.org
- www.nebraskapa.org
- www.nursingworld.org/cmas/ne

## Nebraska Coalition for Patient Safety

*Improving the safety and quality of health care delivery in Nebraska*

NEBRASKA ACADEMY OF PHYSICIAN ASSISTANTS

NEBRASKA MEDICAL ASSOCIATION

INNA NEBRASKA NURSES ASSOCIATION

NHA Nebraska Hospital Association
The influential voice of Nebraska's hospitals

NPA Nebraska Pharmacists Association

## Overview

In 2005, the Nebraska State Legislature passed the Patient Safety Improvement Act. The purpose of the Act is to create a learning environment for health care providers and to foster a culture of quality. The Act calls for the formation of a patient safety organization, the Nebraska Coalition for Patient Safety (NCPS). The ultimate goal is to work together, learning from each other to consistently deliver high quality health care. The Patient Safety Improvement Act does this by establishing a reporting structure for adverse health events and/or "near misses", protecting the information reported to it from discovery, and sharing information designed to improve health care delivery systems and reduce the incidence of adverse health events.

The Nebraska Coalition for Patient Safety is comprised of organizations that are committed to achieving excellence in health care delivery. The founding organizations are the Nebraska Academy of Physician Assistants, the Nebraska Hospital Association, the Nebraska Medical Association, the Nebraska Nurses Association, and the Nebraska Pharmacists Association.

## Board of Directors

The members of the NCPS Board of Directors are:

· Steve Smith, MD, The Nebraska Medical Center, Omaha – President of the Board

· Robert Driewer, CEO, Faith Regional Health Services, Norfolk – Vice President

· Patty Scholting, PA-C, Oakview Internal Medicine PC, Omaha – Secretary

· Edward DeSimone, II, RPh, PhD, Creighton University, Omaha – Treasurer

· Celine Mlady, CEO, Osmond General Hospital, Osmond

· Robert McQuillan, MD, Creighton University, Omaha

· Robert Billerbeck, MD, Good Samaritan Hospital, Kearney

· Darwin Brown, MPH, PA-C, The Nebraska Medical Center, Omaha

· Angie Svoboda, PharmD, RPh, Good Life Discount Pharmacy, Ord

· Carol Kampschnieder, RN, MSN, St. Francis Memorial Hospital, West Point

· Ernestine Olson, APRN-BC, Mitchell Medical Center, Mitchell

· Katherine Jones, PhD – consumer member

· Karen Peppmuller, CPA – consumer member

· Monica Seeland, RHIA, Nebraska Hospital Association (NHA) – staff to the Board

## Responsibilities

The NCPS is responsible for analyzing reported patient safety events and ensuring compliance with the Patient Safety Improvement Act. Once the federal regulations are finalized, the Coalition will apply to serve as the state's patient safety organization for federal reporting purposes.

The NCPS facilitates a learning environment within health care by sharing critical alerts and notifications from national quality and safety organizations, such as the Joint Commission on Accreditation of Healthcare Organizations, the Institute for Safe Medication Practices and the National Patient Safety Foundation. The Coalition communicates and promotes evidence-based best practices, establishes benchmark goals for statewide quality initiatives, and partners with other Nebraska patient safety and quality organizations to avoid duplication of efforts and enhance the effectiveness of current initiatives. The NCPS conducts educational seminars, both regionally and statewide, for quality and patient safety.

To learn more about patient safety and quality, please visit any of the Web sites listed on the next panel.